TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 27, 2020 – 3:30 o'clock p.m.

REVISED TO REFLECT NEW DIAL IN INFORMATION ONLY

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: 957 2270 6736; Passcode: 776106

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	July 2020 Financial Statement Results	10 min.	CFO
6	New Business – None		
7	Old Business - None	--	--
8	Chief of Staff a) August 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on August 24, 2020 b) Rules & Regulations	5 min.	COS

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
	1) Department of Emergency Medicine c) Privilege Card 1) Urology d) Categories of AHP's Eligible to Apply for Clinical Privileges ***FOR INFORMATION ONLY*** e) July 2020 Credentialing Actions and Reappointments Involving the Medical Staff and Allied health Professionals as recommended by the Medical Executive Committee on July 27, 2020. *(Information only)* f) Rules & Regulations – *Information Only* 1) Department of Medicine 2) Division of General Vascular Surgery g) Privilege Card – *Information Only* 1) General & Vascular Surgery Privilege Card		
9	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Consideration to approve the addition of Dr. Kevin Garff to the currently existing ED On Call Coverage Panel for Ophthalmology for a term of 23 months, beginning August 1, 2020 through June 30, 2022. (2) Consideration to approve the addition of Dr. Leticia Campbell to the currently existing ED On-Call Coverage Panel for OB-GYN for a term of 23 months, beginning August 1, 2020 through June 30, 2022. (3) Consideration to approve the addition of Dr. Yuan Hwang Lin to the currently existing ED On-Call Coverage Panel for Cardio-Thoracic Surgery for a term of 24 months, beginning September 1, 2020 through August 31, 2022. (4) Consideration to approve the addition of Dr. Kristen Blaker to the currently existing ED On Call Coverage Panel for General Surgery for a term of 12 months, beginning August 1, 2020 through July 31, 2021. (5) Consideration to approve the addition of Dr. Darrell Wu to the currently existing ED On-Call Coverage Panel for Cardio-Thoracic Surgery for a term of 24 months, beginning September 1, 2020 through August 31, 2021. (6) Consideration to approve the addition of Dr. Morgan Silldorff to the currently existing ED On-Call Coverage Panel for Orthopedics for a term of 21 months, beginning October 1, 2020 through June 30, 2022. (7) Consideration to approve the addition of Dr. Hellen Chiao to the currently existing ED On-Call Coverage Panel for Gastroenterology-General & ERCP for a term of 21 months, beginning October 1, 2020 through June 30, 2022. (8) Consideration to approve the addition of Dr. Richard Liu to the currently existing ED On-Call Coverage Panel for ENT-Otolaryngology for a term of 12 months, beginning August 1, 2020 through July 31, 2021.	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

(9) Consideration to approve the addition of Dr. Aaron Yung to the currently existing ED On-Call Coverage Panel for Cardiology-General for a term of 22 months, beginning September 1, 2020 through June 30, 2022.

(10) Consideration to approve the addition of Dr. Aaron Yung to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 22 months, beginning September 1, 2020 and ending June 30, 2022.

(11) Consideration to approve the addition of Dr. Hanh Bui to the currently existing ED On-Call Coverage Panel for Cardiology-General for a term of 22 months, beginning September 1, 2020 through June 30, 2022.

(12) Consideration to approve an agreement with San Diego Imaging Medical Group to provide radiological services supervision and medical directorship coverage for a term of 36 months beginning July 1, 2020 through June 30, 2023 for an annual and term cost of $0.

(13) Administrative & Board Committees

A. Policies (July, 2020)

1) Patient Care Services Policies & Procedures

a) 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy
b) Abduction Shoulder Splint (Airplane Splint, Don Joy Ultra Sling and ARC Shoulder Brace) Procedure (DELETE)
c) Abduction Splint Application (Hip) Procedure
d) Assault Victims/Domestic Violence, Reporting Requirements
e) Food and Nutrition Relationships with Other Departments Policy
f) Immediate Use Sterilization, Intraoperative
g) Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure
h) Lift Team Policy
i) Missing Patient
j) Nutrition Education of Patients Policy
k) Organ Donation, Including Tissue and Eyes Policy
l) Patient and Family Education Policy
m) Patient Valuables Liability and Control
n) Pertussis Nasopharyngeal (NP) Swab, Adult Procedure (DELETE)
o) Referrals to Social Services for Biopsychosocial Assessment Policy
p) Wound Classification During Surgical Intervention\
q) Wound VAC, Negative Pressure Therapy Policy

2) Administrative Policies & Procedures

a) Decorative Material 248
b) Fair Treatment for Supervisory and Management Employees
c) Security Controls 612

3) Unit Specific – Emergency

a) Boarders – Policy
b) Release of a Minor Under 18 Years of Age Policy

	Agenda Item	Time Allotted	Requestor

4) Unit Specific – Employee Health & Wellness
a) Injury Illness Prevention Program

5) Unit Specific – Home Care
a) Agency Evaluation Indicators (DELETE)
b) Case Conference (DELETE)
c) Committees (DELETE)
d) Contracted Services
e) Mileage Expense Reimbursement
f) Mosby's Clinical Index of Nursing Skills for Procedures to Follow in Home Health
g) Notice of Medicare Provider Non-Coverage – Notice of Medicare Non Coverage for HMO
h) Pain Symptom Management
i) Scope of Services – Description of Setting
j) Staff Safety

5) Unit Specific – Medical Staff
a) Unintended Intraoperative Awareness During General Anesthesia 8710-546

6) Unit Specific – NICU
a) Infection Prevention – NICU
b) Nasojejunal (NJ) Tube Insertion, Maintenance and Removal of (DELETE)
c) Thermoregulation for VLBW Infants

7) Unit Specific – Outpatient Specialty Clinic
a) Age Specific Guidelines (DELETE)
b) Bomb Threat (DELETE)
c) Collaboration/Continuity of Patient Care (DELETE)
d) Custody of Parents
e) Data Management (DELETE)
f) Disseminating Medical Information (DELETE)
g) Emergency Evacuation (DELETE)
h) Environment of Care (DELETE)
i) Fire Alarm/Evacuation PLAN (DELETE)
j) Medical Equipment Maintenance (DELETE)
k) Patient Record Content
l) Registration of Patients
m) Scheduling and Tracking Appointments
n) Staffing Plan (DELETE)
o) Unit Specific Orientation (DELETE)

8) Unit Specific – Patient Management
a) Utilization Management Plan Policy

9) Unit Specific – Surgical Services
a) Discharge of Post Anesthesia and Post Sedation Patients to Inpatient Units Policy
b) Duodenoscope Sampling for Quality Control Culturing Procedure (NEW)

10) Unit Specific – Telemetry
a) Assistant Nurse Manager-Relief Charge Nurse Duties and Responsibilities (DELETE)
b) Bed Flow

	Agenda Item	Time Allotted	Requestor

c) Monitoring Telemetry Patients Using the DASH 3000
d) Nursing Responsibilities for Admissions
e) Orientation of Registration Staff
f) Staff Meetings (DELETE)
g) Telemetry Patient Shift to Shift Hand-off Process (DELETE)

11) Unit Specific – Wound Care
a) Patient Instructions
b) Specimen Transport (DELETE)
c) Unit-Specic Orientation

12) Unit Specific – Wound Hyperbaric Oxygen Therapy
a) Patient Instruction (DELETE)

B. Policies (August, 2020)

1) Patient Care Services Policies & Procedures
a) Advance Healthcare Directives
b) Alcohol Withdrawal Symptom Management
c) Child Passenger Restraint System Education Policy (DELETE)
d) Code Status/Do not Resuscitate (DNR)/Withholding or Withdrawing Life Sustaining Treatment
e) Code Triage Alert, Emergency Department Procedure
d) Continuous Passive Motion (CPM) Machine Procedure (DELETE)
e) Determination of Brain Death
f) Epicardial Pacing Wiring Procedure
g) Interpretation and Translation Services Policy
h) Meals, Patients – Times, Menus, Substitutions & Nourishments Policy
i) Nursing Students in Patient Care Areas Policy
j) Percutaneous Tracheostomy Assist Procedure
k) Rapid Response Team and Condition Help Policy
l) Safe Patient Handling, Bariatric
m) Spiritual Care for Family of Critically Ill or Deceased Infant (DELETE)
n) Spiritual Care of the Patient Policy
o) Thinning of Patient Record Policy (DELETE)

2) Administrative Policies & Procedures/Pay Practices
a) Disclosure of Unanticipated Adverse Outcomes to Patient Family Policy 275
b) Equal Employment Opportunity – 418
c) Coaching and Counseling for Work Performance – 424
d) Leave of Absence – 435
e) Jury Duty – 435.02
f) Flex Float to Activity – 437
g) Reduction in Work Force – 448
h) Diversity – 471
i) Benefit Eligibility Matrix – 472.01 (DELETE)
j) Charge Pay – 473.01 (DELETE)
k) Holiday and Holiday Premiums – 473.02 (DELETE)
l) Interpreter Premium – 473.03 (DELETE)
m) On-Call and Call Back – 473.04 (DELETE)
n) Report in Pay – 473.06 (DELETE)

	Agenda Item	Time Allotted	Requestor

o) Special Pay Practices – 473.08 (DELETE)
p) New Hire Pay Rates – 475.03 (DELETE)
q) Staff Requests not to Participate in Care – 480
r) Step Progression – 481 (DELETE)
s) Hiring and Employment; Screening Current Employees – 485
t) Hiring and Employment; Pending Charges against Current Employees – 486
u) Hiring and Employment; Conviction/Exclusion/License Revocation of Current Employees - 487
v) Hiring and Employment; Employee Requirements to Report Changes in Certification – 488
w) Procedure DevApproval – 775 (DELETE)

3) Unit Specific – Cardiac Rehab
a) Contraindication to Cardiac Rehab Exercise
b) Exercise Prescription
c) Exercise Protocol, Phase II
d) Exercise Protocol, Phase IV
e) Patient Discharge Criteria
f) Patient Enrollment
g) Patient Referral (DELETE)
h) Scope of Practice

4) Unit Specific - Emergency
a) Deaths of Pediatric Patients Procedure
b) Leave Without Treatment (LWOT), Against Medical Advice (AMA) or Elopement
c) Notification Patient Follow up Policy
d) Pediatric Patients, Care of Policy
e) Transfer of Pediatric Patients Procedure

5) Unit Specific – Home Care
a) Care Coordination
b) Critical Lab Values
c) Late Entry Documentation
d) Medical Record Security (DELETE)
e) Procedure for Use of Home Care Nursing Bag

6) Unit Specific – Medical Staff
a) Credentialing Standards for Vertebral Augmentation 8710-534
b) Criteria for Granting Moderate and Deep Sedation/Analgesia Privileges to Non-Anesthesiologists 8710-517
c) Election Process of Member(s) at Large for Medical Executive Committee 8710-531
d) Focused Professional Practice Evaluation – Proctoring 8710-542
e) Quality Review Process for Teleradiologists 8710-525

7) Unit Specific – NICU
a) Cue Based Feeding

8) Unit Specific – Outpatient Specialty Clinic
a) Continuum of Care
b) Diagnostic Tests (DELETE)
c) History and Physical (DELETE)
d) Hospital Admission from the Outpatient Forensic Clinic
e) Medical Emergencies (DELETE)

	Agenda Item	Time Allotted	Requestor
	f) Medical Record Review g) Patient Instructions h) Physician Orders/Request for Services i) Receiving of Patients into the Clinic j) Scope of Services k) Standards of Care and Practice (14) Board Committees **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in July& August, 2020)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in July & August, 2020)* **C. Audit, Compliance & Ethics Committee** Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in July& August, 2020)* (15) Minutes – Approval of: a) June 11, 2020, Special Meeting b) June 25, 2020, Regular Meeting c) July 3, 2020, Special Meeting (16) Meetings and Conferences – None (17) Dues and Memberships - None (18) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (July, 2020) (d) Reimbursement Disclosure Report – (July, 2020) (e) Seminar/Conference Reports – None		CHAC Comm. FO&P Comm. Audit, Comp. & Ethics Comm. Standard
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	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
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
August 12, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 8/28/2020 – 7/31/2022)

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 8/28/2020 through 7/31/2022:

- **DALAL, Aliasgar MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **DESAI, Chirag MD/Anesthesiology (ASMG)**
- **GARRETT, Riley MD/Anesthesiology (ASMG)**
- **LUEVANOS, Ryan MD/Emergency Medicine (TeamHealth)**
- **SINGH, Ajay MD/Teleradiology (StatRad)**
- **SAID, Saema MD/Emergency Medicine (TeamHealth)**
- **SUNTAY, Berk MD/OB/GYN (OptumCare)**
- **VISEROI, Marius MD/Pulmonary (Pulmonary Specialists of North County)**
- **WU, Darrell MD/Cardiothoracic Surgery (North County CVT Surgery Associates)**
- **YUNG, Aaron MD/Cardiology (TriCity Cardiology)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 1
August 12, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: None

RESIGNATIONS: (Effective date 08/31/2020 unless otherwise noted)

Automatic:

- VARNER, Alicia, OT/Orthopedic Technician

Voluntary:

- HENRY, Austin, DO/Anesthesiology
- KHAWAR, Osman, MD/Nephrology
- NAKHLA, Cindy, MD/Obstetrics & Gynecology
- SCHER, Colin, MD/Pediatric Ophthalmology

Tri-City Medical Center
MEDICAL STAFF

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

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **February 28, 2021** would result in these privileges automatically relinquishing.

- YOO, Frank, MD — Neurological Surgery

ADDITIONAL PRIVILEGE REQUEST (Effective 8/28/2020)

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

- LIN, Yuan MD — Cardiothoracic Surgery

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
August 12, 2020

PROCTORING RECOMMENDATIONS

• GUILLEN, Kathleen PA	Allied Health Professional
• HAIGLER, Heather PA	Allied Health Professional
• HEINEN, John PA	Allied Health Professional
• KOTAK, Kamal MD	Cardiology
• LIN, Yuan MD	Cardiothoracic Surgery
• SEIDEN, Grant MD	Orthopedic Surgery

I. **MEMBERSHIP:**

The Department of Emergency Medicine consists of physicians who are Board Certified by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine or have completed an approved residency in Emergency Medicine, and/or are board eligible through the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine and actively pursuing Board Certification in Emergency Medicine through either of those Boards. Board certification is required within two (2) years of joining the Department of Emergency Medicine. If Board certification lapses, the physician will have two (2) years to provide proof of recertification; if after the two (2) years proof of recertification has not been received, the physician will be placed on automatic suspension. If proof of recertification is not received within 90 days following the next available testing date, the physician will be automatically terminated.

The department, at its sole discretion, may also admit Physicians Assistants (PA) upon a majority vote of physician members. These PAs must be certified by the National Commission on Certification of Physician Assistants (NCCPA) or be board eligible and actively pursuing Board Certification as Physician Assistants through the NCCPA. Board certification is required within two (2) years of appointment and must be maintained at all times. Each PA must hold a current valid California PA license issued by the Physician Assistant Examination Committee of the State of California. If the California PA license has lapsed, the PA will be placed on automatic suspension until proof of license renewal is received. If the NCCPA certification has lapsed, the PA will have two-hundred (200) days from notification by the Medical Staff Office to provide proof of recertification; if after the two-hundred (200) days proof of recertification has not been received, the PA will be placed on automatic suspension until proof of recertification is received.

Each Physician who wishes to supervise PAs must sign a Delegation of Services Agreement with the PA. Each physician may supervise only two (2) PAs at a time/day (i.e., per clinical shift). Each PA may have more than one supervisory physician.

II. **FUNCTIONS OF THE DEPARTMENT:**

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

B. Recommend to the Medical Executive Committee guidelines for granting clinical privileges and evaluating 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 the QA/PI/PS Committee and Medical Executive Committee concerning:
   1. Department review and evaluation of 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/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy #8710-509.)
I. Approve On-Going Professional Practice Evaluation Indicators; and
J. Supervise the physician assistants' quality of Emergency Department care.
K. Formulate recommendations for Department rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to approval of the Medical Executive Committee and Board of Directors.

III. **DEPARTMENT MEETINGS**

The Department shall meet ten (10) times per year or at the discretion of the Chair. The Department will consider the findings from the ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Minutes shall be transmitted to the QA/PI/PS Committee, and then to the Medical Executive Committee.

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

Physician Assistants may attend department meetings. They may participate in a non-voting capacity in peer review and performance improvement or other activities as directed by the Chair. They shall have no vote on Departmental affairs.

IV. **DEPARTMENT OFFICERS**

The Department shall have a Chair and a Vice-Chair who shall be members of the Active Medical Staff and shall be qualified by training, experience, and demonstrated ability in the clinical areas covered by the Department.

The Department Chair and Vice-Chair shall be elected every two years by the Active staff members of the Department who are eligible to vote. If there is a vacancy for any reason, the position shall be filled for the unexpired term through a special election. The Chair shall be elected by a simple majority of the members of the Department.

The Department Chair and Vice-Chair 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 in the Department. Department officers shall be eligible to succeed themselves.

~~Emergency Department officers may serve a maximum of two (2) consecutive years.~~

V. **DUTIES OF THE DEPARTMENT CHAIRMAN**

A. The Department Chair, and the Vice-Chair in the absence of the Chair, shall assume the following responsibilities:
B. Be accountable for all professional and administrative activities of the Department.
C. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department.
D. Assure that practitioners practice only within the scope of their privileges as defined within their delineated privilege form.
E. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department.
F. Recommend clinical privileges for each member of the Department.
G. Assure that the quality, safety, and appropriateness of patient care provided by members of the

Department are monitored and evaluated; and

H. 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. **Initial Criteria - Physicians:**

1. Requests for General Patient Care privileges in the Department of Emergency Medicine shall be evaluated on the basis of the requesting physician's education, training, competence, judgment, character, experience (as demonstrated by treatment of at least one-hundred (100) typical Emergency Department patients within the past six (6) months – excluding physicians who have completed an ACGME American Board of Emergency Medicine Residency Program within the past twelve (12) months), ability to perform in Tri-City Emergency Department, the needs of the department, and the ability to function as a member of the Emergency Department team. Formal documentation of procedure experience may be requested at the discretion of the Department Chair.

C. All new physicians in the Department of Emergency Medicine shall be required to work up to eight (8) night shifts per month (or half of their total shifts if working part time) for at least six (6) years. Physicians shall practice only within the scope of the privileges as defined within the Department's rules and regulations and stated on the privilege form. However, in any emergency situation, an Emergency Medicine Physician may perform any procedure(s) for which he/she has proper training and/or experience, even if not delineated on his/her privilege card. The performance of such procedures may be reviewed by the Department Chair or by the QA/QI/PI Committee, at the Chair's discretion.

A. **Initial Criteria- Physician Assistants:**

1. Requests for physician assistant privileges in the Department of Emergency Medicine shall be evaluated on the basis of the needs of the Emergency Department, the requesting PA's education, training, experience, competence, judgment, character, and ability to perform in the Tri-City Emergency Department, and the PA's satisfaction of qualifications as outlined in the "Membership" section above.
2. Physician assistants shall also adhere to the Rules and Regulations for Allied Health Professionals. The Department of Emergency Medicine will review the performance of the physician assistants in order to ensure on-going competency in their field as part of their on-going professional practice evaluation process.
3. A Physician Assistant may provide those Emergency Department services which are consistent with the physician assistant's education, training, experience and "PA Regulations" which are delegated by a supervising physician who is responsible for the patients cared for by that physician assistant. The Physician Supervision requirement (defined by Business and Professions Code Section 3502) is met by the use of protocols, which allow for some or all of the tasks performed by a PA The supervising physician shall review, countersign, and date within seven (7) days the Emergency Department record of any patient for whom the physician assistant issues or carries out a Schedule II drug order.

VII. **REAPPOINTMENT OF CLINICAL PRIVILEGES**

Procedural privileges will be renewed if the minimum number of cases is met over a two-year reappointment cycle. A minimum of 200 Emergency Room cases are required (100 cases must be from TCMC). For practitioners who do not have sufficient activity/volume at TCMC to meet reappointment requirements, documentation of activity from other Emergency Rooms (up to 100 cases) 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).

VIII. **PROCTORING REQUIRMENTS**

A. Each Medical Staff member or Physician Assistant granted initial privileges, or Medical Staff member or Physician Assistant 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 Credentials Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

B. All Active members of the Department shall act as proctors. Additional cases may be proctored as recommended by the Department Chair. It is the responsibility of the Department Chair to inform the monitored member whose proctoring is being continued where deficiencies are noted.

C. 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.

D. A form shall be completed by the proctor, and should include comments on the overall impression and recommendation (i.e., qualified, needs further observation, not qualified). Blank forms will be made available from either the Medical Staff Office or the Emergency Department.

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

IX. **HOSPITAL ADMITTING ORDERS**

A. No members of the department shall write admitting orders.

X. **TELEPHONE ADVICE**

A. Members of the Department shall not give telephone advice, except in the following situations:

1. A departmental professional relationship has previously been established with a patient, involving recent treatment of the patient for the problem about which they are seeking advice.
2. To provide advice unrelated to their capacity as a member of the department (and without representation of same) including non-departmental professional relationships.

XI. **DEPARTMENT QUALITY REVIEW AND MANAGEMENT**

A. The Department will have a Quality Review Committee (QRC). The committee Chairman is the Department's representative on the Medical Staff QA/PI/PS Committee. The QRC shall meet at least four (4) times per year, or at the discretion of the QRC Chair.

B. General Function

1. The QRC provides systematic and continual review, evaluation, and monitoring of the quality and safety of care and treatment provided by the department members for the patients

seen in the Emergency Department.

C. Specific Functions
1. The QRC is established to:
   a) Identify important elements of Emergency Department patients' care in all areas in which it is provided.
   b) Select and approve the Department's performance monitoring indicators;
   c) Identify relevant information for these indicators which will be integrated and reviewed quarterly by the Emergency Department QRC Committee;
   d) Formulate thresholds for evaluation related to these performance monitoring indicators;
   e) Review and evaluate physician practice if specific thresholds are triggered;
   f) Identify areas of concern and opportunities to improve care, safety and educate Department members based on these reviews;
   g) Highlight significant clinical issues and present the specific information regarding quality of care to the appropriate department member, in accordance with Medical Staff Bylaws;
   h) Request Focused Professional Practice Evaluation if/when questions arise regarding a physician's practice;
   i) Monitor and review the effectiveness of any intervention and document any change;

D. Other functions
1. Assist in the reappointment process through retrospective review of charts;
2. Review any issues related to Emergency Department care that are forwarded for review by other Departments/Divisions;
3. Assist in the collection, organization, review, and presentation of data related to Emergency Department patient care and safety;
4. Review all cases involving unanticipated death(s) in the Emergency Department;

E. Reports
1. Minutes will be transmitted to the QA/PI/PS Committee and the Medical Executive Committee. The QRC will provide minutes and, as needed, verbal, or written communication to the Department members and to QA/PI/PS Committee regarding any general educational information gleaned through chart review or the quality review process.

XII. RESIDENT SUPERVISION

A. Department members shall supervise Emergency Department care provided by residents in Tri-City Emergency Department, and shall examine and document an Emergency Department patient record for all patients seen by a resident. Department members shall countersign/authenticate all charts and orders by residents according to Medical Staff Policy #8710-518 (Medical Records Documentation Requirements).

APPROVALS:

Emergency Medicine Department: ~~9/28/2016~~ 6/10/2020
Medical Executive Committee: ~~2/21/2017~~
Board of Directors: ~~2/23/2017~~

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Urology - (Revised 6/14)

Provider Name:

Request	Privilege

CERTIFICATION: The Division of Urology consists of physicians who are board certified or actively pursuing certification by the American Board of Urology, or able to demonstrate comparable ability, training, and experience.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056

Criteria for Admit, Consultation, and H&P:
Initial: Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.
Proctoring: Successful completion of procedure-specific proctoring satisfies proctoring for these privileges.

___ Admit patients

___ Consultation, including via telemedicine (F)

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

___ **BASIC UROLOGY PRIVILEGES** - By selecting this privilege, you are requesting the Basic Urology privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Urology Privilege Criteria
Initial:
1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.
2. Documentation of at least of fifty (50) cases within the previous twenty-four (24) months.
Proctoring: Five (5) cases from the Basic Urology Privileges category
Reappointment: Fifty (50) representative blend of cases within the twenty-four (24) months reappointment period.

Abdominal procedure(s), incidental

Anterior exenteration

Colporraphy

Incisional hernia, incidental

Inguinal hernia, incidental

Lithotripsy

Male Genital System - all procedures for: Scrotum, Testis, Vas Deferens, Penis, Retroperitoneal Surgery (excluding Pro

Radical cystectomy

Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic)

Urinary System - all procedures for: Kidney, Ureter, Bladder, Prostate, Urethra

Provider Name:

Request	Privilege

Urodynamics: Foley catheter placement (F)

SPECIAL UROLOGY PRIVILEGES:

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

___ **Laser Privileges Category** - By selecting this privilege, you are requesting the Laser privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Laser Privileges Criteria
Initial:
1. Documentation of completion of training for specific energy source(s) to be used; or
2. If training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.
Proctoring: One (1) case for each energy source
Reappointment: One (1) case for each energy source within the previous twenty-four (24) months

CO2 laser

Greenlight laser (diode)

Holmium laser

___ Uromedica ProACT Device (Adjustable Continence Therapy for Men)
Initial Criteria: Certificate of ProACT Workshop Completion
Proctoring: Two (2) Cases
Reappointment: Four (4) Cases within the previous twenty-four (24) months ~~every two years~~

___ **Laparoscopic Nephrectomy/Renal Laparoscopy Category** - By selecting this privilege, you are requesting the Laparoscopic Nephrectomy/Renal Laparoscopy privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Laparoscopic Nephrectomy/Renal Laparoscopy Criteria
Initial Criteria:
1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology that included training in laparoscopy; or
2. Successful completion of a hands-on training course for renal laparoscopic and/or laparoscopic nephrectomy procedures; or
3. Documentation of at least three (3) renal laparoscopic and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months (required if training was completed more than two years prior to application).
Proctoring: Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures
Reappointment: Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months

Laparoscopic nephrectomy

Renal laparoscopy

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Urology - (Revised 6/14)

Provider Name:

Request	Privilege

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

___ **Robotic Surgery (da Vinci) Category** - By selecting this privilege, you are requesting the da Vinci Robotic Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

___ Xi Robotic Privileges
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

___ Assist in Xi Robotic

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

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

___ Sacral nerve stimulation

Sacral Nerve Stimulation Criteria
Initial:
1. Successful completion of an ACGME or AOA-accredited residency program and board certified or actively pursuing board certification in Urology; or successful completion of a urogynecology fellowship program; AND
2. Documentation of successful completion of a training course in sacral neuromodulation therapy; or
3. Documentation of performing at least six (6) sacral neuromodulation therapy stimulator tests and implant procedures within the previous twelve (12) months (required if training was completed more than two years prior to application)
Proctoring: One (1) case
Reappointment: Two (2) cases within the previous twenty-four (24) months

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

_____

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Urology - (Revised 6/14)

Provider Name:

Request	Privilege

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

_____

Date

Tri-City Medical Center
MEDICAL STAFF

TO: Interdisciplinary Practice Committee
SUBJECT: Categories of AHPs Eligible to Apply for Clinical Privileges

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I. **CATEGORIES OF AHPs ELIGIBLE TO APPLY FOR CLINICAL PRIVILEGES:**

A. Independent
   1. Clinical Psychologist

B. Dependent
   1. Audiologist
   2. Certified Nurse Midwife
   ~~3. Marriage and Family Therapist Intern~~
   ~~4. Medical Physicist/Radiation Physicist~~
   ~~5.~~3. Nurse Practitioner
   ~~6. Orthopedic Surgery Technician~~
   ~~7.~~4. Physician Assistant
   ~~8.~~5. Registered Nurse First Assist

Tri-City Medical Center
MEDICAL STAFF

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

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/31/2020 – 6/30/2022)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 7/31/2020 through 6/30/2022:

- **ALFIERI, Keith MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **BLAKER, Kristen MD/General Surgery (Coastal Surgeons)**
- **ESFANDIARI, Raheleh MD/OB/GYN (OptumCare)**
- **KLATMAN, Keith MD/Orthopedic Surgery FELLOW – Assist ONLY (San Diego Sports Medicine)**
- **LIU, Richard MD/Otolaryngology (ENT Associates)**
- **NASIRI, Arian MD/Radiology (San Diego Imaging)**
- **NGUYEN, Thu MD/Anesthesiology (ASMG)**
- **POLLACK, Melanie DO/Emergency Medicine (TeamHealth)**
- **SHUMPERT, Stephen MD/Anesthesiology (ASMG)**
- **TO, Harrison MD/Anesthesiology (ASMG)**
- **YOUNAN, Lawrence MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 8/01/2020 –7/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 8/01/2020 through 7/31/2022, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- BERTHELSEN, Steven, DPM/Podiatric Surgery/Provisional
- BROOKER, Jr., George, DO/Anesthesiology/Active Affiliate
- CARR, Kenneth, MD/Cardiology/Active
- CHATURVEDI, Sanjana, MD/Internal Medicine/Refer and Follow
- CLARK, Ma. Belen, MD/Family Medicine/Refer and Follow
- COFFLER, Mickey, MD/Reproductive Endocrinology/Inf/Active
- GABRIEL, Steven, MD/Emergency Medicine/Active
- GOMEZ, Jessica, MD/Ophthalmology/Provisional
- GROVE, Jay, MD/General Surgery/Active
- LOPEZ, Sandra, MD/Obstetrics & Gynecology/Active
- PENVOSE-YI, Jan, MD/Obstetrics & Gynecology/Active
- ROGERS, Christopher, MD/Physical Medicine & Rehab/Active Affiliate
- SIDDIQUE, Nayyar, MD/Oncology/Active
- SMITH, David, DDS/Oral & Maxillofacial Surgery/Provisional
- TOOSIE, Katayoun, MD/General Surgery/Active
- URBANIC, James, MD/Radiation Oncology/Active
- VIERNES, Matthew, MD/Gastroenterology/Active
- WAKEMAN, Gregory, DO/Family Medicine/Refer and Follow

Attachment B

UPDATE TO PREVIOUS REAPPOINTMENT:

Pham, Martin, MD/Neurological Surgery/Provisional

RESIGNATIONS: (Effective date 7/31/2020 unless otherwise noted)

Automatic:

- JAUREGUI, Nicholas, MD/Family Medicine

Voluntary:

- ALARCON, Anthony, MD/Anesthesiology
- BATRA, Munish, MD/Plastic Surgery
- CHAN, Jeffrey, MD/Anesthesiology
- GREIDER-SIDERIS, Kelsi, MD/Ophthalmology
- HONG, Raymond, MD/Diagnostic Radiology
- MOTADEL, Kelly, MD/Pediatrics
- PARK, Christopher, MD/Teleradiology
- PEEL, Avanee, MD/Teleradiology
- TABOREK, Alexander, MD/Anesthesiology
- VELESRUBIO, Felisa, MD/Infectious Disease
- WOLFF, James, MD/Teleradiology
- YEHUSHUA, Liora, MD/Anesthesiology

Tri-City Medical Center
MEDICAL STAFF

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

PROCTORING RECOMMENDATIONS

- **DAIRO, Brandon MD** — **Anesthesiology**
- **HEROLD, Richard MD** — **Emergency Medicine**
- **LEE, Calvin MD** — **Anesthesiology**
- **PASHMFOROUSH, Mohammad MD** — **Cardiology**
- **PRASAD, Nandan MD** — **Emergency Medicine**
- **WALKER, Kolby DO** — **Psychiatry**

Tri-City Medical Center
MEDICAL STAFF

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

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **January 31, 2021** would result in these privileges automatically relinquishing.

- **CAMPBELL, Leticia, MD** — **Obstetrics & Gynecology**
- **KANE, Norman, MD** — **Orthopedic Surgery**
- **MOUKARZEL, Elias, MD** — **Obstetrics & Gynecology**
- **MOUSSAVIAN, Mehran, DO** — **Cardiology**

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 **October 31, 2020** would result in these privileges automatically relinquishing.

- **GENTILUOMO, Jesse, MD** — **Emergency Medicine**
  ion
- **MACEWAN, Jennifer, MD** — **Otolaryngology**
- **SAMANI, Pargol, MD** — **Cardiology**

AUTOMATIC RELINQUISHMENT OF PRIVILEGES (Effective 7/31/2020, unless otherwise specified)

The following practitioners were given 16 months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of July 31, 2020.

- **ONAITIS, Mark, MD** — **Cardiothoracic Surgery**
- **PERRIZO, Nathan DO** — **Pain Medicine**

ADDITIONAL PRIVILEGE REQUEST (Effective 7/31/2020)

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

- **KOTAK, Kamal MD** — **Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
July 20, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 7/31/2020 – 04/30/2022)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 7/31/2020 through 04/30/2022:

- **CHRISTENSEN, Anna PA-C/Allied Health Professional (TeamHealth)**
- **KAUP, Allison PhD/Allied Health Professional (North County Neurology)**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 08/01/2020 – 07/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 08/01/2020 through 07/31/2022, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- CARNELIAN, Alissa, AuD, CNIM/Allied Health Professional
- COWAN, John, PA-C/Allied Health Professional
- Elamparo, Kaye, NP/Allied Health Professional
- FAZZINO, Dolores, NP, RNFA/Allied Health Professional
- FORBES, Beth, RNFA/Allied Health Professional
- HERMANN, Linda, PA-C/Allied Health Professional
- HUANG, Stephanie, PA-C/Allied Health Professional
- Kolt, Thomas, PA-C/Allied Health Professional
- MARTINEZ, Melinda, PA-C/Allied Health Professional
- RICE, William, PA-C/Allied Health Professional
- SCOTT, Katie, PA-C/Allied Health Professional
- WEICHERT, Rachel, AuD, CNIM/Allied Health Professional

RESIGNATIONS: (Effective date 07/31/2020 unless otherwise noted)

- KWAN, Jaclyn, PAC/Allied Health Professional
- VENOR, Kristen, CNM/Allied Health Professional

Tri-City Medical Center
MEDICAL STAFF

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

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **January 31, 2021** would result in these privileges automatically relinquishing.

- **ALLEN, Matthew, PA-C** — **Allied Health Professional**
- **BROWNSBERGER, Richard, PA-C** — **Allied Health Professional**
- **SCHILLINGER, Stephan, PA-C** — **Allied Health Professional**
- **RENNE, Brittany AuD** — **Allied Health Professional**
- **STABLER, Holly, PA** — **Allied Health Professional**
- **TEBON, Renee PA-C** — **Allied Health Professional**

Tri-City Medical Center
MEDICAL STAFF

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

Attachment C

PROCTORING RECOMMENDATIONS

• DEMASCO, Michael PA	Allied Health Professional
• LUU, Jackie PA	Allied Health Professional

I. MEMBERSHIP

A. The Department of Medicine consists of physicians in the Divisions of:
1. Cardiology
2. ~~Gastroenterology~~
3. ~~2.~~ ~~Internal~~ Medicine
   a. ~~Allergy and Dermatology~~
   b. ~~Endocrinology~~
   c. ~~Hospice & Palliative Medicine~~
   d. ~~Infectious Disease~~
      b. ~~Internal Medicine~~
      c. ~~Nephrology~~
   e. ~~Physiatry (Physical Medicine and Rehabilitation)~~
   d. ~~Rheumatology~~
4. ~~Oncology~~
5. ~~Neurology~~
6. ~~Psychiatry~~
7. ~~Pulmonary Medicine~~

II. FUNCTIONS

The general functions of the Department of Medicine, carried out through the functions of the Division 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 within the division and develop criteria for use in the evaluation of patient care;
B. Recommend to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department;
C. Conduct, participate in and make recommendations regarding continuing Medical education programs in clinical practice;
D. Review and evaluate departmental adherence to:
   1. Medical Staff Policies and procedures;
   2. Sound principles of clinical practice.
E. Submit minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Department's review and evaluation of activities, actions taken thereon, and the results of such action;
   2. Recommendations for maintaining and improving the quality of patient care and patient safety provided in the department and the hospital;
   3. Recommend / Request Focused Professional Practice Evaluation as indicated for Medical Staff members (pursuant Medical Staff Policy 509);
   4. Approval of On-Going Professional Practice Evaluation Indicators.
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 and clinical performance, patient safety or opportunities to improve patient care are identified;

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

III. DEPARTMENT MEETINGS

A. The Department of Medicine shall meet quarterly or at the discretion of the chairman. The functions of the Department are carried out through the Divisions; including the monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients. Regular reports shall be transmitted to the Medical Executive Committee;

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

IV. DEPARTMENT OFFICERS

A. The Department shall have a Chairman and a Vice-Chairman who shall be members of the Active Medical Staff and shall be qualified by training, experience and demonstrate ability in at least one of the clinical areas covered by the Department;

B. The Department Chairman shall serve a two-year term, which coincides with the medical staff year unless they resign, be removed from office, or lose their medical staff membership or clinical privileges in that Department. Department officers shall be eligible to succeed themselves). Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department.

V. DUTIES OF THE DEPARTMENT CHAIRMAN

A. The Department Chairman shall assume the following responsibilities of the Department:
   1. Be accountable for all professional administrative activities of the Department;
   2. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Department;

B. Recommend to the Medical Executive Committee the criteria for clinical privileges in the Department;

C. Recommend clinical privileges for each member of the Department; and

D. Assure that practitioner's practice only within the scope of their privileges as defined within their delineated privilege card;

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

F. Continuously assess and improve the quality and safety of care provided in the Department;

G. Other duties may be assigned, in accordance with the Medical Staff Bylaws.

VI. PRIVILEGES

A. Requests for privileges in the Department of Medicine shall be evaluated on the basis of the member's education, training, experience, demonstrated professional competence and judgment, clinical performance and the documented results of patient care and proctoring; Practitioner's practice only within the scope of their privileges as defined within the respective Division's Rules and Regulations. Recommendations for privileges are made to the Credentials and Medical Executive Committees;

B. The Department of Medicine has established the following classifications of medical privileges:
   1. Physicians are expected to have training and/or experience and competence on a level commensurate with that provided by specialty training, such as in the broad field of Internal Medicine although not necessarily at the level of sub specialist.

Such physicians may act as consultants to others and may, in turn, be expected to request consultations 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 in which they are not familiar;

2. Allied Health Professionals – *See Allied Health Professional Rules & Regulations*

VII. REQUIREMENTS FOR INITIAL APPOINTMENT AND REAPPOINTMENT

A. Active certification by the appropriate certifying board or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center;
B. Privileges requested are granted based on Division specified criteria;
C. 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).

VIII. SPECIAL PROCEDURES / PRIVILEGES

A. The applicant will be responsible for checking all procedures he/she wishes to perform and for listing his/her qualifications, training, and experience concerning the requested procedures in accordance with criteria established by various Divisions of the Department of Medicine, copies of which are available in the Medical StaffDepartment.;
   1. The medical privileges granted each physician will be recorded and a copy of which will be forwarded to the applicant with his medical staff appointment;
   2. Pain Management Privileges are delineated per Medical Staff Policy # 541 *Credentialing Criteria for Pain Management Privileges*;
   3. Surgical Assist Privileges as delineated per Medical Staff Policy #536 *Physician Surgical Assistant*;
   4. Each practitioner's privileges will be assessable on Tri-City's Intra-net (MD-Staff) which is located in each patient care area. A paper copy is maintained within the Medical Staff Department.

IX. PROCTORING

A. The new medical staff member granted initial privileges, or medical staff member requesting additional privileges shall be evaluated by a proctor from his/her Division with like privileges until his or her privilege status is established by a recommendation from the Division Chief and subsequently to the Credentials Committee to the Medical Executive Committee with final approval by the Board of Directors. If enough cases have not been admitted, or evaluation of the new Medical Staff member's performance cannot be completed in the first year, then an additional year of provisional staff will be recommended;
B. At the discretion of the retrospective Division Chair(s) the decision to assign further proctoring of cases is based on current clinical competence, practice behavior, and the

ability to perform the requested privilege(s);

C. Supervision of the applicant by the proctor will emphasize concurrent or retrospective chart review of cognitive processes and include direct observation of invasive procedural techniques. The new Medical Staff member must notify his / her proctor at the time a procedure is scheduled or planned. If the proctor is not available, the applicant must notify another physician in the appropriate subspecialty area. Proctors are obligated to be available within seven (7) days after a proctor request has been made to proctor the member concurrently for invasive procedures, or to thoroughly evaluate the practitioner's performance through concurrent or retrospective chart review of cognitive processes. If the procedure must be done emergently without proctoring, the proctor must be informed at the earliest appropriate time following the procedure;

D. All active staff members of the Department of Medicine will act as proctors as delineated by the Divisions of the Department of Medicine to monitor performance of medical care and compliance with assigned privileges. Associate(s) of the new Medical Staff member may monitor up to 50% of the required proctoring;

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

F. When the required number of cases has been proctored, the Division Chief must approve or disapprove the release from proctoring or may extend the proctoring, based upon a review of the proctor reports. It is the responsibility of the Division Chief to inform the monitored member when their proctoring is being continued for noted deficiencies;

G. The proctor's report shall be confidential and shall be completed and returned to the Medical Staff Department;

H. Specific proctoring requirements are outlined in each respective Division's privilege cards.

X. EMERGENCY DEPARTMENT CALL

A. Medical Staff department members shall participate in the Emergency Department Call Roster or consultation panel as determined by the medical staff. Refer to Medical Staff Policy and Procedure #520 *Emergency Room Call Duties of the On-Call Physician*;

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

C. It is the policy of the Emergency Department that when it is discovered that a patient has been previously treated by a staff member, that member will be given the opportunity to provide further care;

D. The member of the Department of Medicine will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care;

E. If a physician has discharged a patient from his practice and the patient comes to the Emergency Department when the physician is on call, the physician is responsible for the disposition of the patient.

F. A physician on-call, who provides care for a patient in the Emergency Department, is responsible for the disposition of that patient for forty-eight (48) hours and must accept responsibility if said patient is readmitted to the Emergency Department within forty-eight (48)

hours. The care provided by an on-call physician will not create an obligation to provide further care.

G. Provisional or courtesy member(s) are able to serve on the Emergency Call panel at the discretion of the Department Chair or Division Chief.

APPROVALS:

Department of Medicine:	~~01/16/2017~~ 7/14/2020
Medical Executive Committee:	~~02/21/2017~~
Board of Directors:	~~02/23/2017~~

Revised: 01/04, 01/06, 02/07, 06/08; 5/13; 7/15

I. **MEMBERSHIP**

The Division of General and Vascular Surgery consists of physicians who practice within the specialties of:

- Cardiothoracic Surgery
- General Surgery (to include Bariatric Surgery)
- Vascular Surgery

The Division of General and Vascular Surgery consists of physicians who are Board Certified or in the first thirty-six (36) months of Board Eligibility and actively pursuing certification by the American Board of Surgery and/or American Board of Thoracic Surgery, or able to demonstrate comparable ability, training and experience.

II. **FUNCTIONS OF THE DIVISION**

The general functions of the Division of General and Vascular Surgery shall include:

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

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

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

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

E. Submit written minutes to the Medical Quality Peer Review Committee and Medical Executive Committee concerning:
   1. Division review and evaluation of activities, actions taken thereon, and the results of such 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/Request Focused Professional Practice Evaluation as indicated (pursuant to Medical Staff Policy 8710-509).

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

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

III. **DIVISION MEETINGS**

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

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

IV. **DIVISION OFFICERS**

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

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

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

V. **DUTIES OF THE DIVISION CHIEF**

The Division Chief shall assume the following responsibilities:

A. Accountability for all professional and administrative activities of the Division.
B. Ongoing surveillance of the professional performance of all individuals who have delineated clinical privileges in the Division.
C. Ensuring practitioners practice only within the scope of the privileges defined within their delineated privilege form.
D. Recommendations to the Department of Surgery and the Medical Executive Committee the criteria for clinical privileges in the Division.
E. Recommendations of clinical privileges for each member of the Division.
F. Ensuring that the quality, safety, and appropriateness of patient care provided by members of the Division are monitored and evaluated; and
G. Other duties as recommended by the Department of Surgery or 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 Department.
B. All practitioners applying for clinical privileges must demonstrate current competency for the scope of privileges requested. "Current competency" means documentation of activities within the twenty-four (24) months preceding application, unless otherwise specified.
C. **Bariatric Surgery Privileges**
   1. Initial Criteria:
      a. Submit proof of a structured Bariatric program that provides or coordinates comprehensive interdisciplinary care of the bariatric patient. As determined by the Metabolic and Bariatric Surgery Committee.
      b. Agrees to attend 75% of the Metabolic and Bariatric Surgery Committee meetings one of which is an annual Comprehensive QI meeting (a written excuse must be submitted to the Director).
   2. Reappointment Criteria:
      a. Proof of attendance at 75% of Metabolic and Bariatric Surgery Committee meetings.

b. Attendance at annual Comprehensive QI meeting or written excused approved by Director.

~~C.~~ D. **Physician Assistants** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.

~~D.~~ E. **Registered Nurse First Assist (RNFA)** – Refer to the Allied Health Professionals Rules and Regulations for basic credentialing requirements.

~~E.~~ F. **Progressive Care Outpatient Site-Specific Privileges** – Privileges annotated with an (F) indicates privileges that may be performed at either Tri-City Medical Center or the Progressive Care Outpatient Clinic.

VII. REQUIREMENTS FOR REAPPOINTMENT

A. Active certification by the Division of General and Vascular Surgery or demonstration of comparable ability, training and experience shall satisfy the requirements for receiving cognitive privileges for all categories as well as for admitting privileges to Tri-City Medical Center.

B. 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 TCHD 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 Division Chief to the Credential Committee and to the Medical Executive Committee, with final approval by the Board of Directors.

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

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

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

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

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

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

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

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

J. The proctor shall have current unrestricted privileges to perform the procedures s/he is proctoring.

IX. **EMERGENCY DEPARTMENT CALL:**

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

B. It is the policy of the Emergency Department that when a patient indicates that a staff member has previously treated him or her, that member will be given the opportunity to provide further care.

C. The member of the Division will then determine whether to provide further care to an emergency room patient based upon the circumstances of the case. If a member declines, the on-call physician will provide any necessary emergency special care.

D. The care provided by an on-call physician should be completed with regard to the particular problem that the physician was called to treat. The care provided by an on-call physician will not create an obligation to provide further care.

E. Provisional or Courtesy staff may participate in the Emergency Call panel at the discretion of the Division Chief or Department Chair.

APPROVALS:

General & Vascular Surgery Division: ~~02/09/2017~~~~1/10/2019~~7/9/2020
Surgery Department: ~~02/24/2017~~7/21/2020
Medical Executive Committee: ~~03/27/2017~~
Board of Directors: ~~03/30/2017~~

Tri-City Medical Center

Delineation of Privileges

General & Vascular Surgery - (Revised ~~12/16~~6/20)

Provider Name:

Request	Privilege

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056.
Privileges annotated with (F) may be performed at either TCMC or 3925 Waring Road, Suite C, Oceanside CA 92056.

___ Admit Patients

___ Consultation, including via telemedicine (F)

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

___ **BASIC GENERAL SURGERY PRIVILEGES**

By selecting this privilege, you are requesting the Basic General Surgery privileges (open or laparoscopic) listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic General Surgery Privilege Criteria:
Initial:

- Board certification, or in the first 36 months of Board eligibility and actively pursuing certification by the American Board of Surgery, or demonstrate comparable ability, training or experience.
- One-hundred (100) general surgery procedures, reflective of the scope of privileges requested, during the previous twenty-four (24) months or demonstrate successful completion of an ACGME/AOA-accredited residency or clinical fellowship within the previous (24) months.

Proctoring: ~~Ten (10)~~Six (6) cases
Reappointment: ~~Sixty (60)~~Thirty (30) cases from this category within the previous twenty-four (24) months

Anal canal biopsy (F)

Anoscopy (F)

Arterial catheterization for monitoring

Basic advancement flaps: rotational and myocutaneous (excluding TRAM and micro-vascular)

Biopsy / excision skin & soft tissue lesions (F)

Central venous catheter placement

Chemical destruction of anal warts (F)

Cricothyroidotomy

Debridement of wound, soft tissue infection

Excision of neuroma, neurofibroma, neurilemoma

Excision of skin, soft tissue neoplasm

I&D abscess (F)

Minor laceration repair

Neurorrhaphy - Suture of Nerve

Provider Name:

Request	Privilege

Paracentesis

Panniculectomy

Parathyroidectomy

Radical neck dissection, modified

Right heart catheterization for monitoring

Rigid proctoscopy (F)

Rubber band ligation of internal hemorrhoids (F)

Sentinel lymph node biopsy

Sigmoidoscopy, includes rigid or flexible

Thoracentesis

Thyroidectomy

Tracheostomy

Tube thoracostomy

Abdomen and Perineum Surgery:

Abdominal perineal resection

Abdominal wall repair, inguinal or femoral hernia

Adrenalectomy

Anal sphincterotomy

Anti-reflux procedures

Appendectomy

Cholecystectomy

Choledochoenteric anastomosis

Colostomy, closure

Colostomy, creation

Common bile duct exploration, transcystic

Diagnostic laparoscopy with or without biopsy

Drainage of anorectal abscess

Drainage of intra-abdominal abscess

Drainage of Pseudocyst

Enterolysis

Provider Name:

Request	Privilege

Esophageal diverticulectomy

Esophagogastrectomy

Exploratory Laparotomy

Fasciotomy

Gastrectomy, partial or total

Hemorrhoidectomy

Hernia, abdominal wall, to include: femoral, inguinal, incisional, lumbar, spigelian, ventral

Hernia, repair of diaphragmatic or hiatal

Ileostomy creation or closure

Intestine resection (small or large intestine)

Intra-Peritoneal Catheter Placement

Liver biopsy

Lymphadenectomy

Lysis of adhesions

Pilonidal cystectomy

Repair of anorectal fistula

Repair of rectal prolapse

Splenectomy

Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc)

Vagus Transection, for peptic ulcer disease

Breast Surgery:

Axillary dissection

Biopsy, incisional or excisional

Breast abscess, drainage of

Intraoperative needle localization

Intraoperative ultrasound

Mastectomy, partial

Mastectomy, total

Mastopexy

Provider Name:

Request	Privilege

Urogenital Surgery:

Bladder repair - incidental

Hydrocelectomy - incidental

Hysterectomy - incidental

Nephrectomy - incidental

Orchiectomy - incidental

Partial cystectomy - incidental

Salpingo-oophorectomy - incidental or in an acute abdominal emergency

Ureteral repair - incidental

Skin grafting

___ **BASIC PERIPHERAL VASCULAR SURGERY PRIVILEGES**

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

Basic Peripheral Vascular Surgery Criteria:
Initial: Board certification by the American Board of Surgery, or in the first 36 months of Board eligibility, or can demonstrate comparable ability, training and experience. Ten (10) cases within the previous twenty-four (24) months.
Proctoring: One (1) case from this category
Reappointment: Five (5) cases from this category within the previous twenty-four (24) months

Amputation, digital

Amputation, foot

Amputation, knee, above

Amputation, knee, below

Ligation of perforating veins (open or minimally invasive using laser or ablation using radiofrequency)

Operations for venous ulceration/split thickness skin grafting (STSG)

Sympathectomy - (Including vascular ischemia)

Vein ligation or stripping of varicose veins/phlebectomy

Portal Decompression

Mesocaval shunt

Portocaval shunt

Splenorenal shunt

ADVANCED GENERAL SURGERY PRIVILEGES:

___ **Advanced Breast Surgery**

Provider Name:

Request	Privilege

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

Advanced Breast Surgery Criteria:
Initial:

- Basic General Surgery privileges which effectively covers the need for board certification.
- For Oncoplastic Repair privileges: Documentation of ten (10) CME credits relating to oncoplastic repair within the previous twenty-four (24) months, OR current oncoplastic repair privileges at another institution, OR completion of a Breast fellowship, OR ten (10) cases performed during residency training or within the previous twenty-four (24) months.

Proctoring: Three (3) cases from this category (Successful completion of proctoring Advanced Breast privileges satisfies proctoring requirement for Basic Breast Privileges)
Reappointment: Ten (10) cases from this category within the previous twenty-four (24) months

Oncoplastic repair

___ **Advanced Laparoscopic Surgery**

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

Advanced Laparoscopic Surgery Criteria:
Initial: Basic General Surgery privileges which effectively covers the need for board certification. Forty (40) advanced general and abdominal procedures during the previous twenty-four (24) months.
Proctoring: Three (3) cases from this category (Successful completion of proctoring Advanced Laparoscopy privileges satisfies proctoring requirement for Basic General Surgery Privileges)
Reappointment: ~~Twenty-four (24)~~Ten (10) cases from this category within the previous twenty-four (24) months

Adrenalectomy

Antireflux/fundoplication procedures (e.g. laparoscopic Nissen/Toupet)

Cholecystoenteric anastamosis

Choledochoenteric anastamosis

Colostomy closure

Esophageal procedures

Gastric resection

Hepatic resection

Hernia repair, diaphragmatic or hiatal

Intestine resection (small or large intestine)

Splenectomy

Ulcer surgery (Omental patch, V&A, V&O, V&GJ, HSV, etc)

___ **Advanced Abdominal Surgery:**

Tri-City Medical Center

Delineation of Privileges

General & Vascular Surgery - (Revised ~~12/16~~6/20)

Provider Name:

Request	Privilege

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

Advanced Abdominal Surgery Criteria:
Initial:
1. Basic General Surgery privileges which effectively covers the need for board certification.
2. Two (2) advanced abdominal procedures during the previous twenty-four (24) months.
Proctoring: One (1) case from this category
Reappointment: Two (2) cases from this category per two-year reappointment

Esophagectomy, including thoracoabdominal approach

Hepatic lobectomy, open

Hepaticoenterostomy

Pancreatic procedures, open or laparoscopic

~~**Advanced Head & Neck Surgery**~~

~~By selecting this privilege, you are requesting the Advanced Head and Neck Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.~~

~~Advanced Head & Neck Surgery Criteria:~~
~~Initial: Basic General Surgery privileges which effectively covers the need for board certification. Twenty (20) advanced head and neck procedures during the previous twenty-four (24) months.~~
~~Proctoring: Two (2) cases from this category~~
~~Reappointment: Ten (10) cases from this category within the previous twenty-four (24) months~~

~~Parotid gland~~

~~Salivary glands and ducts~~

~~Thymectomy~~

ADVANCED PERIPHERAL VASCULAR SURGERY

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

Advanced Peripheral Vascular Surgery Privileges Criteria:
Initial:

- Basic General Peripheral Vascular Surgery privileges which effectively covers the need for board certification.
- Forty (40) vascular cases within the previous twenty-four (24) months (With application, submit list of major procedures done in two (2) years preceding application. Include indications, results, morbidity and mortality data and operative reports.)
- *If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, documentation of five (5) cases within the previous twenty-four (24) months and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed out.

Proctoring: Five (5) cases from this category or * If only Retroperitoneal exposure for spine vertebral body procedures privilege is requested, two (2) cases (Successful completion of proctoring requirement for Advanced Peripheral Vascular Surgery satisfies proctoring requirement for Basic Peripheral Vascular Surgery)
Reappointment: Twenty (20) vascular cases from this category within the previous twenty-four (24) months or *If only Retroperitoneal exposure for spine vertebral body procedures granted, five (5) cases and documentation of current privileges in vascular or trauma surgery at a healthcare facility. All other privileges in the category must be crossed

Provider Name:

Request	Privilege

out.

Aortic, aorto-iliac, aorto-femoral bypass

Axillary-femoral bypass

Bypass of upper extremity vessel

Carotid - Subclavian bypass

Celiac/superior mesenteric axis endarterectomy, repair or bypass

Embolectomy or thrombectomy

Endarterectomy, carotid

Endarterectomy or bypass, vertebral

Endarterectomy, repair or bypass, renal artery

Exploration, repair, thrombectomy, or embolectomy of abdominal aorta, iliac, femoral or infrageniculate artery

Femoral to femoral bypass

Femoral to infrageniculate bypass

Femoral to popliteal bypass

Repair of aortic arch branches

Repair of iliac, femoral, popliteal, or mesenteric aneurysm

Repair of infra or suprarenal aortic aneurysm

Repair of upper extremity vessel

Retroperitoneal exposure for spine vertebral body procedures, includes incidental vascular procedures*

Upper and lower extremity deep or superficial vein procedures

Upper or lower extremity fistula, autogenous or artificial placement of central venous catheter placement

SPECIAL PRIVILEGES:

___ **BARIATRIC SURGERY**

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

Bariatric Surgery Criteria:
Initial:

- Completion of General Surgery residency program.
- Privileges to perform Basic and Advanced Abdominal surgery and advanced laparoscopy.
- Completion of a Bariatric and Metabolic Surgery fellowship, or Minimally Invasive fellowship with documentation of rotation in Bariatrics and the performance of a minimum of five (5) cases within the previous twenty-four (24) months, or case logs documenting the performance of a minimum of fifteen (15) bariatric cases within the previous twenty-four (24) months.

Provider Name:

Request	Privilege

☐ Documentation to indicate malpractice coverage includes bariatric surgery.

Proctoring: Three (3) cases Bariatric and Three (3) Bariatric EGD Cases
Reappointment:

☐ Fifteen (15) cases within the previous twenty-four (24) months

Roux en Y gastric bypass

Sleeve gastrectomy

Adjustable gastric banding

Revisional metabolic and bariatric surgery

Biliopancreatic diversion, with or without duodenal switch

Bariatric Endoscopy

Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures
Initial: Completion of an ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of a refresher training course in upper endoscopy or documentation of fifty (50) cases within the previous twenty-four (24) months is required.
Proctoring: Two (2) cases if training was completed within the previous twenty-four (24) months prior to granting of privileges or if training was completed more than twenty-four months prior to granting privileges and documentation of fifty (50) cases was provided; Five (5) cases if training was completed greater than twenty-four (24) months prior to granting of privileges and documentation of refresher course was provided. Proctoring for this privilege should include proctoring supplied for the Bariatric EGD privilege and/or proctored cases supplied for Transoral Esophagogastric Fundoplication (TIF).
Reappointment: Seven (7) cases within the previous twenty-four (24) months

___ Upper endoscopy (EGD) – intraoperative/as integral part of operation (i.e., Heller myotomy, gastric bypass), or as preoperative evaluation or as follow-up for specific operative procedures

Colonoscopy Criteria:
Initial: Completion of ACGME-accredited training program in General Surgery or Colon and Rectal Surgery within the previous twenty-four (24) months. If training was completed greater than twenty-four (24) months ago, documentation of fifty (50) cases within the previous twenty-four (24) months is required.
Proctoring: Two (2) cases
Reappointment: ~~Ten (10)~~Five (5) cases within the previous twenty-four (24) months

___ Colonoscopy

Endovenous Ablative Therapy Criteria:
Initial: Documentation of completion of product-sponsored training, which included the performance/interpretation of twenty (20) endovenous ablative therapy procedures.
Proctoring: Three (3) cases
Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Endovenous Ablative Therapy

___ Endovascular Repair of Aortic Aneurysms (Refer to Credentialing Policy, Standards for Endovascular Repair of Aortic Aneurysms #8710-503 for Initial, Proctoring, and Reappointment criteria)

Tri-City Medical Center

Delineation of Privileges

General & Vascular Surgery - (Revised ~~12/16~~6/20)

Provider Name:

Request	Privilege

KTP Laser Criteria:
Initial: Documentation of completion of training for specific energy source(s) to be used. Or, if training completed greater than two years prior to privilege request, submit case logs from previous 24 months identifying specific energy source used.
Proctoring: Two (2) cases
Reappointment: Two (2) cases within the previous twenty-four (24) months

___ KTP Laser

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

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

___ Robotic surgery - Multiple Port (da Vinci) - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)

___ Robotic surgery - Single Port (cholecystectomy only) (da Vinci) - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)

___ Assist in robotic surgery (da Vinci) - (Refer to policy #8710-563 for Initial, Proctoring, and Reappointment Criteria)

___ Xi Robotic Privileges
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

___ Assist in Xi Robotic
Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case
Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

Transoral Esophagogastric Fundoplication (TIF) Criteria:
Initial:
1. Completion of ACGME accredited residency program and possess board certification or board eligibility in Surgery; and
2. Documentation of completion of product-sponsored training course, or have performed at least five (5) TIF procedures in the previous twelve (12) months.
Proctoring: Three (3) cases
Reappointment: Six (6) cases within the previous twenty-four (24) months

___ Transoral Esophagogastric Fundoplication (TIF)

Placement of Vagal Nerve Stimulator Criteria:
Initial:
1. Basic General Surgery privileges which effectively covers the need for board certification.
2. Documentation of performing five (5) vagal nerve stimulator cases in the previous twenty-four (24) months or successful completion of VNS Therapy System Surgeon Training Program.
Proctoring: Two (2) cases
Reappointment: Five (5) cases within the previous twenty-four (24) months

___ Placement of vagal nerve stimulator

Tri-City Medical Center

Delineation of Privileges

General & Vascular Surgery - (Revised ~~12/16~~6/20)

Provider Name: _____

Request	Privilege

Print Applicant Name

_____

Applicant Signature

_____

Date

_____

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

_____

Date

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Ophthalmology

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

Physician's Name: Kevin Garff, M.D.

Area of Service: Emergency Department On-Call: Ophthalmology

Term of Agreement: 23 months, Beginning, August 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

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

Position Responsibilities:

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

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

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 approve the addition of Dr. Kevin Garff to the currently existing ED On-Call Coverage Panel for Ophthalmology for a term of 23 months, beginning August 1, 2020 and ending June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – OB/GYN

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

Physician's Names: Leticia Campbell, M.D.

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

Term of Agreement: 23 months, Beginning, August 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

OB-GYN - Rate/Day	Panel Days per Year	Panel Annual Cost
Weekday $800 Weekend/holiday $1,000	FY21: 254 FY21: 111	$203,200 $111,000
Weekday $800 Weekend/holiday $1,000	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 approve the addition of Dr. Leticia Campbell to the currently existing ED On-Call Coverage Panel for OB-Gyn for a term of 23 months, beginning August 1, 2020 and ending June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardio-Thoracic Surgery

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

Physician's Names: Yuan Hwang Lin, M.D.

Area of Service: Emergency Department On-Call: Cardio-Thoracic Surgery

Term of Agreement: 24 months, Beginning, September 1, 2020 – Ending, August 31, 2022

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

Rate/Day	Panel Days per Year	Panel Annual Cost
$1,000	FY2021: 365 days FY2022: 365 days	$365,000 $365,000
	Total Term Cost:	**$730,000**

Position Responsibilities:

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

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

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 Dr. Yuan Hwang Lin as an ED On-Call Coverage physician for Cardio-Thoracic Surgery for a term of 24 months, beginning September 1, 2020 and ending August 31, 2022, at the daily rate of $1,000 for an annual rate of $365,000 and a total term cost of $730,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – General Surgery

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

Physician's Name: Kristen M. Blaker, M.D.

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

Term of Agreement: 12 months, Beginning, August 1, 2020 – Ending July 31, 2021

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

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

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

Position Responsibilities:

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

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

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 approve the addition of Dr. Kristen M. Blaker to the currently existing panel agreement for ED On-Call Coverage-General Surgery for a term of 12 months, beginning August 1, 2020 and ending July 31, 2021.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardio-Thoracic Surgery

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

Physician's Names: Darrell Wu, M.D.

Area of Service: Emergency Department On-Call: Cardio-Thoracic Surgery

Term of Agreement: 24 months, Beginning, September 1, 2020 – Ending, August 31, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared call panel; no increase in expense

Rate/Day	Panel Days per Year	Panel Annual Cost
$1,000	FY2021: 365 days FY2022: 365 days	$365,000 $365,000
	Total Term Cost:	**$730,000**

Position Responsibilities:

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

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

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 Dr. Darrell Wu as an ED On-Call Coverage physician for Cardio-Thoracic Surgery for a term of 24 months, beginning September 1, 2020 and ending August 31, 2022, at the daily rate of $1,000 for an annual rate of $365,000 and a total term cost of $730,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 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: Morgan Silldorff, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 21 months, Beginning, October 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of physician to current shared call panel; no increase in expense

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 Orthopedics 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, Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the addition of Dr. Morgan Silldorff to the currently existing ED On-Call Coverage Panel for Orthopedics for a term of 21 months, beginning October 1, 2020 and ending June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE - Gastroenterology – General & ERCP

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

Vendor's Name: Hellen Chiao, M.D.

Area of Service: Emergency Department On-Call: Gastroenterology

Term of Agreement: 21 months, Beginning, October 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of physician to current shared call panel; no increase in expense

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

Description of Services/Supplies:

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

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

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 approve the addition of Dr. Hellen Chiao to the currently existing ED On-Call Coverage Panel for Gastroenterology-General & ERCP for a term of 21 months, beginning October 1, 2020 and ending June 30, 2022.

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

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

Vendor's Name: Richard Liu, M.D.

Area of Service: Emergency Department On-Call: ENT - Otolaryngology

Term of Agreement: 12 months, Beginning, August 1, 2020 - Ending, July 31, 2021

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

Rate/Day	Annual Cost	Total Term Cost
$650	$237,250	$237,250

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors approve the addition of Dr. Richard Liu to the currently existing ED On-Call Coverage Panel for ENT-Otolaryngology for a term of 12 months, beginning August 1, 2020 and ending, July 31, 2021.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, General

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

Vendor's Name: Aaron Yung, M.D.

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

Term of Agreement: 22 months, Beginning, September 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

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

Description of Services/Supplies:

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

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

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 approve the addition of Dr. Aaron Yung to the currently existing ED On-Call Coverage Panel for Cardiology-General for a term of 22 months, beginning September 1, 2020 and ending, June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, STEMI

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

Vendor's Name: Aaron Yung, M.D.

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

Term of Agreement: 22 months, Beginning, September 1, 2020 – Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

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

Description of Services/Supplies:

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

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

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

Motion:
I move that the TCHD Board of Directors approve the addition of Dr. Aaron Yung. to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 22 months, beginning September 1, 2020 and ending, June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Cardiology, General

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

Vendor's Name: Hanh Bui, M.D.

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

Term of Agreement: 22 months, Beginning, September 1, 2020 - Ending, June 30, 2022

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Addition of new physician to current shared call panel; no increase in expense

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

Description of Services/Supplies:

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

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

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 approve the addition of Hanh Bui, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-General for a term of 22 months, beginning September 1, 2020 and ending June 30, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 27, 2020
PHYSICIAN AGREEMENT for Radiological Services & Radiology Medical Director Services

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

Physician's Name: San Diego Imaging Medical Group

Area of Service: Radiology Services

Term of Agreement: 36 months, Beginning, July 1, 2020 – Ending, June30, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$0	$0	$0

Position Responsibilities:

- Provide 24/7 Physician Coverage for diagnostic radiological supervision and radiologic procedure coverage.
- Provide 24/7 consultation services to assure high quality radiological services
- Provide written diagnostic results for all radiologic tests / procedures performed per regulatory guidelines
- Provide Medical Direction / Supervision and overall responsibility for radiological services
- Complete related medical records in accordance with all Medical Staff, accreditation, and regulatory requirements.
- No fees are associated with the agreement other than facility space and business supply needs for the physician on-site operations.

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

Person responsible for oversight of agreement: Scott Livingstone, Chief Operating Officer

Motion: I move that the TCHD Board of Directors approve the agreement with San Diego Imaging Medical Group to provide radiological services, supervision and medical directorship coverage for a term of 36 months beginning July 1, 2020 and ending June 30, 2023 for an annual and term cost of $0.

ADMINISTRATION CONSENT AGENDA
July 16th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. 72 Hour Hold, Evaluation and Treatment of the Involuntary Patient Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Abduction Shoulder Splint (Airplane Splint, Don Joy Ultra Sling and ARC Shoulder Brace) Procedure	DELETE	Forward To BOD For Approval
3. Abduction Splint Application (Hip) Procedure	3 Year Review	Forward To BOD For Approval
4. Assault Victims/Domestic Violence, Reporting Requirements	3 Year Review	Forward To BOD For Approval
5. Autopsy, Authorization of Policy	3 Year Review	Forward To BOD For Approval
6. Food and Nutrition Relationships with Other Departments Policy	3 Year Review, Practice Change	Forward To BOD For Approval
7. Immediate Use Sterilization, Intraoperative	3 Year Review, Practice Change	Forward To BOD For Approval
8. Knee Immobilizer Application and Range of Motion (ROM) Brace Procedure	3 Year Review	Forward To BOD For Approval
9. Lift Team Policy	3 Year Review, Practice Change	Forward To BOD For Approval
10. Missing Patient	3 Year Review, Practice Change	Forward To BOD For Approval
11. Nutrition Education of Patients Policy	3 Year Review, Practice Change	Forward To BOD For Approval
12. Organ Donation, Including Tissue and Eyes Policy	3 Year Review, Practice Change	Forward To BOD For Approval
13. Patient and Family Education Policy	3 Year Review	Forward To BOD For Approval
14. Patient Valuables Liability and Control	3 Year Review, Practice Change	Forward To BOD For Approval
15. Pertussis Nasopharyngeal (NP) Swab, Adult Procedure	DELETE	Forward To BOD For Approval
16. Referrals to Social Services for Biopsychosocial Assessment Policy	3 Year Review, Practice Change	Forward To BOD For Approval
17. Wound Classification During Surgical Intervention	3 Year Review, Practice Change	Forward To BOD For Approval
18. Wound VAC, Negative Pressure Therapy Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Administrative Policies & Procedures		
1. Decorative Material 248	3 Year Review	Forward To BOD For Approval
2. Fair Treatment for Supervisory and Management Employees 427	3 Year Review, Practice Change	Forward To BOD For Approval
3. Security Controls 612	3 Year Review, Practice Change	Forward To BOD For Approval
Unit Specific		
Emergency		
1. Boarders-Policy	3 Year Review,	Forward To BOD

ADMINISTRATION CONSENT AGENDA
July 16th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
	Practice Change	For Approval
2. Release of a Minor Under 18 Years of Age Policy	3 Year Review, Practice Change	Forward To BOD For Approval
Employee Health & Wellness		
1. Injury Illness Prevention Program	3 Year Review, Practice Change	Forward To BOD For Approval
Home Care		
1. Agency Evaluation Indicators	DELETE	Forward To BOD For Approval
2. Case Conference	DELETE	Forward To BOD For Approval
3. Committees	DELETE	Forward To BOD For Approval
4. Contracted Services	3 Year Review,	Forward To BOD For Approval
5. Mileage Expense Reimbursement	3 Year Review, Practice Change	Forward To BOD For Approval
6. Mosby's Clinical Index of Nursing Skills for Procedures to Follow in Home Health	3 Year Review, Practice Change	Forward To BOD For Approval
7. Notice of Medicare Non Coverage HMO	3 Year Review, Practice Change	Forward To BOD For Approval
8. Notice of Medicare Provider Non Coverage - Notice of Medicare Non Coverage for HMO	3 Year Review	Forward To BOD For Approval
9. Pain Symptom Management	3 Year Review, Practice Change	Forward To BOD For Approval
10. Scope of Services - Description of Setting	3 Year Review, Practice Change	Forward To BOD For Approval
11. Staff Safety	3 Year Review, Practice Change	Forward To BOD For Approval
Medical Staff		
1. Unintended Intraoperative Awareness During General Anesthesia 8710-546	3 Year Review	Forward To BOD For Approval
NICU		
1. Infection Prevention - NICU	2 Year Review, Practice Change	Forward To BOD For Approval
2. Nasojejunal (NJ) Tube Insertion, Maintenance, and Removal of	DELETE	Forward To BOD For Approval
3. Thermoregulation for VLBW infants	2 Year Review, Practice Change	Forward To BOD For Approval
Outpatient Specialty Clinic		
1. Age Specific Guidelines	DELETE	Forward To BOD For Approval
2. Bomb Threat	DELETE	Forward To BOD For Approval
3. Collaboration / Continuity of Patient Care	DELETE	Forward To BOD For Approval
4. Custody of Patients	3 Year Review	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
July 16th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
5. Data Management	DELETE	Forward To BOD For Approval
6. Disseminating Medical Information	DELETE	Forward To BOD For Approval
7. Emergency Evacuation	DELETE	Forward To BOD For Approval
8. Environment of Care	DELETE	Forward To BOD For Approval
9. Fire Alarm / Evacuation Plan	DELETE	Forward To BOD For Approval
10. Medical Equipment Maintenance	DELETE	Forward To BOD For Approval
11. Patient Record Content	3 Year Review, Practice Change	Forward To BOD For Approval
12. Registration of Patients	3 Year Review, Practice Change	Forward To BOD For Approval
13. Scheduling and Tracking Appointments	3 Year Review, Practice Change	Forward To BOD For Approval
14. Staffing Plan	DELETE	Forward To BOD For Approval
15. Unit Specific Orientation	DELETE	Forward To BOD For Approval
Patient Care Management		
1. Utilization Management Plan Policy	1 Year Review	Forward To BOD For Approval
Surgical Services		
1. Discharge of Post Anesthesia and Post Sedation Patients to Inpatient Units Policy	3 Year Review, Practice Change	Forward To BOD For Approval
2. Duodenoscope Sampling For Quality Control Culturing Procedure	NEW	Forward To BOD For Approval
Telemetry		
1. Assistant Nurse Manager-Relief Charge Nurse Duties and Responsibilities	DELETE	Forward To BOD For Approval
2. Bed Flow	3 Year Review, Practice Change	Forward To BOD For Approval
3. Monitoring Telemetry Patients Using the DASH 3000	3 Year Review, Practice Change	Forward To BOD For Approval
4. Nursing Responsibilities for Admissions	3 Year Review, Practice Change	Forward To BOD For Approval
5. Orientation of Registry Staff	3 Year Review, Practice Change	Forward To BOD For Approval
6. Staff Meetings	DELETE	Forward To BOD For Approval
7. Telemetry Patient Shift to Shift Hand-off Process	DELETE	Forward To BOD For Approval
Wound Care		
1. Patient Instructions	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
July 16th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
2. Specimen Transport	DELETE	Forward To BOD For Approval
3. Unit-Specific Orientation	3 Year Review	Forward To BOD For Approval
Wound Hyperbaric Oxygen Therapy		
1. Patient Instruction	DELETE	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/07	**SUBJECT:** ~~72-Hour~~ Holds, Evaluation and Treatment of Involuntary Patients
REVISION DATE: 12/08, 05/11	**POLICY NUMBER:** II.B

Department Approval:	~~11/16~~05/18
Clinical Policies & Procedures Committee Approval:	~~12/16~~03/20
Nursinge Leadership ~~Executive Council~~ Approval:	~~01/17~~04/20
Division of Psychiatry Approval:	~~06/17~~05/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~06/20
Administration Approval:	07/20
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. To ensure individuals presenting to **the Emergency Department (ED) or admitted to a medical floor at** Tri-City Healthcare District (TCHD), **a non-Lanterman-Petris Short (LPS) designated facility,** with symptoms that **place**~~put~~ them at high risk for danger to themselves or others or who meet criteria for being considered gravely disabled are evaluated and treated in accordance with the procedural requirements set forth in the Lanterman-Petris-Short (LPS) Act, **Welfare and Institutions Code (WIC), section 5150, California Assembly Bill No. 1424 (AB 1424), California Health and Safety (H&S) Code section 1799.111, and the San Diego County Board of Supervisors' Resolution No. 05-232.**
2. To ensure patient rights are respected **while on involuntary holds**~~for those patients receiving behavioral health services at TCHD~~.
3. To clarify the **legal** process **along with** each staff member's legal responsibilities for **WIC** 5150s, **and patients eligible for a 24-hour hold under H&S 1799.111** ~~5151s, and 5152s~~ **at a non-LPS designated facility, such as TCHD**.

B. **SCOPE AND APPLICABILITY:**

1. This policy applies to all patients evaluated and treated on an involuntary basis for an emotional or behavioral disorder in the Emergency Department (ED) as well as inpatient ~~and outpatient settings of TCHD~~.

C. **DEFINITION(S):**

1. Lanterman-Petris-Short (LPS) Act **(WIC 51000 et seq.)**: This act establishes procedural requirements under which persons found to be dangerous to themselves or others or are gravely disabled due to **a** mental disorder **which,** ~~inebriation, or the use of narcotics or restricted dangerous drugs~~ may be involuntarily detained for specified periods for evaluation and treatment. ~~These periods include:~~
   - **a. Prolonged holds cannot be used at non-LPS facilities regarding additional hold, thus do not apply to TCHD (WIC 5152, 5250, 5260, 5270, 5300).**
   - ~~a.~~**b. In certain instances, LPS designation guidelines require that the LPS designated facility first conduct a WIC 5151 assessment to determine whether or not the involuntary detention is appropriate and inpatient admission is required. This requires the involvement of a professional with admitting privileges at the LPS**

designated facility. Because TCHD is a non-LPS facility, this is not applicable to TCHD.

2. **5150 hold or 72-hour hold:** An initial 72-hour hold for evaluation and treatment **that applies only in the Emergency Department (WIC 5150).**
   a. **This is a "hold and transport" to a designated LPS facility and is for the temporary, involuntary psychiatric commitment of individuals who present a danger to themselves or others due to signs of mental illness.**
3. **1799.111 hold or 24-hour hold: A 24-hour hold for evaluation and treatment, while admitted to the hospital (H&S 1799.111).**
   a. **The law provides for a 24-hour 1799 medical hold, placed by a physician, in which a patient who comes to the emergency room for medical treatment and is then discovered also to have a psychiatric problem that requires attention. If necessary, a 1799 hold can be converted into a 5150 hold.**
   ~~b. An additional 14-day intensive treatment period.~~
   ~~c. An additional 30-day intensive treatment period after the 14-day period of treatment has ended.~~
   ~~d. Further confinement depending on the patient's condition~~
      ~~i. A second 14-day intensive treatment period for persons who are imminently suicidal.~~
      ~~ii. An additional 180-day confinement for persons who present a demonstrated danger to others.~~
      ~~iii. Confinement pursuant to a conservatorship for persons who are gravely disabled.~~

~~2.~~4. Gravely **Disabled (defines how one can be placed on a hold)**:
   a. A condition in which a person, due to mental disorder or, in some cases, chronic alcoholism, is unable to provide for his/her basic personal needs for food, clothing, or shelter. **(WIC 5008(h)(1); H&S 1799.111(a)(1)).**
   b. **A person, as a result of a mental disorder, is in danger of serious physical harm resulting from failure to provide for his or her essential human needs of health or safety**~~A condition in which a person has been found mentally incompetent under California Welfare and Institutions Code §5008(h)(1) Code~~.
   c. Mental retardation, by itself, does not constitute a grave disability
5. **Probable Cause (defines when one can be placed on a hold): To constitute probable cause to detain a person pursuant to section 5150, a state of facts must be known to the law enforcement officer (or other authorized person) that would lead a person of ordinary care and prudence to believe, or to entertain a strong suspicion, that the person detained is mentally disordered and is a danger to himself or herself or is gravely disabled. In justifying the particular intrusion, the person initiating the hold must be able to point to specific and articulable facts which, taken together with rational inferences from those facts, reasonably warrant his or her belief or suspicion. (*See People v. Triplett* (1983) 144 Cal. App.3d 287-288).**
   a. **When determining if probable cause exists to detain a person all available relevant information about the historical course of the person's mental disorder shall be considered if it has reasonable bearing on the determination (HS 1799.111, WIC 5150, AB 1424). This information must be documented in the medical record.**
      i. **The evidence does not have to be personally observed by the evaluator and may be observations reported to the evaluator by a reliable witness, which includes family members and/or significant others.**
      ii. **See "Detention of Patient with Psychiatric Emergency In a Nondesignated Health Facility" form**
6. **Writ of Habeous Corpus: A legal proceeding during which the individual being detained may challenge the grounds of their involuntary hold. This may occur when the 5150 or 1799.111 hold expires.**

7. **Medical Emergency: Medical condition manifesting as acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of an individual (or with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.~~ (42 California Code of Regulations CFR Section 489.24(b))~~.**

~~3. California Welfare and Institutions Code Section 5150:~~

~~a. When a person, due to mental disorder, is a danger to self or others or is gravely disabled, the person may be taken into custody by authorized persons and placed in a facility designated and approved by the county and the Department of Mental Health as a facility for 72 hour evaluation and treatment.~~

~~b. A 5150 gives the issuing party the authority to only detain and transport the patient until a 5151 has been completed. A 5150 may be released only under the following two circumstances:~~

~~i. The 5150 issuing party obtains further information that the patient does not meet criteria and discontinues the 5150 or~~

~~ii. The 5151 (Psychiatric Assessment) is complete and the 5151 designee determines through assessment that the patient does not meet 5150 criteria.~~

~~4. California Welfare and Institutions Code Section 5151:~~

~~a. Prior to admitting a person for 72 hour treatment and evaluation, a professional person in charge of the facility or his/her designee shall assess the individual in person to determine the appropriateness of the involuntary detention (5150). This designation has been placed with the Psychiatric Liaison (PL) to complete the 5151 face to face assessments.~~

~~i. It is to be determined by the PL whether to drop the 5150 or proceed with a 5152.~~

~~ii. The PL has the authority designated upon them to discontinue any 5150s placed on individuals. 5150's initiated by TCHD emergency physicians do not need a psychiatrist to discontinue them, but may be discontinued by the PL upon completion of the 5151 face to face assessment.~~

~~5. California Welfare and Institutions Code Section 5152:~~

~~Once admitted the individual is now detained under a 5152, which gives authority to the LPS facility to admit, observe and treat individuals for a period of 72 hours. Individuals may be released before 72 hours has elapsed only under the direction of a Psychiatrist's personal evaluation.~~

D. **POLICY:**

1. **Persons detained under WIC 5150 and/or H&S 1799.111 retain their legal rights regarding consent for medical treatment.**
   a. **A person does not give up the right to control his or her medical treatment simply because he or she has been diagnosed with a mental disorder.**
      i. **Capacity to consent to medical treatment is a separate issue and must be assessed by the treating physician with all mental health patients before proceeding with medical treatment.**
      ii. **Emergency treatment exception: Treatment of a medical emergency may be provided without consent if~~were~~ the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or of a patient authorized to consent on behalf of the patient.**
         1) **A medical emergency exists when:**
            a) **Immediate services are required for alleviation of severe pain; or**
            b) **Immediate diagnosis and treatment of unforeseeable medical conditions are required, is such conditions would lead to serious disability or death if not immediately treated.**
      ~~i.~~iii. **See Patient Care Services Policy: Consent for Operative or Other Procedures and Patient Care Services Policy: Consent for Minors.**

~~D.~~E. **72-HOUR HOLD (WIC 5150):**

1. Individuals who **may**~~are able to~~ initiate a 72-hour hold include:
   - a. Peace ~~officers~~**Officers**
     - i. **Peace Officers/ Psychiatric Emergency Response Team (PERT) should only bring 5150 hold to ED if there is a medical emergency or a life threatening condition.**
   - b. Members of the ~~Psychiatric Emergency Response Team (~~PERT~~)~~
   - c. **ED Physicians who are authorized to admit a person to the facility and who have been designated/certified by the Board of Supervisors of the County of San Diego, Resolution No. 05-232, and WIC section 5150, specifically at TCHD, a non LPS facility.**
     - i. **To be authorized, the ED Physician must complete the San Diego County training, pass the test with at least 85%, and be certified by the County.**
     - ii. **All TCHD ED Physicians must obtain this certification in order to place a 5150 hold.**
       - 1) **The Board of Supervisors of San Diego authorizes only those ED physicians to place a hold who meet the following criteria:**
         - a) **The professional person will be appropriately licensed within his/her discipline in the State of CA and act only within the scope of his/her practice, and**
         - b) **The individual will have successfully completed training and testing approved by the Local Mental health Director or Local Mental Health Director Designee related to the WIC sections 5150 and 5585.50 detention process.**
     - iii. **Only ED physicians may place a 5150 in the ED in acute care hospitals with non- LPS hospitals.**
       - 1) **Note: Psyche Liaisons (PL) do not have the authority to initiate a 5150 hold. PL's may, however, evaluate a patient and make recommendations to the ED Physician.**
     - iv. **An ED Physician should only place the patient on 5150 hold if the patient must be transferred to LPS facility.**
       - 1) **If an ED physician examines patient and determines patient is voluntary vs involuntary, no need for to renew 5150 or place on a 5150 while in the ED.**

   ~~b. Members of the attending staff who are authorized to admit a person to the facility and who have been designated by San Diego County to do so, specifically at TCHD.~~
   ~~c. Other professional persons designated by the county including registered nurses and/or PL personnel~~
2. Designated personnel initiating a 72-hour evaluation (5150) are required to complete a written application which states the following:
   - a. Circumstance under which the individual's condition was called to his/her attention
   - b. Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled.
3. The written application must be completed for individuals brought to the ED as well as for those patients already being treated in the ED. **The application must include the circumstances under which the patient's condition was called to the attention of the law enforcement officer or authorized professional person; and that there is probable cause to believe that the patient is, as a result of mental disorder, a danger to others, or to themself, or gravely disabled.**

   ~~a. When determining if probable cause exists to detain a person pursuant to Welfare and Institutions Section 5150 and California AB 1424, all available relevant information about the historical course of the person's mental disorder shall be considered if it has reasonable bearing on the determination.~~

4. Specific Considerations for 5150 patients brought in by law enforcement agencies:
   a. WIC sections 5150.1 and 5150.2 restrict mental health professionals from interfering with law enforcement officers who may be transporting a person to TCHD for assessment to a LPS-designated facility for assessment. However, when law enforcement brings an individual on a 5150 hold to a non-LPS facility and leaves the patient in the ED, such as TCHD, the 5150 transport is not complete and the hold is terminated.
   b. The law enforcement officer who initiated the 5150 is encouraged to remain with the patient until he or she is medically cleared for transport to a LPS facility and thus the 5150 hold stays intact for transport.
      i. Once medically cleared, the law enforcement officer is required to transport the patient to a LPS Facility to complete the 5150 process.
   c. If the law enforcement officer leaves the patient at TCHD, the hold is no longer in effect.
      i. The ED Physician may then place a new 5150 hold if, in the physician's opinion, the patient meets the criteria. However, the time of the 72-hour hold initiated by the ED physician begins at the time of the first law enforcement hold.(time must be credited with new 5150 hold), i.e. if law enforcement placed the patient on a 5150 hold at midnight and transfers the patient to the ED at 5:00 am and leaves, then the ED Physician must credit 5 hours to the new 72 hour hold.
5. A 5150 gives the issuing party the authority to only detain and transport the patient until a 5151 has been completed. A 5150 may be released under the following two circumstances:
   a. The 5150 issuing party obtains further information that the patient does not meet criteria and discontinues the 5150.
      i. For instance, if the patient is a voluntary admission and wants help, because the person is voluntary, this does not require a 5150, or if the patient is not a danger to self or others and is not gravely disabled, or the person does not meet the criteria for a 5150 hold.
      ii. The admitting non-designated LPS facility ED physician determines the patient is not a 5150, with same criteria immediately above.
   b. The 5150 issuing party is a law enforcement officer or PERT member, and he or she presents the patient to a non-LPS Facility ED and does not remain with the patient until the patient is medically cleared for transport (the 5150 is by operation of law is terminated or void).
6. A 5150 remains in effect:
   a. If the issuing outside agent places the 5150, remains with the patient in the ED until the patient is medically cleared for transport to a LPS facility, that 5150 remains in effect for purposes of detention and transport to a LPS facility.
      i. For example, if a law enforcement officer brings a patient to TCHD on a 5150, who has cut their wrists wanting to harm self and the officer stays with the patient until they are sutured and medically safe/stable, then the patient can be transported and discharged with that officer to another LPS facility and the 5150 remains in effect.
   b. 5150 holds can only be used in the ED. If a patient is transferred to a medical floor of a non-LPS facility, the hold is invalid.
7. Individuals who may remove a 72-hour hold at a TCHD (a Non-LPS Facility) include:
   a. The LPS Act and WIC are silent on who may remove a 5150 hold at non-LPS facility.
   b. TCHD's policy, custom and practice authorizes the below licensed professionals to remove 5150 holds:
      i. ED Physicians

ii. PLs under the direction of the ED Physician and who have been certified by the County of San Diego. ED physicians should monitor PL's removal.
iii. On call Psychiatrists

8. If the 72-hour (5150) hold expires before the PL and/or ED Physician finds placement for the patient at a LPS facility, TCHD can continue to hold the patient if the PL and/or ED Physician provide the patient with information regarding requesting a Writ of Habeas Corpus (because the patient will continue to be on a hold). The following is required:
   a. Proper Documentation of the following is required:
      i. The patient received Writ of Habeas Corus paperwork, including education materials.
      ii. The hospital staff, treating physician, or appropriately licensed mental health professional have made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person.
         1) Efforts to find placement at a LPS facility must begin when the treating physician has determined the time at which the patient will be medically stable for transfer.
         2) The efforts to find placement at LPS facility must not begin after the time when the patient becomes medically stable for transfer.
   b. If the patient chooses to seek a writ, PL will help patient complete the form and fax to the Office of the Public Defender.
   c. If patient declines to seek a writ, PL will ask patient to sign declination form and document the medical record.
      i. If patient refuses to sign the declination, PL will note the refusal in the medical record.
   d. PL will continue to make efforts to obtain placement at LPS facility and document all efforts in the medical record.
   e. If the patient admitted to the ED is suicidal and not medically stable, it should be determined whether the patient is alert enough for 5150 hold. If the patient is comatose, etc., it is not necessary for 5150 hold since the patient is not a danger to ~~themsleft~~themselves since they are not alert. ED physicians should use their own discretion. An ED physician can later place a 5150 hold when the patient begins wakening~~, to reserve time for hold while in the ED~~.
      ~~i. The officer(s) shall not be detained unreasonably when presenting with a patient to the ED.~~
      ~~ii. Once on Tri-City Medical Center's campus, the officers may not be directed to transport the patient to another facility nor asked to wait outside the ED.~~
      ~~iii. The ED clinical staff shall expeditiously process the patient into the ED and place the patient in the safest available space as quickly as possible.~~
      ~~iv. When a patient brought into the ED for evaluation by law enforcement is not admitted pursuant to the 5150 hold, and declines alternative mental health services, that person will have their custody transferred to the law enforcement agency when there is a criminal detention pending.~~

~~b. All efforts shall be made to ensure the peace officers are relieved of their responsibility for the patient within one (1) hour of arrival.~~
~~During ED saturation, ED Staff may not be immediately available to relieve the peace officer. The peace officer shall be asked to remain with the patient for safety reasons. Every effort shall be made to minimize the time a peace officer is needed to monitor the patient.~~

F. <u>24-HOUR HOLD (H&S 1799.111):</u>

~~4.~~1. Under California Health and Safety Code section 1799.111~~:~~ ~~N~~non-LPS Facilities may use Health and Safety Code section 1799.111 to hold a patient up to 24-hours for the purposes of transferring to a LPS Facility, when, in the opinion of the treating physician, licensed professional staff (PL) or a clinical psychologist with medical staff privileges,

the person cannot be safely released from the hospital because, as a result of a mental disorder, the patient presents a danger to himself or herself, or others, or is gravely disabled (as defined above).

~~5.~~2. If a patient is on a 5150 hold and is transferred from the ED to the floor, the 5150 hold is void.

3. The 24-hour hold should be used only when admitted to the medical floor and may be initiated by licensed professional staff of TCHD (i.e., PLs), or any physician and/or surgeon at TCHD.
   a. The code does not mandate the need for a certification or authorization to hold an individual like a 5150 for physicians, rather ~~it~~the code provides immunity when a patient must be held for reasons of safety in a non-LPS facility until transfer to a LPS facility for appropriate care that can be arranged.

4. Section 1799.111 hold may be initiated if the following criterion are met:
   a. The patient cannot be safely released from the hospital because, in the opinion of the licensed professional staff, physician or surgeon, the patient, as a result of a mental disorder, presents a danger to themselves, or others, or is gravely disabled (as defined above).
      i. There must be probable cause for the detention, as defined above.
   b. The licensed professional staff, physician or surgeon, has made and documented repeated unsuccessful efforts to find appropriate mental health treatment for the person. (this must be conducted at time of patient admission to the floor).
      i. Telephone calls or other contacts shall commence at the earliest possible time when the treating physician has determined the time at which the person will be medically stable for transfer, and documented in the medical record.
      ii. The efforts to find placement at a LPS facility shall not be delayed until ~~begin after~~ the time when the patient becomes medically stable for transfer. Rather, they should begin as soon as possible and should be documented once the hold is in place. (H&S 1799.111((a)(2)(B)).
         1) In other words, to be protected by the immunity in Section 1799.111, the efforts to find placement at a LPS Facility must begin <u>before the patient is medically stable.</u>

5. The licensed professional staff, physician or surgeon initiating the 24-hour hold shall complete the: "Detention of Patient with Psychiatric Emergency in a Non-designated Health Facility" form, which states the following:
   a. How the individual's condition was called to the attention of the licensed professional staff, physician or surgeon;
   b. Probable cause to believe the person is, due to mental disorder, a danger to self or others or is gravely disabled; and
   c. Licensed professional staff, physician or surgeon, have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.
   d. Complete Form, and place into medical records.

6. Section 1799.111 24-hour detention starts when the patient is medically stable for transfer.

7. If the 24-hour hold expires and the patient still poses a threat to themselves or others, or is gravely disabled, and placement at a LPS Facility has not been secured despite documented efforts, medical staff must inform the patient of the following:
   a. The continued need to hold the patient;
   b. That the 24-hour hold is expiring;
   c. That efforts have been made and continue to be made to find placement at LPS Facility, and
   d. PL and/or physician MUST advise the patient of their right to request a writ hearing.

i. **Provide the patient the "Notice of Request for Writ of Habeas Corpus" form and education materials.**

ii. **If the patient would like to request a Writ of Habeas Corpus:**

1) **PL or other healthcare provider shall assist the patient to complete the Notice of Request for Writ of Habeas Corpus form.**

2) **PL or other healthcare provider will fax the completed form to the Office of the Public Defender.**

3) **A copy of the completed form shall be maintained in the medical record.**

4) **If the patient declines to request a writ, the PL or other healthcare provider shall document the declination in the medical record.**

5) **PL or other healthcare provider shall present a declination form to the patient to sign and memorialize his/her decision not to request a writ.**

6) **If patient refuses to sign the declination form, PL or other healthcare provider shall notate the refusal in the medical record.**

8. **The hold, with proper documentation, continues until placement of patient at LPS facility.**

~~E.~~**G.** **PROCEDURE FOR ED:**

1. ED Clinical staff shall

a. Notify the Security Department when an individual is admitted to the ED pursuant to the initiation of a 5150.

b. For patients identified as a high risk for elopement, the clinical staff shall:

~~i.~~**c.** Place the patient in a secure room ~~with only one exit~~ that facilitates close observation **by Patient Safety Technician.** ~~and monitoring.~~ **Refer to Patient Care Services: Sitter Policy.**

~~ii. Offer a nicotine patch for those patients requesting to smoke; they are not allowed to leave the ED for this purpose.~~

~~iii. Arrange for a sitter to remain in direct observation of patient. Refer to Patient Care Services: Sitter Policy.~~

~~iv.~~**i.** Assist the patient with removing his/her clothing including all undergarments, shoes and socks, and place the patient in a hospital gown.

1) Secure all the patient's personal belongings in a locked cabinet and out of reach of the patient.

~~v.~~**ii.** Place the wandering bracelet on the patient's wrist after activation.

~~vi.~~**iii.** Perform an initial assessment of the patient and implement necessary interventions to ensure the patient's immediate safety and the safety of the environment.

~~vii.~~**iv.** Communicate the patient's status to the **Charge RN,** ~~ED Assistant Nurse Manager (ANM)/designee, the~~ Physician, and Security.

~~c.~~**d.** Facilitate an evaluation by the PL as soon as possible and whenever possible before the patient has been given medications that may be sedating or restrict his/her ability to participate in a mental status evaluation.

~~d.~~**e.** Maintain ongoing communication with the PL regarding the plan for treatment.

f. Monitor the patient at regular intervals, as clinically indicated to provide safe and effective nursing care.

~~e.~~**g.** **If patient is suicidal, Patient Safety Technician must continuously monitor, and documenting patient status every 15 minutes monitoring per Patient Care Services Policy: Assessing and Managing Patients at Risk for Suicide.**

~~f.~~**h.** Ensure that the patient's rights are respected including:

~~i. The right to refuse medications unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment~~

~~ii.~~**i.** The right to be free from restraint or seclusion and to be treated in the least restrictive environment unless the presenting behavior constitutes an imminent threat to the safety of the patient or others in the immediate environment

~~iii.~~**ii.** The right to be treated with dignity and respect.

~~g.~~**i.** Complete all necessary documentation in accordance with TCHD policy, including documentation associated with the use of restraint or seclusion.

~~2. The PL shall:~~

~~a. Perform a mental status examination and other assessments for individuals referred for a psychiatric evaluation, including:~~

~~i. Suicide Risk Assessment~~

~~ii. Elopement Risk Assessment~~

~~b. Maintain availability for 1st hour evaluations of patients placed in restraints for violent/self-destructive behavior, if ED physician unable to evaluate patient. Only specially trained RN's can do a First Hour Assessment.~~

~~c. Act as a resource for ED personnel caring for the patient.~~

~~d. Ensure patient rights are preserved during the course of evaluation and care.~~

~~e. Assist the ED staff with evaluation, assessment, care planning, and implementation of care for the patient.~~

~~i. ED psychiatric patient evaluations shall be documented on the Behavioral Health Liaison (BHL) tracking log.~~

~~f. Relay medication and diagnostic recommendations from the on-call Psychiatrist to the ED physician within the PL scope of professional practice (RN PL only).~~

~~g. Collaborate with ED registration staff to identify funding resources and benefit status.~~

~~i. Pre-authorization is required for all psychiatric patients admitted to Behavioral Health Unit (BHU) and shall be documented in the medical record.~~

~~h. Determine and recommend the level of psychiatric care as indicated by the patient's presenting problem(s).~~

~~i. Ascertain if/when following procedures for using the hospital gown or wandering bracelet may increase a patient's agitation or escalate a situation and communicate the determination to staff.~~

~~i. The PL shall reassess patient frequently. If the patient does not have the capacity to participate in the 5151assessment, the PL is to document every effort made to interview the patient in the BHU Liaison Assessment.~~

~~1) Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.~~

~~j. Provide for expeditious patient disposition utilizing all available community resources and communicate the status of discharge planning with the ED clinical staff at regular intervals.~~

~~i. The BHU ANM or designee shall be notified by the PL when a determination is made regarding the patient's admission to the unit.~~

~~ii. The PL shall facilitate transfers to the BHU or to another psychiatric facility.~~

~~iii. The PL is responsible to obtain the pre-authorization on any patient transferred to the BHU or other psychiatric hospital from a TCHD medical unit.~~

~~k. Collaborate with the ED physician when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as possible.~~

~~l. Once the 5151 assessment is completed and it is determined to proceed to a 5152, in collaboration with the on-call Psychiatrist, the PL shall complete an Involuntary Patient Advisement form.~~

~~i. The patient shall receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed, the 72-hour hold may not be discontinued, except by a psychiatrist after personal evaluation.~~

m. Collaborate with the Security Officer to communicate changes in the patient condition that may require more frequent surveillance or concerns about the patient's imminent safety or safety of the environment.
n. Provide direction to ED clinical staff and Security Officer(s) in the management of situations requiring de-escalation or physical management.
o. Participate in debriefing with ED clinical staff and Security Officer(s) following incidents requiring physical management or restraint application to determine opportunities for process improvement.
p. Complete all necessary documentation in accordance with established policy.

3. The assigned Security Officer notified when a patient is being evaluated and cared for in the ED shall:
a. Make his/her presence known to the PL and ED clinical staff as soon as possible.
b. Communicate with staff to ascertain the patient's current condition as it relates to the safety and security of the patient and the immediate environment.
c. Assist in episodes of verbal de-escalation and/or restraint application in accordance with TCHD policy at the direction of the PL, ED Physician, or ED clinical staff (depending upon who is at the scene and designated as the team leader of the situation).
d. Ensure the patients who are at high risk for elopement are not permitted to leave the treatment area of the ED until an evaluation has been completed, a disposition for treatment is completed, or a determination has been met indicating the individual does not meet criteria for further treatment pursuant to the evaluation.
i. The security officer shall assist with transporting the patient from the ED to admitting unit (usually BHU) ensuring the patient is wearing a gown and all items that may cause harm to self or others are not in the patient's possession.
e. Communicate observed changes in the patient's behavior that may indicate a change in safety risk to the designated clinical staff member on the scene.
f. Advocate for the patient to ensure all patient rights are preserved during the course of treatment while maintaining the safety of the patient and the immediate environment.
g. Participate with clinical staff in debriefing following all episodes of physical management and/or restraint application in accordance with TCHD policy.

F. PROCEDURE FOR CSU TCHD:

1. When a patient on a 72 hour hold arrives at the CSU, security will assist with the patient's belongings to ensure there are no contraband, and locked the belongings in the appropriate, assigned patient locker.
2. The PL shall reassess the patient frequently. If the patient does not have the capacity to participate in the 5151 assessment, the PL is to document every effort made to interview the patient in the BHUL Assessment.
a. Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.
3. The PL will collaborate with the CSU psychiatrist or Allied Health Professional (AHP) when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as possible.
4. Once the 5151 assessment is completed and it is determined to proceed to a 5152, in collaboration with the on-call Psychiatrist or AHP, the PL shall complete an Involuntary Patient Advisement form.
a. The patient shall receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed, the 72-hour hold may not be discontinued, except by a psychiatrist after personal valuation.
5. If the patient is not admitted to an acute inpatient setting pursuant to the 5150, CSU staff will adhere to the following steps:
a. Make sure the patient understands and agrees with the discharge plan

b. Assure the patient has sufficient medications and/or prescriptions for medication to fill at local pharmacy (sufficient to bridge the gap until the patient is able to be seen by the outpatient provider)
c. Coordinate for pick up and or transportation needs
d. Review the appropriate outpatient resources and referrals with the patient and family or friend, as indicated. All minors will have discharge plans reviewed with legal parent or guardian
e. Develop a safety plan, if indicated, and document in medical record
f. Encourage patient to ask for help from support and professional providers when in crisis immediately
g. All patients will be provided the San Diego County Access and Crisis Line phone number 1888-724-7240

G. **PROCEDURE FOR INPATIENT UNITS of TCHD:**

1. There are occasions when an individual is hospitalized pursuant to a 5151 assessment on an inpatient unit because a co-existing medical condition requires stabilization. If the patient does not have the capacity required to complete a 5151 assessment in the ED and it is unknown when medical clearance or capacity can be obtained, the 5150 may be discontinued.
2. In circumstances when a patient is hospitalized on the inpatient units on a 72-hour hold, pursuant to a 5151 assessment the clinical staff shall:
   a. Notify the attending physician.
   b. The attending physician shall order a PL consult.
   c. Unit Secretary or clinical staff will contact the PL directly or notify Inpatient BHU of request for PL consult.
   d. Inform the PL when the patient's medical condition allows an adequate assessment to be conducted, i.e., patient is conscious, extubated, awake, and able to participate in an assessment.
   e. Assign a sitter to remain with the patient if it is determined the patient is at risk for self-harm or elopement until they are medically cleared.
   f. Collaborate with the PL in their provision of care, treatment, and disposition of the individual.
   g. Notify the Security Department.
3. The PL shall:
   a. Contact the nursing unit to acknowledge receipt of consultation request, and discuss the patient's medical and psychiatric condition.
      i. If the patient is able, communicate a time frame to complete the assessment.
      ii. If the patient does not have the capacity to participate in the 5151 assessment the PL is to document every effort made to interview the patient in the BHU Liaison Assessment. Capacity is dependent upon the patient's sedation level or intensity of being under the influence of drugs or alcohol.
   b. Determine and recommend the level of psychiatric care as indicated by the patient's presenting problem(s).
   c. Collaborate with the attending physician when the assessment indicates the patient does not meet requirements for further treatment pursuant to California Welfare and Institutions Code Section 5150 and ensure the 5151 face-to-face assessment is completed in a timely manner or the 5150 is discontinued as soon as practicable.
   d. Once the 5151 assessment is completed and it is determined to proceed to 5152, the PL is to complete an Involuntary Patient Advisement form. The patient is to receive the advisement both orally and in writing. Once the Involuntary Patient Advisement process has been completed the 72-hour hold cannot be discontinued except by a psychiatrist after a personal evaluation.
   e. Inform the on-call psychiatrist there is a patient who meets 5150 criteria and the 5151 assessment has been completed on the medical floor to collaborate for psychiatric admission of the patient to the TCHD BHU, or another psychiatric hospital, as indicated.

f. Collaborate with the clinical staff to ensure pre-authorization from insurance is obtained prior to all transfers to the BHU.
g. Ensure patient rights are preserved during the course of evaluation and care.
h. Assist the Inpatient clinical staff with assessment, care planning, and implementation of care for the patient.
i. Collaborate with the Security Department to communicate changes in the patient condition that may require more frequent surveillance or concerns about the patient's imminent safety or safety of the environment.

4. Notify the on-call psychiatrist to:
   a. Assess the patient, if the PL has completed the 5151 assessment and Involuntary Patient Advisement process. These shall occur within 24 hours of the patient's arrival on the medical unit, or as soon as the patient is responsive enough for a psychiatric evaluation, but in all cases before the expiration of the 72-hour hold to determine if the patient continues to meet criteria for the hold.
      i. The on-call psychiatrist is the only clinical staff that may discontinue a hold at this point in the treatment episode.
   b. Initiate the paperwork for a 14-day hold if in his/her assessment it is clinically appropriate and shall ensure the patient receives all necessary advisements in accordance with hospital policy.
   c. Act as a resource to the staff providing on-going care to the patient.
5. When a patient has been hospitalized, the assigned security officer shall:
   a. Respond to requests for assistance from clinical staff in the event the patient's behavior constitutes a threat to self or others.
   b. Collaborate with unit-based clinical staff and/or the BHU clinical staff representative to ensure on-going evaluation and care of the patient is conducted in a safe manner while ensuring all patient rights are upheld.

H. PROCEDURE FOR (BHU):

1. When individuals are admitted to the BHU pursuant to a 72-hour hold they shall be assigned a bed in the Inpatient Behavior Health Unit. The BHU ANM or Charge RN will assign bed based on presenting symptoms of patient upon admission.
2. The nursing staff shall document on the Information Board, the patient's legal status and the date and time the 72-hour evaluation was initiated as well as the date and time it expires.
   a. This information shall be communicated in all change of shift reports.
3. The patient may be released from the involuntary 5150 hold before 72 hours have elapsed only if the psychiatrist directly responsible for the person's treatment believes, as a result of his/her personal observations, that the person no longer requires evaluation or treatment. However, should there be a situation in which both a psychiatrist and psychologist have personally evaluated or examined a person who is placed under a 72-hour hold and there is a collaborative treatment relationship between them, either may authorize the release but only after they have consulted with each other.
   a. In the event of a clinical or professional disagreement the hold will be maintained unless the medical director overrules the decision of one or the other.
   b. In this event, both the psychiatrist and the psychologist must enter their findings, concerns, or objections into the patient's medical record.
4. The attending psychiatrist shall be kept informed of the patient's legal status as well, to ensure an application for an additional 14-day hold may be initiated in a timely manner if it is clinically indicated.
5. The level of observation shall be determined by the attending psychiatrist in collaboration with the nursing staff, based on assessment data.
6. The involvement of the Security Department shall be solely dependent upon the patient's behavior as it relates to imminent danger to self or others.

~~a. When a Security Officer(s) is called to the BHU to assist in the containment of imminently dangerous behavior, the Officer shall wait for and follow direction from the nursing staff.~~

~~b. The Security Officer(s) shall participate in all scheduled debriefing sessions related to physical management occurrences including seclusion and/or restraint.~~

H. **FORM(S):**

1. **Declination Form**
2. **Detention of Patient with Psychiatric Emergency in a Non-designated Health Facility (1799.111) CHA Form 12-12**
3. **Notice of Request for Writ of Habeas Corpus**
4. **Application for Assessment, Evaluation and Crisis Intervention or Placement for Evaluation and Treatment (WIC 5150)**

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

1. **Administrative Patient Care Policy: Advisement of Legal Status 24-Hour Hold/72-Hour Hold**

~~**Application for Assessment, Evaluation and Crisis Intervention or Placement for Evaluation and Treatment (WIC 5150)**~~

~~1. Behavioral Health Services: Exclusionary Criteria~~

~~**CHA Form 12-12: Detention of Patient with Psychiatric Emergency in a Non-designated Health Facility (1799.111)**~~

2. **Patient Care Services Policy: Assessing and Managing Patients at Risk for Suicide**
3. **Patient Care Services Policy: Consent for Minors**
4. **Patient Care Services Policy: Consent for Operative or Other Procedures**
5. Patient Care Services: Sitter Policy

J. **REFERENCE(S):**

1. Detention of Mentally Disordered Persons for Evaluation and Treatment, CA Welfare and Institution Code § 5150 (1969)

~~2. Certification for Intensive Treatment, CA Welfare and Institution Code § 5250 (1982)~~

~~3.~~2. Lanterman–Petris–Short Act, CA Welfare and Institution Code § 5000 (1967)

3. **CA Health and Safety Code § 1799.111**~~CA Welfare and Institution Code § 5008, 5150, 5150.1, 51510.2, 5151, 5152~~
4. **California Hospital Association (CHA). (2019) Consent Manual.** ~~**2018, Chs. 15 & 16**~~
5. **San Diego County Board of Supervisors' Resolution No. 05-232**
6. **California Assembly Bill 1424**

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ABDUCTION SHOULDER SPLINT**
Purpose:	To outline the nursing responsibilities in applying a splint and applying and monitoring the abduction s
Supportive Data:	An abduction splint is a temporary means of secu alignment and support. A sling is used as a temporary means of securing alignment and support. A brace is used as a temporary means of securing a part of the body to maintain alignment and support.
Equipment:	Shoulder abduction splint Abduction Sling with Pillow Abduction and Rotation Control (ARC) Shoulder Brace

DELETE – follow Elsevier Should Immobilization Skill

~~A. **ABDUCTION SLING WITH PILLOW:**~~

~~1. Detach shoulder strap and open front panel, placing arm inside sling with elbow as far back as possible.~~
~~2. Secure front strap through the lower D-ring.~~
~~3. Affix the snaps/straps along the top of the sling to secure the arm in its cradle. The thumb may be placed through the loop inside the sling for additional comfort, if desired.~~
~~4. Bring the shoulder strap across the back and over the shoulder and fasten through the middle D-ring of the sling per manufacturer's recommendation.~~
~~5. Trim shoulder strap by removing the Y tab at the end of the strap and cutting the strap then reapplying the Y tab, if there is excess strap.~~
~~6. Place the pillow at the waistline with the large end facing forward. Attach the sling to the pillow, lining up the hook and loop strips so they adhere. The pillow typically has a groove to place at the patient's waist.~~
~~7. Secure the waist strap through the D-ring on the front end of pillow.~~
~~8. Position the pillow for desired internal and external rotation by sliding the pillow anterior or posterior along the waistline.~~
~~9. Position head of bed a minimum of 30 degrees for patient comfort. Place pillow behind affected shoulder for support.~~
~~10. Document splint application, patient's tolerance, and when the times the splint is on and off in the medical record.~~

~~B. **ARC SHOULDER BRACE:**~~

~~1. Brace will be custom fit by outside vendor~~
~~2. Follow manufacturer's directions for applying brace.~~
~~3. Document brace application, patient's tolerance, and times the brace is on and off in the medical record.~~

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

~~1. National Association of Orthopedic Nurses (NAON): Core Curriculum for Orthopedic Nursing Practice 3rd Edition, April 12, 2013.~~
~~2.~~1. ~~NAON: Scope and Standards of Orthopedic Nursing Practice 3rd Edition, April 12, 2013.~~

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Division of Orthopedics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/93, 01/11, 10/19	02/11, 11/15, 12/19, 03/20	03/11, 12/15, 04/20	05/16, 05/20	04/11, 10/16, 06/20	07/20	05/11, 01/17, n/a	6/00, 7/03, 1/06; 6/08; 05/11, 01/17

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ABDUCTION SPLINT APPLICATION (HIP)**
Purpose:	To outline the nursing responsibilities when applying an abduction splint or abduction wedge.
Supportive Data:	Splints maintain hip abduction to prevent dislocation in total hip replacement patients. Application requires a physician order.
Equipment:	Abduction Splint

A. **APPLICATION:**

1. Verify physician order.
2. Explain procedure to patient.
3. Position splint so the top is as close to patient's perineum as possible.
4. Place patient's leg on either side of the splint.
5. Run dorsal straps under patient's thigh and calf.
6. Bring dorsal straps around patient's leg to anterior section and apply Velcro straps (snugly, but not restricting venous flow).
7. Ensure splint is in proper placement prior to turning and/or after repositioning patient.
8. Loosen Velcro straps on patients received from Post-Anesthesia Care Unit (PACU) on arrival to unit and every four hours for skin inspection of pressure points and alignment.
9. Assess splint alignment to patient on arrival to unit and every four hours.
10. Assess patient's skin for pressure points every four hours and PRN.
11. Document presence of abduction splint in the medical record.

B. **REFERENCES:**

1. National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.
2. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Division of Orthopedics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/93; 02/11, 10/15, 10/19	03/11, 11/15, 12/19, 03/20	03/11, 12/15, 04/20	05/16, 05/20	n/a	04/11, 10/16, 06/20	07/20	05/11, 01/17, n/a	5/93, 5/00, 6/00, 7/03, 1/06; 6/08; 05/1, 01/17

Tri-City Health Care District
Oceanside, California

Administrative Policy
Patient Care

ISSUE DATE: 04/93

SUBJECT: Assault Victims/Domestic Violence, Reporting Requirements

REVISION DATE: 05/93, 08/94, 04/95, 07/99, 04/02, 06/03, 12/05, 04/09, 06/11

POLICY NUMBER: 8610-310

Patient Care Services Content Expert~~Department~~ Approval:	**~~04/17~~12/19**
Clinical Policies and Procedures Approval:	**~~05/17~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~05/17~~06/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/17~~06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To provide guidelines for compliance with the mandatory reporting requirements for any patient injuries incurred through assault with a deadly weapon, a criminal act or instances of domestic violence presenting at Tri-City Hospital District (TCHD).
   (For assault and battery occurrences against on-duty Medical Center personnel refer to Administrative: Assault and Battery Reporting Process Policy #241, and for Uniform Reporting and Reporting Requirement Grid, refer to Administrative: Mandatory Reporting Requirements Policy #236).

B. **DEFINITIONS:**

1. Victim – A person who has been subjected to injury through assault, a criminal act, or incident of domestic violence.
2. Injury – Any physical injury which requires any form of professional medical treatment.
   a. Does not include any psychological or physical condition brought about solely through voluntarily administration of a narcotic or restrictive dangerous drug.
3. Abuse – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, pinching or kicking. Also includes controlling behavior through corporal punishment.
   c. Sexual Abuse – Includes sexual harassment, coercion and assault.
   d. In ~~out-of-~~home care - situations where child abuse is suspected and the person responsible for the child's welfare is a licensee, administrator, or employee of a child care facility, private or public residential home, school, or other institution.
4. Imminent Danger – Foreseen danger that will likely result in irreparable physical or mental harm unless conditions are changed.
5. Exploitation – An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
6. Domestic Violence – The occurrence of any of the following: battery; simple battery; simple assault; assault; stalking; criminal damage to property; unlawful restraint; or criminal trespass by a present or past spouse, parents of the same child, parents and children, stepparents and stepchildren, foster children and foster parents or others living or formerly living in the same

household.

7. Health Practitioner - Physician, psychiatrist, psychologist, social worker, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist, emergency medical technician, or any person who is licensed under Business and Professions Code Section 500.
8. Reporting - Refers to mandated verbal and written report to law enforcement agencies pursuant to California Penal Code 11160 et seq. Failure to report an injury caused by an assault with a deadly weapon or an incident of domestic violence is a criminal offense.

C. **POLICY:**

1. California Penal Code Sections 11160 and 11161 require health practitioners and physicians, to immediately report, both by phone and in writing: (A single report may be made when the obligation to report falls to two or more persons)
   a. All injuries resulting from the use of a gun, knife, firearm, or other deadly weapon, whether **self-inflicted,** ~~inflicted by ones own act~~ or by the actions of another.~~, and~~
   b. Any wounds or physical injuries inflicted upon a person where the injury is the result of assaultive or abusive conduct. (Penal Code Section 11160)
   c. The following criteria may indicate a need for further assessment (including but not limited to):
      i. Injuries inconsistent with what **is reported by patient or caregiver** ~~the patient reports~~ to have happened (i.e., burns, welts, bites and scratches).
      ii. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
      iii. Poor hygiene, malnourishment.
      iv. **Exhibiting** ~~F~~**fear by** ~~of~~ parent or caregiver; ~~,~~being withdrawn or tearful.
      v. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
      vi. Inappropriate responses to questions about a safe environment or being threatened at home.
   d. Duty to report is required when the health practitioner provides medical services to a patient for any physical condition, not just the condition or injury from an assault, battery, or firearm incident.
   e. The report shall be prepared even if the patient has expired or declines to report.
2. Pursuant to Penal Code Section 11161.9, a health practitioner who makes a report of injury or abuse as specified under the law shall not incur any civil or criminal liability as a result of making such report.
3. Any evidence procedure or with a victims injured by a deadly weapon or criminal act must be properly handed, retrieved and proper chain of custody maintained. (See Administrative Policy # 315)
4. Physician-patient privilege does not relieve any physician from his/her obligation to report acts of domestic violence to law enforcement pursuant to Penal Code Sections 11161 (a).
5. Other Health Practitioners are not relieved of their reporting obligation if a physician or surgeon fails to report an injury by deadly weapon or criminal act. Any health practitioner may make the report. No supervisor or administrator shall impede or inhibit the reporting duties required pursuant to Penal Code 11160.
6. For the purposes of this section, "assaultive or abusive conduct" shall include any of the following offenses:
   a. Murder, (violation of Section 187).
   b. Manslaughter, (violation of section 192 or 192.5).
   c. Mayhem, (violation of Section 203).
   d. Aggravated mayhem, (violation of Section 205).
   e. Torture, (violation of Section 206).
   f. Assault with intent to commit mayhem, rape, sodomy, or oral copulation, (violation of Section 220).
   g. Administering controlled substances or anesthetic to aid in commission of a felony, (violation of Section 222).
   h. Battery, (violation of Section 242).

i. Sexual battery, (violation of Section 243.4).
j. Incest, (violation of Section 285).
k. Throwing any vitriol, corrosive acid, or caustic chemical with intent to injure or disfigure, (violation of Section 244).
l. Assault with a stun gun or taser, (violation of Section 244.5).
m. Assault with a deadly weapon, firearm, assault weapon, or machine gun, or by means likely to produce great bodily injury, (violation of Section 245).
n. Rape, (violation of Section 261).
o. Spousal rape, (violation of Section 262).
p. Procuring any female to have sex with another man, (violation of Section 266, 266a, 266b, or 266c).
q. Child abuse or endangerment, (violation of Section 273a or 273d).
r. Abuse of spouse or cohabitant, (violation of Section 273.5).
s. Sodomy, (violation of Section 286).
t. Lewd and lascivious acts with a child, (violation of Section 288).
u. Oral copulation, (violation of Section 288a).
v. Genital or anal penetration by a foreign object, (violation of Section 289 or 289.5).
w. Elder abuse, (violation of Section 368).

7. All assault or domestic violence cases must be reported within mandated time lines by phone and written report to the appropriate law enforcement agency where the alleged incident occurred.
8. Victim of Assault: Upon learning or reasonably suspecting that a patient may be a victim of assault, the Health Practitioner will use the following procedure.
   a. Make a report by phone immediately or as soon as practically possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.
   b. Complete a written report on the form "Health Practitioner and Hospital Report of Injuries by Deadly Weapon or Criminal Act". Distribute as follows:
      i. Keep one copy for patient's chart.
      ii. Mail one copy to appropriate law enforcement agency where alleged assault occurred.
      iii. Mail written report within 2 working days to appropriate law enforcement agency.
   c. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.
9. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:
   a. The health care provider believes, in the exercise of professional judgement, that informing the patient would place him or her at risk of serious harm.
   b. The health care provider would be informing a personal representative, and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient.
   c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.
10. In the Emergency Department the social worker may be requested to provide a psychosocial assessment or consultative services to the Emergency Department or attending physician. They may also provide crisis intervention, problem solving advocacy, information and referral to community resources.
11. In the acute care setting, social work services are available to provide assessment, crisis intervention problem solving, advocacy, and information and referral to community resources.
12. According to Government Code Sections 13959 through 13969.1, California residents may apply for restitution for pecuniary losses they suffer as a direct result of criminal acts.
    a. The Emergency Department will display information regarding the "Victims of Crime Program". (Refer to CHA Consent Manual)

b. A referral may be made to Social Services, to provide information and an application to the patient, for assistance through the "Victims of Crime Program".
c. The nurse can provide the patient with the following information and the patient and/or family can follow-up:
~~i.~~ State Board of Control
P.O. Box 3036
Sacramento, CA 95812-3036
(916) 322-4426

13. Victim of Domestic Violence: Upon learning that a patient may be a victim of domestic violence, the Health Practitioner will use the following procedure:
a. Make a report by phone immediately or as soon as possible to the law enforcement agency in whose jurisdiction the alleged offense occurred.
b. Request the presence of a police officer at the hospital to interview the victim and conduct an investigation. Every effort should be made to keep the victim at the hospital until an officer arrives.
c. The Health Practitioner will complete a written report on the form "Domestic Violence and Violent Injury Report" and will forward the written report immediately to TCHD's Social Services Department. One copy will be mailed to the appropriate law enforcement agency (within 2 working days). One copy will be filed in Social Services to protect patient safety and confidentiality.
d. Health Practitioner making the reports shall document in the patients chart that both telephone and written reports have been completed and the written report submitted to Social Services Department.
14. All suspected, or confirmed, domestic violence cases identified on any inpatient unit, are to be referred to TCHD's Social Services Department. A clinical social worker may assess the patient/family system and will coordinate with the attending physician and nursing staff to ensure the required telephone and written reports are completed within the required time frames.
15. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of assault/violence to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
16. Social Services Department will be notified of all cases of suspected assault/violence by one of the following methods:
a. Making a Social Services referral through the computer.
b. By telephone to the Social Services Department or page to a specific Social Worker.
c. By completing a "Health Practitioner Report of Injuries by Deadly Weapon or Assaultive/Abusive Conduct" Reporting Form and forwarding it to the hospital Social Services Office.
17. Any problematic cases are reported to the Director/Manager of Social Services and the Director/**Manager** of Risk Management for additional review.
18. As high-risk patients, all alleged or confirmed victims of child abuse, elder abuse and domestic violence cases presenting in the Emergency Department should involve an assessment by the Emergency Department social worker.
19. In instances where victims include children, seniors or dependent adults, or domestic violence situations, the respective county social service hot lines (for child or elder abuse) are called, and mandated written reports are completed and mailed. Refer to Administrative: Reporting Suspected Child Abuse Policy #308 and Administrative: Reporting Suspected Dependent Adult Elder Abuse Neglect #309.

D. **RELATED DOCUMENT(S):**
1. Administrative: Assault and Battery Reporting Process Policy #241
2. Administrative: Mandatory Reporting Requirements Policy #236
3. Administrative: Reporting Suspected Child Abuse Policy #308
4. Administrative: Reporting Suspected Dependent Adult Elder Abuse Neglect #309

~~4.~~5. **Health and Human Services Domestic Violence Intimate Partner Violence Reporting**

E. **REFERENCE(S):**

1. California Hospital Association. (2017). *California Hospital: Consent Manual*. CHA Publications: Sacramento. ;
2. California Penal Code
3. www.jointcommission.org

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/03	**SUBJECT: Autopsy, Authorization of**
REVISION DATE(S):	01/04, 12/05, 05/11 ~~POLICY NUMBER: IV.P.4~~
Patient Care Services Content Expert:	~~05/18~~05/20
Clinical Policies & Procedures Committee Approval:	~~11/14~~05/20
Nursing Leadership~~Executive Council~~ Approval:	~~11/14~~06/20
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/15~~06/20
Administration Approval:	07/20
Professional Affairs Committee Approval:	~~02/15~~ n/a
Board of Directors Approval:	02/15

A. **PURPOSE:**
1. To outline the responsibilities for obtaining the legal signature of the next of kin or other to allow an autopsy to be performed.

B. **POLICY:**
1. A family member, physician, or the Medical Examiner may request an autopsy.
   a. If the agent and/or family requests an autopsy, ensure the family understands the financial obligation.

C. **PROCEDURE:**
1. It is the responsibility of the Registered Nurse (RN) assigned to care for the patient~~,~~ **or** Administrative Supervisor ~~or the Patient Representative~~ to obtain signature for an autopsy.
2. The following individuals may authorize an autopsy:
   a. Agent appointed in patient's power of attorney for health care
   b. Spouse/Registered domestic partner
   c. Children of patient over age 18 or parent
   d. Patient's sibling
   e. Any other kin or person who has acquired the right to control the disposition of the remains
   f. A public administrator
   g. A coroner or any other duly authorized public officer (i.e., the state Curator of the Unclaimed Dead)
      i. Their signature shall authorize the performance of a postmortem examination upon the decedent.
3. List any restrictions on the "Autopsy, Authorization of" form
   a. If there are no restrictions, please write, "No Restrictions" in the same area on the form.
4. Place completed "Autopsy, Authorization of" form with completed "Release of Deceased" form and deliver both to ~~the Patient Representative or~~ Administrative Supervisor.

D. **FORM(S):**
~~5.~~1. **Authorization for Autopsy 7520-1001- Sample**

3-Hole 1/4 1 3/8 c-to-c

SAMPLE

AUTHORIZATION FOR AUTOPSY

Patient's Name: _____

Date: _____

Time: _____

1. I am one of the following persons authorized by law to direct disposition of the remains of the above-named patient.

   ☐ Patient ☐ Parent

   ☐ Spouse ☐ Brother/Sister

   ☐ Registered domestic partner

   ☐ Child (over the age of 18) ☐ Agent appointed in patient's Power of Attorney for health care (copy of Power of Attorney must be attached.)

   ☐ Other: _____

2. I hereby authorize the performance of a post-mortem examination upon the above-named patient.

3. In the hope that the above-authorized examination may benefit others by protecting or preserving their lives and well-being, the undersigned also authorizes the examining physician and surgeon to remove such specimens, tissues, and/or organs, and to retain, preserve, and/or contribute the same for such diagnostic, therapeutic, or other scientific purposes as he/she shall deem proper.

4. This authorization shall be subject to the following restrictions: _____
   _____
   _____
   _____

5. I understand that the examining physician and other physicians are not employees or agents of the hospital. They are independent contractors.

Signature: _____

Witness: _____

Witness: _____

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

Affix Patient Label

AUTHORIZATION FOR AUTOPSY

7520-1001
(Rev 5/05)

White - Medical Recs Yellow - Admin Coord Pink - Labs

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/78

SUBJECT: Food and Nutrition Relationships with other Departments

REVISION DATE: 04/00, 06/03, 07/05, 07/07, 03/10, 04/13

~~**POLICY NUMBER: I.P**~~

Patient Care Services Content Expert~~Department~~ Approval:	~~02/17~~02/20
Clinical Policies and Procedures Committee Approval:	~~03/17~~05/20
Nursing Leadership~~Executive Committee~~ Approval:	~~03/17~~06/20
Medical Staff Department or Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	~~04/17~~ n/a
Board of Directors Approval:	04/17

A. **POLICY:**

1. Food and Nutrition Services is organized, staffed and integrated with other units and departments of the hospital in a manner designed to assure the provision of optimal nutritional care and quality food service. The department maintains operating relationships with most of the medical care and administrative activities of the hospital. Close relationships are maintained with the medical staff on special dietetic needs of patients; with nursing services on provisions of regular and modified diets and between meal nourishments; and with administration on management matters.

B. **NURSING SERVICE:**

1. Food and Nutrition personnel are responsible for:
   a. Preparation and delivery of all trays to patient units, including the provision of nourishment supplies.
   b. Return of soiled trays and dishes to the kitchen on food carts. Check soiled utility room for soiled trays / dishes, put on food carts, and bring back to kitchen.
   c. Dietitians screen and assess nutritional status of patients to provide optimal nutritional care or instruction regarding special dietary needs.
   d. Upon receiving a physician's order, or as deemed appropriate, dietitian instructs patients in maintenance of modified diets at home, prior to discharge **if needed and appropriate.**
   e. **Attempt to** ~~V~~visit patients daily to pick up or assist with completion of selective menu for the next day. Both nursing and food service personnel may help the patients with menu selections.
   f. Preparation and delivery of mid-morning, mid-afternoon, and evening nourishments to nursing stations.
   g. **Storage and** ~~Preparation and~~ delivery of enteral feedings.
   h. Preparation **and delivery of nutritionally sound meals** ~~, delivery, and service of attractive, nutritional, and satisfying meals~~ under approved standards of sanitation.
   i. The clinical dietician will **assess** ~~establish priorities of care, determine~~ nutritional status, and develop nutritional care plans **with appropriate interventions.**
   j. **Educate food and nutrition staff on department related regulatory and food safety procedures and expectations.**~~Providing in-services on nutrition-related and food and nutrition services related topics as requested.~~

k. Communicate ~~ting with nursing regarding~~ **patient nutritional needs and concerns with nursing.** ~~patient's nutritional needs and concerns~~.

2. Nursing personnel are responsible for:
   a. Obtaining a physician's order for each patient's diet.
   b. Transmitting diet orders to Food and Nutrition Services.
   c. Assisting patients with choices on selective menus **as needed**.
   d. Preparing patients to receive trays.
   e. Passing trays to patients upon arrival of food carts under direction of Primary Registered Nurse.
   f. Ensuring two patient identifiers are used when delivering trays and nourishments.
   g. Feeding patients who need assistance.
   h. Serving special interval nourishments (for example snacks).
   i. Obtaining height and weight and recording in patient's chart.
   j. Complete Braden Scale Score and initiate nutrition consult for patients at high risk for skin breakdown.
   k. Notifying the Food and Nutrition Services Dietitian if a patient is not eating well.
   l. Transmitting guest tray orders.
   m. Collecting finished food trays and placing on food cart if still on floor, or storing in dirty utility room.
      i. Remove protected health information from tray.
   n. Completion of patient history related to nutrition risk factors (generating nutrition consults if any risks are identified.)

C. **BUSINESS OFFICE:**
1. Food and Nutrition personnel are responsible for:
   a. Submitting a cafeteria cash report.
   ~~a.~~**b. Submitting statistical data for the department**
2. Business Office personnel are responsible for:
   a. Initiating receipts for cafeteria cash received.

D. **INFORMATION TECHNOLOGY:**
1. Food and Nutrition personnel are responsible for entering physicians' cafeteria charges into the computer at the end of each month.
2. Information Technology personnel are responsible for:
   a. Consulting with Food and Nutrition when initiating new dietary data processing procedures.
   b. Providing the system for receiving patient discharges, admissions, and room changes.
   c. Assisting Food and Nutrition in the use of the computer system.
   d. Providing support for Cerner.

E. **EMPLOYEE HEALTH:**
1. The Employee Health Nurse and/or the Emergency Room handle all Food and Nutrition Services employee accidents, pre-employment physicals, and annual physical reviews.

F. **ENVIRONMENTAL SERVICES:**
1. Food and Nutrition personnel are responsible for:
   a. Returning soiled mop heads to the laundry.
2. Environmental Services personnel are responsible for:
   a. Providing clean mop heads for use in Food and Nutrition Services.
   b. Cleaning Food and Nutrition offices and carpeted and tiled areas of cafeteria.
   ~~b.~~**c. Provides hand soap, sanitizer, and paper towels.**

G. **FACILITIES MANAGEMENT:**
1. Food and Nutrition personnel are responsible for:
   a. Initiating work requests for repair of equipment.

a. Reporting hazardous working conditions.

2. Facilities personnel are responsible for:
   b. Preventive maintenance and repair on all **required** Food and Nutrition equipment unless under contract with an outside agency.
   c. Keeping records of preventative maintenance in Facilities Management.
   d. Keeping files on maintenance of Food and Nutrition equipment.

H. **EDUCATION:**

1. Education **provides** ~~facilities~~ in-service education for Food and Nutrition personnel for hospital orientation and other areas as needed and/or requested.

I. **AUXILIARY:**

1. Food and Nutrition Services provides refreshments for Auxiliary meetings.
2. Food and Nutrition Services provides supplies for Auxiliary functions.

J. **PHARMACY:**

1. Pharmacy personnel are responsible for:
   a. Conferring with RDs regarding drug-nutrient interactions.
   b. Conferring with RDs regarding best means to achieve nutritional needs via TPN for those patients receiving TPN.
2. Dietitians are responsible for:
   a. Conferring with Pharmacists regarding potential drug -- nutrient interactions.
   b. Conferring with Pharmacists on patients receiving TPN to optimize nutrition support via TPN.

K. **ALL TRI-CITY HEALTHCARE DISTRICT (TCHD)~~MEDICAL CENTER~~ DEPARTMENTS:**

1. Food and Nutrition Services provides room set-ups and catering upon request for meetings/events for departments, Board of Directors, and the **TCHD**~~medical center~~ in general.
   a. Coordination is completed by contacting the Event Coordinator, the Catering/Cafeteria Supervisor, and/or the Operations Manager of Food & Nutrition.
2. Individual departments may request catering with approval from the department director/manager.
3. Individual departments/cost centers are charged for internal catering.
   a. Departments may authorize payment via an external source (i.e. a vendor).

L. **REFERENCE(S):**

1. Title 22

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**IMMEDIATE USE STERILIZATION, INTRAOPERATIVE**
Purpose:	To ~~ensure safe and effective~~**provide guidelines for** rapid sterilization of surgical instruments and devices intended for immediate use in an operative procedure. The effectiveness of the sterilization process is dependent upon effective cleaning, **decontamination, and packaging**. ~~The process of sterilization is negatively affected by the amount of bioburden and the number, type, and inherent resistance of microorganisms, including biofilms, on the items to be sterilized. Soils, oils, and other materials may shield microorganisms on items from contact with the sterilant or combine with and inactivate the sterilant.~~**Substances such as bioburden, biofilm, plaques, soils, and oils inhibit sterilization. The degree to which sterilization is inhibited is correlated with the amount, number, type, and inherent resistance of these substances. Any of these substances may shield microorganisms on items from contact with the sterilant or combine with and inactivate the sterilant.**

A. **DEFINITIONS:**

1. **Biofilm: A coating containing biologically active organisms that have the ability to develop in water, water solutions, or in vivo, which coat the surface of structures and become trapped within a matrix of organic matter, preventing antimicrobial agents from reaching the cells.**
2. ~~1.~~ Decontamination: **Any physical or chemical** ~~the~~ process ~~of removing~~**that removes or reduces the number of** ~~disease producing~~ microorganisms **or infectious agents** and renders~~ing the object~~ **reusable medical products** safe for handling **or disposal**.
3. ~~2.~~ Immediate Use Steam Sterilization (IUSS): **A sterilization method that involves the shortest possible time between a sterilized item's removal from the sterilizer and its aseptic transfer to the sterile field. Immediacy implies that a sterilized item is used during the procedure for which it was sterilized and in a manner that minimizes its exposure to air and other environmental contaminants. IUSS is the** rapid steam sterilization of unwrapped instruments and accessories for immediate use in emergencies or when the only instrument available of its kind is contaminated.
4. ~~3.~~ Implant: ~~t~~**T**issue or material placed within the body with the intent of permanent or long-term retention~~.~~ (i.e., over thirty days).
5. ~~4.~~ Steam Sterilization: ~~s~~**S**aturated steam under pressure in a process that destroys all forms of microbial life including bacteria, viruses, spores, and fungi.
6. ~~5.~~ Liquid **Chemical Sterilization (i.e.,** Peracetic Acid) ~~Sterilization~~: ~~a~~**A** method of sterilization used for items that are heat sensitive, ~~and~~ can be immersed, **are approved for this process by the device manufacturer, and cannot be sterilized using terminal sterilization methods. A** ~~P~~peracetic Acid (Steris®) processor~~s are~~ **is** maintained and operated in the Operating Room. ~~and Sterile Processing Department (SPD).~~

B. **POLICY:**

1. **Perform IUSS only when all of the following conditions are met:**
   a. **The device and sterilizer manufacturer's written instructions for use (IFU) include instructions for IUSS.**
   b. **The device manufacturer's written instructions for cleaning, cycle type, exposure times, temperature settings, and drying times (if recommended) are readily available and followed.**
   c. **Items are placed in a containment device that has been validated for IUSS and cleared by the FDA for this purpose and in a manner that allows steam to contact all instrument surfaces.**

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/10;8/12; 8/15; 04/20	5/10; 8/12, 9/15, 04/20	8/12, 09/15, 05/20	03/16, 05/20	n/a	06/10; 10/12, 03/16, 06/20	07/20	08/10; 11/12, 04/16, n/a	08/10;12/12, 04/16

d. **The rigid sterilization container manufacturer's IFU are followed.**
e. **Measures are taken to prevent contamination during removal form the sterilizer and transfer to the sterile field.**

2. **IUSS of implants shall only be performed in extreme emergency when no other option is available.**
   a. **When IUSS of an implant is unavoidable, determine cycle selection by the device manufacturer's IFU and include a biological indicator with the load. A preassembled challenge device may be used.**
3. **Sterilize reusable medical devices according to manufacturer's IFU for the specific device, packaging, and sterilizer equipment.**
   a. **When the device, sterilizer, and packaging manufacturer's IFU conflict, follow the device manufacturer's IFU.**

~~1.~~**4.** Decontamination and sterilization activities shall be done in compliance with current infection control standards, state and federal regulations and Tri-City Medical Center policies and procedures.

~~2.~~**5.** All ~~autoclaves~~ **sterilizers** will be operated**, monitored and maintained** per manufacturer's ~~instructions~~**IFU**.

~~3.~~**6.** All Items will be ~~thoroughly~~ cleaned and **decontaminated** ~~rinsed~~ prior to **IUS**~~sterilization~~.

7. Contain devices processed using IUSS in a rigid sterilization container and transport them to the point of use in a manner that minimizes the risk of contamination of the item and thermal injury to patients or personnel.

~~4.~~**8.** A **challenge pack (including a** Class V integrator **and biological indicator)** will be ~~placed~~ **included** in every ~~basket/tray of instruments/equipment when performing Immediate Use Steam Sterilization~~**IUSS cycle. Results of the biological indicator shall be reported to the surgeon and documented in the IUSS logbook.**

~~5.~~**9.** Autoclave doors will be kept closed when not is use.

~~6.~~**10.** Items processed via IUS shall be used immediately and not stored **for future use or held from one procedure to the next**.

~~7.~~**11.** Sterilizer function shall be monitored**/tested** daily with mechanical, chemical, and biological indicators **(as applicable)** to meet all of the monitoring parameters established for each type of sterilizer**, per sterilizer manufacturer's IFU**.

~~8. A biological indicator (BI) shall be run with each load containing an implant. The results of the BI are reported to the surgeon as soon as available and documented on the Immediate Use Sterilization Log.~~

~~9. Steris machines shall be tested daily, including both diagnostic and chemical tests.~~

~~10.~~**12.** Sterilizer logs shall be kept for a period of seven (7) years.

C. **PROCEDURE:**

1. ~~Thoroughly c~~**C**lean **and decontaminate** ~~items~~ **devices** prior to IUS, according to **device** manufacturer's ~~instructions~~**IFU**.
2. ~~Immediate Use Steam Sterilization~~**IUSS**:
   a. Place ~~items~~ **devices** in ~~an open bottom mesh pan, transfer pan or~~ **a rigid container designed for immediate use sterilization (i.e.,** FlashPak**)** ~~for sterilization~~.
   b. ~~Place a Class V integrator in all pans~~**Include a challenge pack (containing chemical and biological indicators) in the cycle, according to manufacturer's IFU.**
   ~~c. Obtain two 3M Attest 1292 Rapid Readout Biological Indicators with the same lot number (brown cap, 3 hour readout) when item to be flashed is an implant.~~
      ~~i. Place one of the Biological Indicators in the load to be sterilized.~~
      ~~ii. Set aside the second Biological Indicator to use as the control during incubation. This ampule is not run in the autoclave.~~
   ~~d.~~**c.** Select the appropriate sterilization cycle, according to **device** manufacturer's ~~written instructions for Immediate Use Sterilization~~**IFU**. Follow ~~autoclave~~ **sterilizer** manufacturer's ~~written instructions~~**IFU** to load sterilizer, close door, and select cycle ~~for~~ **according to** load contents. Cycles are:

i. Cycle 1: 4-minute Prevac Cycle (Express): ~~For large amounts of instruments, porous items, instruments with lumens, linen lined pans, surgical implants.~~
ii. Cycle 2: 4-minute Prevac Cycle (20-minute dry): ~~for wrapped loads; may occasionally be used if manufacturer lists these parameters as necessary for sterilization of a specific item; not usually used by OR staff for IUS.~~
iii. ~~Cycle 3: 3-minute Gravity Cycle: For three or fewer single part, non lumened, non-porous instruments.~~

~~e. Cycle 4: 10-minute Gravity Cycle: more than three metal instruments, instruments with lumens, porous items (i.e.., rubber, plastic, glass).~~

~~f.~~**d.** At the end of the sterilization process, the staff member who removes the load shall review and initial the print-con strip, **and retrieve the challenge pack**. At the end of the day the data strip is taped to the sterilizer log sheet as a permanent record.

~~g.~~**e.** If any of the parameters (i.e., time, temperature, pressure, completion of cycle) are not reached, the load is not sterile.
i. Circle the parameters that do not meet the acceptable standard.
ii. Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR **Nursing Leadership**~~Assistant Nurse Manager/~~**or** ~~D~~**d**esignee of the sterilizer malfunction.
1) Place tape across the sterilizer door with an "OUT OF SERVICE" sign.
2) Notify ~~Clinical~~ **Building** Engineering (Ext. 7711).
3) Enter a **Building Engineering** Work Order via TCMC Intranet.
4) In surgery, make note on the schedule board and ~~pass~~ **communicate** information at report**/huddle**.
5) DO NOT USE the sterilizer until ~~Clinical~~ **Building** Engineering**/designee** has completed repairs. A major repair requires three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".
iii. Remove ~~supplies~~ **devices** from sterilizer and reprocess in another sterilizer.
iv. Document in the sterilizer log book that the load was aborted and reprocessed.

3. Liquid **Chemical**~~(Peracetic Acid)~~ Sterilization **(Peracetic Acid)**- Steris:
a. Before use, ensure daily testing of liquid chemical sterilant processing system has been completed.
~~a.~~**b.** Assemble clean instruments in the appropriate Steris tray and tray insert, according to manufacturer's ~~instructions~~**IFU**.
~~b.~~**c.** Obtain appropriate ~~quick connector~~**adaptor** (matched to manufacturer and equipment identification number) and connect to Steris tray and ~~scope~~ **equipment** ports, if applicable, **as recommended by the manufacturers of both the device and the liquid chemical sterilant processing system**. Ensure all ports/lumens of the ~~device~~ **equipment** to be sterilized are attached to a connector.
~~c.~~**d.** **Include a** ~~Obtain~~ Steris chemical indicator **in each cycle, according to manufacturer's IFU.**~~and attach to orange holder. Place in the Steris tray with the item to be sterilized.~~
~~i. Check expiration date of chemical indicator before use.~~
~~ii. Chemical indicator starts blue and turns pink when passing.~~
~~d.~~**e.** Place lid on the Steris tray insert.
~~e.~~**f.** Place Steris S40 sterilant container in sterilant chamber and insert aspirating probe according to manufacturer's ~~instructions~~**IFU**. Ensure tubing is not kinked.
i. Follow precautions for safe handling of peracetic acid according to manufacturer's ~~instructions~~ **IFU.**~~and Surgical Services Policy: Peracetic Acid: Disposal of.~~
~~f.~~**g.** Close lid of Steris machine and press START to begin cycle, **according to manufacturer's IFU**.
~~g.~~**h.** Upon completion of cycle, check printout to ensure the cycle has completed and the following sterilization parameters have been met, **according to manufacturer's IFU**:
i. Temperature (45.5-60°C)
ii. Exposure time (6 minutes)
iii. Concentration (greater than 175)

4. Maintain sterility during transport to the point of use.

a. ~~Immediate Use Steam Sterilization~~**IUSS**:

~~i. Avoid removing sterile items from the autoclave in the presence of un-masked personnel.~~

~~ii.~~**i.** Open the sterilizer door cautiously, and prepare to remove the sterilized~~r~~ tray for transport to the operating room.

~~1) The circulating nurse shall hold the sub-sterile door open for the scrub person.~~

~~2) The scrub person, with gown, gloves, and sterile hand towels, shall remove trays from the sterilizer.~~

~~3) Drape a ring stand or prep stand with a sterile impervious drape to hold the trays prior to transfer to the sterile field.~~

~~iii. At the sterile field (point of use), present or open the tray and inspect the Class V Integrator to ensure parameters have been achieved.~~

~~1) The scrub person must also verify the Class V Integrator strip changed color into the "pass" range before removing instruments from the container.~~

~~2) The scrub person hands off the Class V Integrator strip to the circulating nurse to affix to the Immediate Use Sterilization log sheet.~~

~~iv.~~**ii. Retrieve the challenge pack and read the chemical indicator (i.e., Class V Integrator).** If the Integrator did not change color into the "pass" range, the load is not considered sterile and must be run again.

1) If the indicator line has not moved past the "Accept/Reject" mark, on the second load, place the sterilizer "OUT OF SERVICE".
2) Notify the SPD Manager, the SPD Shift Supervisor, and/or the OR **Nursing Leadership**~~Assistant Nurse Manager/~~ **or** ~~D~~designee of the sterilizer malfunction.
3) Place tape across sterilizer door with an "OUT OF SERVICE" sign.
4) Notify ~~Clinical~~ **Building** Engineering (Ext. 7711).
5) Enter a **Building Engineering** Work Order via TCMC Intranet.
6) In surgery make note on the schedule board and ~~pass~~ **communicate** information at report**/huddle**.
7) DO NOT USE the sterilizer until ~~Clinical~~ **Building** Engineering has completed repairs. A major repair requires three (3) successive Biological Tests and for the Pre-Vac cycle three (3) bowie dick tests have been returned as "NEGATIVE".

b. Steris:

i. Remove the sterilized tray insert from the Steris machine. Instruments that remain in the covered tray insert are sterile and may be delivered **immediately** to the point of use. **Items may not be stored for later use or held from one procedure to another.**

ii. If applicable, ensure connector is still connected to the ~~scope~~**equipment before accepting the load.**

iii. ~~Verify~~ **Read** chemical indicator **within 30 minutes of cycle completion, according to manufacturer's IFU.**~~changed color into the pink acceptable color range.~~

5. If the item immediate use sterilized was an implant, ~~the scrub person hands off~~ the **nurse retrieves the** Biological Indicator ~~to the circulating nurse, who~~**and incubates it according to manufacturer's IFU.** ~~places it along with the control BI ampule, into the incubator according to manufacturer's written instructions.~~

~~a. Results must be read in 3 hours and reported to the implanting surgeon.~~

~~b.~~**a.** Implants sterilized via Immediate Use Sterilization shall be quarantined on the sterile field until results of the BI are obtained.

~~c.~~**b.** If a positive test Biological Indicator occurs, **immediately** notify the surgeon and the ~~OR Assistant Nurse Manager/Designee~~**Surgical Services Nursing Leadership**~~Director/Assistant Director~~**/designee**.

i. The ~~OR Assistant Nurse Manager/Designee~~**Surgical Services Director/Assistant Director/designee** will notify the implanting physician (if not already aware) and the infection control practitioner.
ii. The primary circulator must complete a Quality Review ~~Report~~ **Report via the RL Solutions system.**

D. **DOCUMENTATION:**

1. Document every load run in the autoclave on the appropriate Immediate Use Sterilization Log sheet. Information recorded from an IUSS cycle shall include:
   a. Sterilizer number
   b. Date
   c. ~~OR suite~~**Operating Room** number **where the items were used**
   d. Name and signature of person**nel** starting cycle
   ~~d.~~**e.** ~~and~~**Name and signature of personnel** removing sterilized items at the end of the cycle
   ~~e.~~**f.** Cycle number
   ~~f.~~**g.** Load contents
   ~~g.~~**h.** Identify if load contains implant
   ~~h.~~**i.** Print-Con strip record of cycle parameters (i.e., exposure time, temperature, pressure, vacuum)
   ~~i.~~**j.** Patient Identification label~~.~~
   ~~j.~~**k.** Class V integrator for IUS**S** load is affixed to the log sheet
   ~~k.~~**l.** Reason for IUS**S**
   ~~l.~~**m.** Biological Indicator information, if the load contains an implant:
      i. Incubator well numbers of test ampule and control ampule
      ii. Date/Time/Initials when ampule is placed in incubator
      iii. Date/Time/Initials when test read/completed ~~(3 hours)~~
      iv. Test results ("+" or "-")
      v. Control results ("+" or "-")
      vi. Lot # of biological indicators~~.~~
2. Document every ~~load~~**cycle** run in the Steris, including:
   a. Steris machine ID
   b. Date
   c. Patient identification label
   d. Cycle number
   e. OR suite in which item ~~will be~~**was** used
   f. Item**(s)** sterilized
   g. Affix processed chemical indicator
   h. Reason for IUS
   i. Initials of person sterilizing item
3. Accurate and complete records are required for process verification, infection control monitoring, and sterilizer malfunction analysis.

E. **REFERENCES:**

1. ~~AORN Guidelines for Perioperative Practice (2015).~~ **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**
2. **Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition*. St. Louis, MO: Elsevier.**
~~Rothrock, Jane. (2015). Alexander's Care of the Patient in Surgery, 15th Edition. Mosby.~~

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**KNEE IMMOBILIZER APPLICATION AND RANGE OF MOTION (ROM) BRACE**
Purpose:	To outline the nursing responsibilities in the application of knee immobilizer.
Supportive Data:	Knee immobilizers provide support to prevent knee flexion. Requires a physician order.
Equipment:	Knee immobilizer/universal knee splint; ROM brace.

A. **KNEE IMMOBLIZER:**

1. Assess neurovascular status and skin integrity of patient pre and post application of splint and ongoing (ie. minimum every 4 hours or per physician orders). Include proper placement of the splint while splint is on.
2. Place leg inside immobilizer with posterior fossa resting in posterior panel so that when the immobilizer is secured, it is in alignment with patella if visible (if not compare with contra-lateral patella). It is not necessary for the patella strap to fasten.
3. Apply Velcro straps through metal loops snugly, s but not restricting venous flow.
4. Record neurovascular assessment, application of immobilizer/splint, and patient's tolerance in the medical record.

B. **RANGE OF MOTION (ROM) BRACE:**

1. Assess neurovascular status and skin integrity of patient pre and post application of brace. (ie. minimum every 4 hours or per physician orders.)
2. Set dial for extension and flexion per physician order.
3. Open brace and place under leg. Line padding up for lower and upper sections of leg and making sure that circular padding lines up with knee joint, using popliteal fossa as a point of reference.
4. Close padding with Velcro, starting at the bottom and working upwards.
5. Apply Velcro straps snugly, but not restricting venous flow.
6. Record neurovascular assessment, application of brace, and patient's tolerance in the medical record.

C. **REFERENCES:**

1. National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 7th~~3rd Edition, April 12, 2013~~.
2. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Division of Orthopedics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/93, 01/11, 10/19	02/11, 11/15, 12/19, 03/20	03/11, 12/15, **04/20**	05/16, **05/20**	**n/a**	04/11, 10/16, **06/20**	**07/20**	05/11, 02/17, **n/a**	12/93, 5/00, 6/00, 7/03, 1/06, 6/08, 05/11, 02/17

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**04/00**	**SUBJECT:**	**Lift Team Technician**
REVISION DATE(S):	**06/03, 09/05, 6/08, 08/11, 05/15 02/19**		

Patient Care Services Content Expert Approval:	**~~11/18~~02/20**
Clinical Policies & Procedures Committee Approval:	**~~12/18~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~12/18~~06/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Administration Approval:	**~~01/19~~07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/19**

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) is committed to providing a safe environment for patients and staff. To minimize the risk of workplace injuries associated with the handling of patients, TCHD shall implement and maintain a safe patient handling policy for all patient care units.
2. This will include **Lift Team Techniciansa** ~~lift team~~ and safe patient handling procedures with mechanical lifting devices for every total body lift of non-ambulatory patients weighing more than 50 pounds.
    a. TCHD personnel shall not be required to lift non-ambulatory patients weighing more than 50 pounds by themselves, except in an urgent or emergent situation.
3. Lift Team Technicians (LTT) are available for lifting assistance in the hospital.
    a. When a LTT is not available on a unit or outpatient area, the ~~Assistant Nurse Manager (ANM)/Relief~~ Charge **Nurse,** Registered Nurse (RN) or Supervisor shall obtain assistance with lifts from other patient care areas as well as other unit staff.
    b. LTT duties in Women and Newborns Services and Surgical Services are provided by the peri-operative aides as well as other unit staff.
4. LTT shall remain on their designated units during working hours unless instructions are received from the unit's leadership team.
5. LTT shall respond to all Rapid Response **Team** (RRT), Code Blue, and Dr. Strong alerts to assist as needed.
    a. At the scene of the emergency event, LTT will be released to regular duty by an ~~ANM/Relief~~ Charge **Nurse**~~RN~~ or Administrative Supervisor (AS) if not needed
    b. LTT assigned to the Intensive Care Unit shall accompany the RRT or Code Blue RNs, and released to regular duty when directed.
6. RNs and Advanced Care Technicians (ACTs) are expected to assist in the transfer and repositioning of ambulatory patients not requiring full body lift (i.e., bed to chair/wheelchair, bed to commode, or floor to bed.)
7. A RN or ACT shall be present when patients require repositioning by a LTT
8. LTTs shall follow the practices of their unit for the following:
    a. Change of shift task
        i. Obtain a brief shift hand-off to identify the patient's requiring repositioning
        ii. Assist with answering telephones and call lights during the RN and ACT shift hand-off on Acute Care Services and the Telemetry unit
    b. Patient rounding times
        i. Scheduled rounds shall occur at least every two hours on assigned units

ii. Initial the patient education/rounding board in the appropriate time space after repositioning a patient

c. **Lift Team Technicians will be assigned, when available, in the following manner:** ~~Floor assignments when a unit is comprised of more than one floor~~
   i. Women and Newborn Services
      1) Assist with the transport of patients from the Emergency Department when notified per department practices i.e., pager system
   ii. Acute Care Services (ACS)
      1) One LTT will be assigned to 4 Pavilion (4P) and ~~O~~one LTT will be assigned to 1 North (1N) on ~~the~~**each** day shift **and will assist on 2P**.
      ~~2) One LTT will be assigned to 2P and One LTT will be assigned to 1N on the night shift.~~
         ~~a) Both LTTs will alternate tasks on the floor without an assigned LTT.~~
   iii. Intensive Care Unit:
      1) One LTT will be assigned to the 1East and ~~O~~one LTT will be assigned to 1West when rounds are completed
      2) LTTs shall work together as needed
   iv. Telemetry Unit:
      1) One LTT will be assigned to the second floor
      2) One LTT will be assigned to the fourth floor
      3) Both LTT will collaborate to assist with task on the third floor

d. Break and meal times
   i. Follow unit practices
   ii. Acute Care Services
      1) LTTs will sign up for their lunch/break times on the **designated break**~~LTT~~ logs at the beginning of the shift
      2) LTTs will notify all ACS floors of their lunch/break times
   iii. Telemetry
      1) Sign-up for break by documenting your name in an allotted time on the break sheet.
      2) One LTT will be on the unit all times

9. The LTT personnel shall use a mechanical lifting device, when available, for every total body transfer. Equipment available may include:
   a. Mechanical vertical or horizontal lifts
   b. Full Length Slide Boards
   c. Gait Belts
   d. Mechanical Weighing Devices
   e. Glide mat
10. The Lift Team shall be called for all lifts as specified in this policy on their assigned units.
   a. Lifts are defined as total body transfers to and from:
      i. Bed to chair/wheelchair
      ii. Bed to gurney
      iii. Bed to commode
      iv. Floor to bed
      v. Bed or chair to scale
      vi. Any other lift where total body movement of the non-ambulatory patient is required.
11. Patient Safety
   a. Prior to leaving a patient's room ensure the following:
      i. Patient's room is clean and uncluttered
      ii. Bedside tray within patient's reach
      iii. Call button, television remote control and patient's other personal items are within their reach

iv. Patient's bed is in low position with upper side rails in the raised position
v. Patients are covered with a blanket or per their preference
vi. Ask if there is anything they can get for the patient

12. Performs the following task as directed by an RN and assist ACTs as directed by RN:
    a. Assist ACTs and RNs with the following:
        i. Admission and daily weights
        ii. Positioning patients during baths
        iii. Ambulating patients to bathroom that are potential risk for falls and the patient requires more assistance than one RN or ACT
    b. Answers telephones and patient call lights during the RN shift hand-off, Protected Time, Quiet Time and PRN as directed by RN or per unit practices
    c. Answers patient's call lights and relays message to RN or ACT
    d. Transport specimens to the lab
    e. Transport patient belongings or equipment to other nursing departments
    f. Pick up medications (not controlled substances) from the pharmacy department and transport to nursing unit as directed by a RN
    g. Obtain blood products from Transfusion Services
    h. Transfers inpatients to other inpatient nursing departments
    i. Transports discharged patients to personal vehicles
    j. Keeps halls free from clutter and equipment and ensures equipment is not placed near or blocking fire doors or entrance to patient's room
    k. Assist with positioning patients during bedside procedures and treatments as delegated by RNs
    l. Assist with stocking supplies as directed by RN
    m. Assist with inventorying supplies and equipment as directed by RN
    n. Other duties as assigned by RN/**Charge Nurse**~~AMN~~
13. The Lift Team shall respond to a priority lift (in their designated area or when delegated by a ~~CM, ANM/Relief~~ Charge **Nurse** or Supervisor) immediately or as soon as it is safe to leave their current patient assignment.
14. Personnel who do not comply with this policy may be subject to discipline under Administrative Policy, Employee Health and Safety.

B. **RELATED DOCUMENT(S):**
1. Lift Team Helpful Hints (ICU, Telemetry, and ACS)

Lift Team Helpful Hints (ICU, Telemetry, and ACS)

TIME	TASKS	HELPFUL HINTS
0700-0759 And 1900-1930	1. Obtain Shift Hand-off Remain near nurses' station during RN shift hand-off to assist with answering telephones and patient call lights	<u>Breakfast</u> ➢ Ask patients the following questions prior to leaving their rooms: 1. Would you like to sit in the chair or dangle on the side of the bed for breakfast? 2. Can I get you anything before I leave? 3. Ensure patients are covered with a blanket <u>Lunch and Dinner</u> ➢ Ask patients the following prior to repositioning or assisting or leaving room: 1. Would you like to be repositioned? 2. Would you like to sit in the chair or dangle on the side of the bed for lunch? Dinner? 3. Would you like to take a walk before or after lunch? Dinner? 4. Can I get you anything before I leave? ➢ **Rapid Response (RR), Code Blue, Dr. Strong** • All LTTs shall respond, and either assist or return to regular duties as directed.
0800- until 1900 And 2000-0700	1. Begin Rounding (round every 2 hours) 2. Note the patients who will require assistance with repositioning every two hours 3. Note the patients who will require assistance ambulating 4. Knock prior to entering a patient's room 5. Introduce yourself to patient 6. Write your name on patient's education board 7. Assist ACT with weights, repositioning patients. 8. Assist ACT as directed by RN with: • Assisting patients to chairs for meals • Repositioning positions for meals • Assist with repositioning for hygiene care 9. Perform duties assigned by RNs 10. Assist with discharges, transfers, and admissions	
Breaks	1. Take breaks as assigned 2. Inform RNs and ACTs prior to leaving the floor for break 3. Inform 2nd LTT, if applicable	
PRN Task examples	1. Assist with answering call lights and telephones during Protected Time and Quiet Time 2. Remove unused equipment from halls, ensure fire doors are not blocked with equipment 3. Ensure halls are free of clutter 4. Ask RNs or ACTs if new admissions or transfer patients require assistance with repositioning or ambulating	

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**03/90**	**SUBJECT:**	**Missing Patient**
REVISION DATE:	**9/91; 12/96; 6/99; 5/03; 4/06 6/09; 6/11**	**POLICY NUMBER:**	**8610-305**

Patient Care Services Content Expert Approval:	**04/20**
Clinical Policies & Procedures Committee Approval:	**~~03/15~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~03/15~~06/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~04/15~~ n/a**
Board of Directors Approval:	**04/15**

A. **PURPOSE:**

1. To define the process and responsibilities **regarding**~~governing the protection of~~ missing patients.

B. **POLICY:**

1. In the event that a patient cannot be located, an immediate search ~~plan~~ will be **conduc**~~implemen~~ted **by**~~, coordinating the combined effort of~~ Clinical and Security personnel.~~:~~
2. ~~When a patient is deemed missing, an organized search will be made, escalating in intensity, as deemed appropriate by the nurse or supervisory staff in charge of this patient's unit.~~
3. ~~2.~~ To initiate ~~a~~**the** search, the **Charge Nurse**~~Assistant Nurse Manager (ANM)~~/designee~~/relief charge~~ will contact:
   a. **Nursing Leader**~~The Clinical Manager~~/Administrative Supervisor.~~:~~
   b. Security - Inform Security of all patient identifying information including:
      i. **Whether the**~~If~~ patient is on a 5150 hold or 72 hour hold.~~:~~
      ii. **Whether the**~~If~~ patient is on conservatorship of any kind, ~~if patient~~ is confused, ~~incompetent~~ and/or at risk for harm.~~:~~
   c. **The Leader**~~Director~~ of the Unit/Service, Chief Nurse Executive and, **if after hours or on weekends,** the Administrator ~~on call~~.
4. ~~3.~~ Nursing will coordinate an immediate search of patient's unit~~, utilizing the "Nursing: Missing Patient Search Checklist."~~
   a. This search will include: the surrounding stairwells, (entire flight up, and entire flight down), surrounding bathrooms/showers, treatment rooms, waiting rooms, supply rooms and elevator areas.
5. ~~4.~~ Security will, simultaneously, conduct a search of the hospital grounds utilizing the ~~"~~Security: Missing Patient Search Checklist.~~"~~
   a. Areas included are: All waiting rooms, lobbies, gift shops, designated smoking areas, cafeteria, all restrooms within immediate area of patient's~~'~~ unit (other than on patient floor) and exterior grounds~~.~~
6. ~~5.~~ The Security Department will contact other designated ~~Medical Center~~ employees including: Facilities Services, Lis**ft** Team ~~Personnel, Courtesy Shuttle~~ and Public Branch Exchange (PBX) **as necessary**~~.~~
7. ~~6.~~ Open communication between Security and **Nursing Leader**~~Clinical Manager~~ or designee will be maintained throughout the entire search~~.~~
8. ~~7.~~ If **the** patient is located, notify PBX immediately. PBX will contact Security via radio and **the**

Nursing Leader~~Clinical Manager~~ or designee by phone

a. Search will be continued by all personnel until such time they are requested to discontinue~~.~~

b. Patients shall be returned to **the** unit if they are on a hold, under conservatorship**,**~~,~~ ~~p or~~ are confused**,**~~,~~ **or a clear risk to themselves or others.** (If unsure **whether**~~, if~~ a patient **may**~~can~~ leave AMA or is at risk, detain the patient until a determination is made with the assistance of Nursing, Social Services, ~~Behavioral Health Service staff,~~ or a Hospital Administrator)~~.~~

~~9.~~**8.** If **the** patient is not located within a reasonable amount of time, **Nursing Leader**~~the Clinical Manager~~ will contact the **Clinical**~~Director of~~ Risk Manager~~ment.~~

a. The **Nursing Leader**~~Clinical Manager~~ will delegate **the task of** ~~someone to~~ contacting listed relatives for information regarding possible whereabouts of patient~~.~~

b. The **Nursing Leader**~~Clinical Manager~~ will ensure MD notification (and psychiatrist if one is involved).

c. The Security Department will be responsible to notify the appropriate law enforcement agencies as indicated. Examples of high-risk patients include: frail, elderly, those on **a mental health**~~72 hour~~ hold, and confused patients~~.~~

d. Social Services will be contacted as indicated~~.~~

C. **FORMS/RELATED DOCUMENTS:**

~~1. Missing Patient Search Checklist - Nursing~~

~~2.~~**1.** Missing Patient Search Checklist - Security

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/96 **SUBJECT:** Nutrition Education of Patients

REVISION DATE: 6/03, 1/04, 05/11 ~~**POLICY NUMBER: V.D**~~

Patient Care Services Content Expert~~Department~~ Approval:	**~~02/17~~03/20**
Clinical Policies and Procedures Approval:	**~~03/17~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~03/17~~06/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/17~~06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~05/17~~ n/a**
Board of Directors Approval:	**05/17**

A. **POLICY:**

1. Registered Dietitian (RD) shall educate patients, family, and/or significant others, as appropriate, regarding prescribed diet and means by which nutritional goals can be met.
2. RD shall determine the need for patient education based upon nutritional assessment and assessment of patients' knowledge of prescribed diet.
3. The patient's educational needs shall be assessed for language, cognitive, and emotional barriers. Readiness to learn shall be assessed and available support networks are determined.
4. The patient/family/significant other shall be educated regarding diet so as to improve dietary compliance or nutritional needs **as needed.**. Appropriate tools are utilized to enhance patient understanding of education. Both verbal and written tools are utilized; copies of written materials are provided for use at home **as appropriate.**.
5. Patients are educated at a time when they are ready to learn. ~~For example, education is timed so that it does not occur when the patient is distracted, in pain, or awaiting imminent discharge~~.
6. Questions are asked of patient to solicit assessment of patient understanding. Diet history may be obtained. The patient is encouraged to develop a plan for implementing necessary changes in diet/nutrition.
7. Documentation of any educational activity is completed in the patient's medical record. ~~Documentation shall include description of materials provided, assessment of patient's understanding of education and motivation to comply with restrictions.~~
8. Follow up teaching is accomplished throughout ~~-~~the patient's stay **as needed. The RD P**phone number is given for patient to contact RD with questions as needed after discharge.
9. The Registered Nurse (RN) is responsible for the initial functional assessment during the admission process, as well as reinforcing education provided by the dietitian as needed and upon discharge.
10. The RN shall also initiate the appropriate plan of care and per the Patient Care Services Policy; Interdisciplinary Plan of Care (IPOC).

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

1. Patient Care Services Policy: Interdisciplinary Plan of Care (IPOC).

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/86**	**SUBJECT:**	**Organ Donation, Including Tissue and Eyes**
REVISION DATE(S):	**01/90, 04/94, 03/97, 07/03, 10/05 07/07, 05/08, 01/11, 08/11, 01/16 08/19**		

Patient Care Services Content Expert Approval:	**~~05/19~~03/20**
Clinical Policies & Procedures Committee Approval:	**~~07/19~~05/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~07/19~~06/20**
Medical Staff Department or Division:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/19~~06/20**
Administration Approval:	**~~08/19~~07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **PURPOSE:**
1. This policy provides staff with guidance for:
   a. Recognition of imminent death and provision of patient and family care needs.
   b. The hospital's obligations for the referral of potential donors for organ, tissue, and eye donation.
   c. Delineation of the hospital's responsibilities and the Organ Procurement Agency's responsibilities in completing the referral and donation of anatomical gift process.
   d. The management of potential donors to include billing responsibilities.

B. **DEFINITIONS:**
1. Anatomical Gift: Donation of all or part of a human body to take effect upon or after death. Donation categories are as follows:
   a. Organ Donor:
      i. A brain dead individual whose cardiopulmonary function is being artificially maintained for the purpose of solid organ donation.
      ii. An individual whose organ(s) can be recovered for transplant after the heart has stopped (Donation after-~~Cardiac~~ Circulatory Death/DCD.)
   b. Tissue Donor: Brain dead or cardiac dead individual who may donate their skin, heart valves, bone or cartilage.
   c. Eye Donor: Brain or circulatory dead individual who may donate their eyes.
2. Imminent Death: Anticipated death of a patient on a ventilator or potentially brain dead. Guidance for determining imminent death include the following:
   a. A ventilated patient with a devastating illness or injury who is in Intensive Care Unit or Emergency Department; and, in addition has one of the following:
      i. Clinical findings that are consistent with a Glasgow Coma Scale (GCS) that is less than or equal to 4 (<4) without sedation or paralytics; or:
   b. For whom physicians are evaluating a diagnosis of brain death; or
   c. For whom a physician is considering that life-sustaining therapies be withdrawn, pursuant to the family's decision.
   d. Reference Patient Recognized as Imminent Death Flowchart
3. Brain Death: An irreversible cessation of all functions of the entire brain, including the brain stem. (Health and Safety Code Section 7180). A physician may determine an individual has

suffered brain death (as defined by statute.) Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code Section 7181.) **Refer to PCS Policy: Determination of Brain Death for complete details.**

4. Circulatory Death: Irreversible cessation of cardiac and respiratory functions. Declaration of death will be determined when there is no palpable pulse, no heart beat by auscultation (mechanical heart beat), and no respiratory efforts. A five minute wait period is required to confirm cessation of vital functions to declare circulatory death.
5. Designated Requestor: Staff from the Organ Procurement Agency, Lifesharing or the San Diego Eye Bank or their representative who has completed appropriate training. Training includes the methodology for approaching potential donor families and informed consent process for requesting organ, tissue and eye donation.
6. Organ Procurement Organization (Agency): Lifesharing has been designated by the United States Department of Health and Human Services (DHHS) as the organ procurement agency for San Diego and Imperial Counties within the meaning of 42 C.F.R. 486.301 et. Sew.; is a member, in good standing, of the Organ Procurement and Transplantation Network established under the Act; and is a certified member, in good standing, of the American Association of Tissue Banks.
7. CDCR: California Department of Corrections and Rehabilitation
8. SDSD: San Diego County Sheriff Department

~~C. **PERSONNEL:**~~

~~1. Care Team Members: Registered Nurses, Physicians, Social Services, Case Managers, Chaplains, or members of Spiritual Care Services.~~

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

1. Tri-City Medical Center **(TCMC)** recognizes that patients and families facing imminent death have special needs and to the extent possible, will be afforded any reasonable religious or cultural practices surrounding the issue of death. Families or next of kin will be afforded time to gather family or next of kin at the patient's bedside and understand the diagnosis and treatment options as well as the patient's right to donate or not donate organ and tissues.
2. **TCMC**~~Tri-City Medical Center~~ is committed to ensuring that every individual or family of a potential donor in collaboration with Lifesharing (Organ Procurement Organization) is informed by a designated requestor of their option to donate organs or tissue or not to donate. Additionally, Lifesharing, San Diego Eye Bank and **TCMC**~~Tri-City Medical Center~~ are dedicated to educating staff of donation issues and are accountable for the Organ Procurement Program effectiveness.
    a. Lifesharing is the federally designated organ procurement agency for TCMC. Lifesharing has:
        i. Consulted with the San Diego Eye Bank and developed a protocol for identification and notification of potential eye donors.
        ii. Specified the San Diego Eye Bank as an appropriate third party for death notification on potential eye donors.
    b. Hospital obligations at time of death and imminent patient death:
        i. Make a reasonable search for a document of anatomical gift or donation, e.g. advance directive, statement attached to driver's license, or other information specifying refusal of donation, if there is not immediately available any other source of that information.
        ii. Refer to Lifesharing, in a timely manner, of all deaths and imminent deaths that occur in the hospital (regardless of the deceased's medical suitability for organ donation and regardless if patient is in CDCR or SDSD Forensics/Custody.
            1) Neonatal death defined as live birth delivery requiring death certificate is reportable.
        iii. Miscarriage/abortion or fetal deaths are not reportable.

c. Lifesharing staff/representative, as Designated Requestors, are responsible for approaching potential donor families and obtaining authorization in the process of requesting organ, tissue and eye donation.

d. Lifesharing will ensure there is a diligent search for a legal representative or evidence of an individual's wishes regarding donation. If a search does not reveal a legal representative or documentation of wishes, a release from the Medical Examiner Office will be obtained and the Hospital Risk Manager contracted to facilitate donation authorization from hospital administration.

3. All healthcare providers will display discretion and sensitivity with respect to the circumstances, views, wishes, and beliefs of the families of potential donors.

4. Lifesharing shall monitor and provide reports of eligible organ donors and organ donor conversion rates for inclusion in the hospital performance improvement activities.

~~E.~~**D. RESPONSIBILITIES:**

1. Hospital
   a. Primary nurse or physician must notify Lifesharing referral service of all imminent deaths as soon as possible, and within one hour of circulatory death.
      i. Nurse/physician is not responsible for screening potential donors. This is the responsibility of Lifesharing or its designated representatives, such as the San Diego Eye Bank.~~.~~
   b. At the time of referral, provide the following information:
      i. Name and medical record number~~;~~
      ii. Age/Sex/Race~~;~~
      iii. Height and weight~~;~~
      iv. Time and cause of death (for **circulatory**~~cardiac~~ death~~.~~)
   c. Document all referrals including imminent deaths on Expiration Record in Cerner or if necessary on a hard copy Release of Deceased form. (Refer to Patient Care Services Procedure Manual, Release of Deceased) Documentation includes:~~:~~
      i. Date and time of referral
      ii. Name of person contacted at Lifesharing~~;~~
      iii. Referral number (when provided by Lifesharing)~~;~~
      iv. Determination by procurement agency
      v. Either:
         1) Patient was declined as donor; or
         2) Agency will further evaluate patient as a potential donor and approach the family for donation.
2. Ensure families are not approached regarding potential donation until:
   a. Attending physician (or his/her representative) has informed family of patient's irreversible condition, brain death or imminent death.
   b. Circulatory death has occurred and patient's death has been reported via donor referral service.
3. Family Notification of Donation Options and Discussion:
   a. The health care team members should not initiate the donation discussion with the family. Health care team member having a relationship with the patient or family should, when possible, collaborate with, and facilitate the discussion between the Lifesharing Designated Requestor and the family regarding options for organ and tissue donation.
   b. If the patient's family initiates discussion regarding donation, Lifesharing will be notified immediately and the family informed that all their questions can be fully answered by staff from Lifesharing or the San Diego Eye Bank. Lifesharing or the San Diego Eye bank shall notify the nurse or physician of the potential donor's suitability for donation.
   c. Upon notification by Lifesharing and/or the San Diego Eye Bank that the potential donor is found to be registered on the Donate Life California Organ and Tissue Donor Registry, collaborate with them to confirm:
      i. The identity is correct per the legal decision maker

ii. Plans are consistent with any expressed wishes in a valid document pursuant the Uniform Anatomical Gift Act (UAGA) as defined in California Law (CA H&S 7150), and the Motor Vehicle Code (CA MVC 12811), an anatomical gift, that is not revoked by the donor before death, is irrevocable and does not require authorization or concurrence of any other person after the donor's death. This includes an anatomical gift that is made by means of and/or is registered in the California Organ and Tissue Donor Registry or other State registry designated by law.

iii. In circumstances of preauthorization by the patient, support Lifesharing efforts with sensitivity and cultural consideration, to communicate to the legal decision maker, the plans to proceed with donation.

4. Physician
   a. The medical management of the patient prior to brain/circulatory death remains the responsibility of TCMC attending physician. Medical Management to ensure organ viability will be continued until Lifesharing confirms suitability and options have been presented to the family.
   b. When a hospital refers an individual at or near death to a procurement organization, the organization may conduct any reasonable examination necessary to ensure the medical suitability of an organ/tissue that is or could be the subject of an anatomical gift for transplantation, therapy, research, or education from a donor or a prospective donor. During the examination period, measures necessary to ensure the medical suitability of the part may not be withdrawn unless the hospital or procurement organization knows that the individual expressed a contrary intent.
5. Lifesharing
   a. Screen each referred patient based on current medical criteria for organ, tissue and eye donation. Lifesharing will refer circulatory dead patients to the appropriate agency for screening for potential eye and tissue donation.
   b. The "Designated Requestor" (in collaboration with the health care team when possible) will initiate contact with family about donation options and obtain authorization from the legal decision-maker upon report of death, imminent death or brain death.
   c. Collaborate with the primary physician to provide physiological maintenance while suitability for donation is being evaluated. The cost associated with a procedure required or medication given solely for the purpose of maintaining organ viability for donation will be assumed by Lifesharing.
   d. Document authorization on Lifesharing Form "Authorization for Organ and Tissue Donation".
      i. Authorization may be obtained via telephone utilizing recording device, a hospital staff witness or a recorded line.
      ii. Provide family with a copy of the authorization form.
      iii. Place original copy of the authorization form in the patient's medical record.
   e. Screen all deaths for Medical Examiner criteria and obtain consent from the Medical Examiner for donation, if applicable.
   f. Inform the Medical Examiner of the intent to pursue Donation by Circulatory Death.
   g. Advise hospital staff of suitability for donation and subsequent steps to follow, i.e. implement corneal protective measures or provide the reason for the patient being declined as a donor.
   h. **Schedule the donation procedure with the Surgery department, including which organs are planned for donation.**
   ~~h.~~i. Update nurses, physicians, operating room staff and others as appropriate for status of donation.
   ~~i.~~j. Document all events, procedures and donor management in the medical record.
   ~~j.~~k. Notify appropriate hospital staff of final outcome of referral.

~~F.~~E. **PROCEDURES:**

1. Primary nurse in collaboration with or the physician must notify Lifesharing referral service by calling 1-888-4ADONOR (1-888-423-6667) for all circulatory deaths within one hour and in the case of recognition of imminent death, as soon as possible, ideally within one hour. (See Patient Identified as Imminent Death Flowchart)
2. Management of Brain Death Donation (See Brain Death Donation Option Flowchart).
   a. Once family is informed of brain death, assess and document in plan of care spiritual, cultural needs and accommodate as possible. Encourage family/health care decision maker to obtain as much information as possible from the clinical staff to understand the diagnosis and prognosis provide family reasonable brief period of time (generally not greater than 24 hours) to gather family/next of kin at bedside and agree to discontinuation of cardiopulmonary support.
   b. Primary nurse and physician will collaborate regarding status of potential donor and confirmation of brain death diagnosis with Lifesharing.
   c. Refer to the Lifesharing Catastrophic Brain Injury Guidelines at Lifesharing's website at http://www.lifesharing.org.
   d. Primary nurse will assist Procurement Coordinator to maintain potential internal organ donors on support systems until recovery of organs can occur in the operating room.
3. Management of the process for Donation after Circulatory Death (See Circulatory Death Donation Option Flowchart)
   a. A note by the physician, documenting the decision to withdraw life supporting therapy must be placed in the chart prior to requesting decision to withdraw life sustaining treatment or advise the family or hospital regarding medication used or procedure for withdrawal of support.
   b. Lifesharing is notified to determine suitability for the purpose of establishing donation options to be offered to the family.
   c. Care staff allows family time to plan end of life care decisions, autopsy, and timing of withdrawal, palliative care options, and spiritual care.
   d. Lifesharing Designated Requestor advises the family of donation options. Family selects option and Lifesharing obtains all required authorizations. If the family does not select any donation option, the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
   e. If the family authorizes the option of donation after circulatory death, the hospital care team will continue to provide the treatment to optimize organ viability until life sustaining measures are withdrawn. This may include line placement, laboratory testing, medications to improve organ function and reduce possibility of infection, and procedures to establish organ suitability, i.e. bronchoscope, x-rays, ultrasound, CT scan. All procedures and invasive studies and heparin will require separate authorization from the family and orders from the physician of record.
   f. Plan with the family when and where life support will be discontinued and transfer patient as necessary. Consider accommodations for the family as requested. Withdrawal of life sustaining treatment will proceed as agreed upon by the family and care team.
   g. Lifesharing personnel will be available to support the family and act as official time keeper for organ viability. This may include the presence of the Lifesharing Coordinator during withdrawal of life support. Lifesharing surgeons will not be present during withdrawal of life sustaining treatment.
   h. After circulatory death is declared, includes a five minute wait period to confirm cessation of vital functions by a physician or nurse with validated competency (not associated with the procurement team or a hospital transplant team), organ recovery will proceed as directed by Lifesharing team.
   i. If circulatory death does not occur within the timeframe for viable recovery, likely not to exceed two (2) hours, of the withdrawal of life support, the organ recovery plan will be terminated and the patient may be transferred to the appropriate level of care and palliative care will continue as planned.
4. Management of Potential Eye Donor

a. Implement corneal integrity protective measures:
   i. Close eyelids;
   ii. Elevate head;
   iii. Place light eye packs over closed eyelids within two (2) hours of death. Be sensitive to the family. This may be done after the family has left.

5. Billing Process
   a. No charges related to organ, tissue or eye donation will be billed to the donor, the donor's family or estate, or donor's third party payer. The appropriate recovery agency will assume all charges related to donation.

6. Organ Procurement Program Effectiveness
   a. Health Information Department will, on monthly basis or as requested, provide Lifesharing with the following data:
      i. Patient name;
      ii. MR number;
      iii. Admit date;
      iv. Date of Birth;
      v. Date of death;
      vi. All ICD10 diagnoses assigned to patient during hospitalization.
   b. Lifesharing will review records on a monthly basis, or as needed, to evaluate referral effectiveness of imminent and actual deaths for the opportunity of organ and tissue donation.
   c. Lifesharing will analyze data and provide organ donor conversion rates to the hospital as requested.
   d. Lifesharing will collaborate with performance improvement representatives to analyze data and identify actions to improve process where applicable.

~~G.~~F. **RELATED DOCUMENT(S):**
1. Donation Option: After Circulatory Death Flowchart
2. Donation Option: Brain Death Flowchart
3. Patient Recognized as Imminent Death Flowchart

~~H.~~G. **EXTERNAL LINK(S):**
1. http://www.lifesharing.org

~~I.~~H. **REFERENCE(S):**
1. 42 CFR 482.45
2. American Academy of Neurology, current evidenced-based guidelines for Determining Brain Death
3. California Hospital Association, Consent Manual, Current Edition
4. California's Uniform Anatomical Gift Act (Health and Safety Code Sections 7150-7156.5, 7184. 1254/4
5. Lifesharing website: www.lifesharing.org
6. Physiologic Maintenance of Patients with Catastrophic Brain Injuries (Lifesharing)
7. San Diego Eye Bank website: www.sdeb.org
8. Section 9318 OBRA Hospital protocol

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Patient and Family Education**
REVISION DATE:	**06/03, 04/06, 10/07, 02/09, 06/11, 08/14, 4/2020, 07/17**	~~**POLICY NUMBER: V.A**~~	

Patient Care Services Content Expert~~Department~~ Approval:	**~~03/17~~04/20**
Clinical Policies and Procedures Approval:	**~~05/17~~05/20**
Nursing Leadership~~Executive~~ Committee Approval:	**~~05/17~~06/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**07/17**
Board of Directors Approval	**07/17**

A. **PURPOSE:**
1. To ensure every patient is provided with the necessary information to address individual health needs and challenges.

B. **DEFINITIONS:**
1. Patient – refers to patient, family, caregiver, and significant other(s) who may benefit from patient education.

C. **POLICY:**
1. Healthcare providers shall ensure the patient receives education and training specific to the patient's needs and abilities and as appropriate to the care, treatment, and services provided.
2. All patient and family education shall be documented in the Electronic Health Record (EHR)
3. Healthcare providers shall support the provision and coordination of patient education activities and identify and provide the resources necessary for achieving educational objectives.
4. Tri-City Healthcare District (TCHD) shall provide all patients with basic safety related information at the time of admission to Tri-City Medical Center **(TCMC)**.
5. All patient care providers participate in patient education in the course of daily patient care.
6. Patient education is a collaborative process that promotes independence and self-care.
   a. All patients are entitled to information that helps them better understand and cope with their medical condition and treatment plan.
   b. Education enables the patient to resolve health problems, make informed decisions, and institute healthy behaviors.
7. Education provided is based on the patient's assessed needs.
8. The assessment of learning needs addresses age, cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, barriers to communication, literacy, living environment, previous experience and resource availability as appropriate.
9. As appropriate to the patient's condition and assessed needs and the hospital's scope of services, the patient is educated about the following:
   a. Plan for care, treatment, and services
   b. Basic health practices and safety
   c. Safe and effective use of medications
   d. Food-drug interactions

e. Nutrition interventions, modified diets, or oral health
f. Safe and effective use of medical equipment or supplies when provided by the hospital
g. Understanding pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
h. Rehabilitation techniques to help them reach the maximum independence possible
i. Infection prevention measures
j. Measures taken to **help ensure safety**~~prevent adverse events~~ in surgery
k. Community resources and when necessary, how to obtain further care, services, or treatment to meet identified needs
l. Appropriate information about patient responsibilities and self-care activities
m. Discharge instructions to the patient and those responsible for providing continuing care
n. Information on oral health
o. Fall reduction strategies

10. Patients receive education and training specific to the patient's abilities as appropriate to the care, treatment, and services provided.
    a. Education is coordinated among the disciplines providing care, treatment, and services.
    b. The content is presented in an understandable manner.
    c. Teaching methods include verbal discussion, written materials, electronic care notes, demonstration and videos.
    d. Teaching methods accommodate various learning styles and readiness to learn
    e. Patient education is documented in the EHR
        i. Assessment of learning needs
        ii. Interventions to meet those needs
        iii. Patient response to education
        iv. Educational materials provided
    f. Comprehension is evaluated and documented
11. Patients receive education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/76**	**SUBJECT:**	**Patient Valuables, Liability and Control**
REVISION DATE:	**9/91; 6/94; 6/97; 5/00; 6/03; 4/06; 6/09; 02/11, 03/15**	~~**POLICY NUMBER: 317**~~	

Patient Care Services Content Expert Approval:	**04/20**
Clinical Policy & Procedures Committee Approval:	**~~10/14~~05/20**
Nursinge Leadership~~Executive Council~~ Approval:	**~~10/14~~06/20**
Medical Staff Department or Divisions Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~03/15~~ n/a**
Board of Directors Approval:	**03/15**

A. **PURPOSE:**

1. To establish a consistent method for the collection and disbursement of **patient** valuables during the admitting process. In the event that a **patient** arrives to the floor in possession of valuables, this policy provides prudent and reasonable safekeeping of these items. ~~The following items are considered valuable:~~**Valuable items include, but are not limited to:**
   a. Money
   b. Credit cards
   c. Jewelry
   d. Watches
   e. Hearing aids
   f. Eyeglasses
   g. Dentures

B. **POLICY:**

1. **During the admission process, a**~~All patient~~**patients is**~~are~~ strongly encouraged ~~during the admission process~~ to leave items of value at home or to send them home with family members. If this task is accomplished on the nursing unit, documentation **must**~~needs to~~ be completed **e**in the **electronic health record**~~Valuables/Belongings section of the Admission Assessment – Patient History P~~**p**~~owerform in Corner~~.
   a. **While in the hospital, p**~~P~~atients may retain their eyeglasses, hearing aids, and dentures as needed ~~while in the hospital,~~ however, these valuables will be the responsibility of the ~~patient~~**patient** and/or family.
2. ~~Patient~~**Patients are**~~will be~~ informed **on the Conditions of Admission** that the District will not be responsible for valuables kept in ~~patient~~**patient** rooms or at the bedside.~~.~~
3. Under no circumstances will a weapon be accepted from a ~~patient~~**patient** for storage in **the** hospital safe. In these instances, security **must**~~should~~ be notified.
4. **If the** decision **is** made to admit the ~~patient~~**patient**, the nurse will ~~first~~ strongly encourage the ~~patient~~**patient** to send valuables home with the family/friend.
5. If the ~~patient~~**patient** is unable to remove any piece of jewelry due to physical constraints, the jewelry will be secured with tape as appropriate
6. If sending valuables home is unacceptable to the ~~patient~~**patient**, the nurse will call Security **to lock such valuables in the hospital safe**~~personnel~~.

C. **PROCEDURE:**

1. The responding Security Officer will first encourage the ~~patient~~**patient** to send the item(s) home with a family member for safe keeping.
2. If the ~~patient~~**patient** is unable or unwilling to send the item(s) home for safe keeping, the Officer will bring a grey UniVault bag to the location of the ~~patient~~**patient**.
3. The Officer will collect the item**(s)** with the **p**~~P~~atient's **n**~~N~~urse as a witness to the collection process.
   a. Once the item **or items are** ~~is~~ collected, the Officer will inventory them ~~item(s)~~ and write a complete and accurate description of the item(s) on the outside of the UniVault bag using a sharpie or other permanent type marker, then place the item(s) in the bag securing it.
   b. Only valuables will be collected and placed in the bag (i.e. if the ~~patient~~**patient** is securing a wallet, the valuables are removed from it in the ~~patient~~**patient**'s presence, and placed in the UniVault bag, then the wallet is returned to the ~~patient~~**patient**.)
   c. All information on the bag must be filled out completely, and signed by the ~~patient~~**patient**. If the ~~patient~~**patient** is unable to sign, the **p**~~P~~atient's nurse will sign as a witness.
   d. The top flap portion of the bag is to be removed and filled out, then given to the ~~patient~~**patient** as receipt of collection.
   e. Two (2) copies of the completed inventoried bag must be made by placing the bag directly on a copy machine, one copy is to be given to the **p**~~P~~atient's **n**~~N~~urse to be included in the ~~Patient~~**patient**'s chart~~,~~ and the second copy is to be placed in the "For Copies Only" tray located on the counter above the Small (Drop) Safe in the Lost and Found office.
   f. The Officer must verify the ~~patient~~**patient**'s phone number with the ~~patient~~**patient** (***not collected from the chart***) to ensure current and accurate contact information.
4. All applicable information will be logged into the ~~Patient~~**Patient** Valuables Property Logbook #4 including the ~~Patient~~**patient**'s name, **p**~~P~~hone number, and bag serial number. The bag will be placed in the slot and dropped with the Officer verifying the bag fully dropped in.
5. Documentation of the UniVault bag number must be documented in Cerner on the Valuables/Belongings **P**~~p~~owerform.
6. Returning ~~Patient~~**Patient** Valuables.
   a. When requested to return a ~~Patient~~**patient**'s **v**~~V~~aluables, every attempt will be made to ensure that the item is being returned to the proper owner.
   b. The Officer will collect the UniVault r~~R~~eceipt from the owner, or if it has been lost or misplaced, will receive the copy of the bag from the ~~Patient~~**patient**'s **c**~~C~~hart.
   c. The Officer will take the UniVault r~~R~~eceipt or chart copy and contact the Cashiering Department or Administrative Supervisor (After Hours) to meet and open the Small (Drop) Safe to collect the ~~Patient~~**patient**'s **v**~~V~~aluables.
   d. The Officer will return to the floor and in the presence of the ~~Patient~~**patient** and **n**~~N~~urse, will cut the bag open on the dotted line of the bag.
   e. The Officer will inventory the contents of the UniVault **b**~~B~~ag and compare them to the **i**~~I~~nventory listed on the outside of the bag while checking off the inventory items.
   f. When the ~~Patient~~**patient** is satisfied that all their **v**~~V~~aluables are accounted for, the Officer will have the ~~Patient~~**patient** sign the UniVault **b**~~B~~ag and the copy.
   g. The Officer will make two copies of the signed inventory sheet and give **one** to the ~~Patient~~**patient**'s nurse to be included in the ~~Patient~~**patient**'s chart as a permanent record of receipt.
   h. The Officer will return the signed UniVault **b**~~B~~ag and the signed inventory sheet and place both in the "For Copies Only" tray located on the counter above **the** small (Drop) safe.
   i. The Lost and Found Administrator will collect the signed receipts and attach them to the copy filed in Lost and Found, **then**~~and~~ file them together in the Disposition section of ~~Patient~~**Patient** Valuables filing cabinet.
7. Destruction of ~~Patient~~**Patient** Valuables Property
   a. If any ~~Patient~~**patient** **v**~~V~~aluables ~~items~~ are not claimed within 180 days **of the patient leaving the hospital**, the items will be disposed of in a manner specified by the Director**s** of the Risk, Legal, and **or** Regulatory Department**s**.

D. **LIMITATIONS AND LIABILITY:**

1. The limitation on liability does not extend to those situations in which the hospital or its employees are responsible for a loss when valuables are given to the hospital for safekeeping. Although, the extent of possible liability is limited by statute to $500.00, unless a written receipt for a greater amount has been given to the ~~patient~~**patient** (Civil Code, Section 1859). The amount of liability for those items whose use or availability are required while hospitalized that have been lost or damaged due to willful wrongdoing or negligence on the part of the hospital or its employees shall not exceed $1,000 (Civil Code 1859).

E. **RELATED DOCUMENTS:**

1. Administrative Policy: ~~# 202~~ Lost and Found Articles **202**
2. Administrative Policy: ~~# 280~~ Unclaimed Property – Financial **280**
3. ~~Patient~~**Patient** Care Services **Policy:** ~~# 318~~ ~~Patient~~**Patient** Complaints and Grievances

F. **REFERENCES:**

1. Title 22, California Code of Regulations, Section 70755
2. **CA Civil Code Section 1859**
3. CHA Consent Manual (201~~9~~5) pages 2~~2~~0.1-20.3~~2~~.2

Tri-City Medical Center	Distribution	**DELETE – follow Online Skills Specimen Collection: Nose and Throat**
PROCEDURE:	**PERTUSSIS NASOPHARYNGEAL (NP) SWAB**	
Purpose:	To identify the process for obtaining a nasopharyngeal swab for *Bordetella pertussis*.	
Supportive Data:	Proper technique for obtaining a nasopharyngeal specimen for isolation of *Bordetella pertussis* is essential for optimal results. Once a NP swab has been collected it should be placed into a collection container and transported immediately to the lab.	
Equipment:	Nasopharyngeal Swab with flexible wire handle Transport Container Personal Protective Equipment (i.e. Mask, Gloves, Face Shield) Tissue Nurse Collectable Requisition Patient Label	

~~A. **ORDERING A PERTUSSIS SWAB**~~

~~1. Place patient in droplet isolation until an order is obtained to discontinue isolation.~~
~~2. Ensure a physician order is obtained prior to collecting a NP swab~~
~~3. Ensure an order is entered in Cerner as Bordetella Pertussis by PCR - Nurse Collectable and notify the laboratory.~~
~~4. Obtain the following equipment from the Microbiology laboratory department:~~
~~a. Nasopharyngeal swab with flexible wire handle (blue top).~~
~~b. Specimen collection container (blue top).~~

~~B. **LABELING**~~

~~1. Refer to Patient Care Services Specimen Labeling Procedure~~

~~C. **OBTAINING SPECIMEN**~~

~~1. Perform hand hygiene~~
~~2. Don personal protective equipment.~~
~~3. Identify patient per TCMC policy.~~
~~4. Place supplies on clean surface.~~
~~5. Open Culture Swab Collection and Transport package.~~
~~6. Remove nasopharyngeal swab with flexible wire handle (blue top) from package.~~
~~7. Remove the collection and transport culture from the package and discharge (white top).~~
~~8. Have patient sit up in bed, place pillow behind shoulders to assist in maintaining an upright position.~~
~~9. Insert swab into one nostril **straight back** (not upwards) along the floor of the nasal passage for several centimeters until reaching the posterior wall of the nasopharynx (resistance will be met). See diagram below.~~
~~a. The distance from the nose to the ear gives an estimate of the distance the swab should be inserted. Do not force the swab, if obstruction is encountered before reaching the nasopharynx, remove swab and try the other side.~~

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Pharmacy & Therapeutics Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/10; 09/14, 11/16, 03/20	12/10;10/14, 01/17, 04/20	12/10;10/14, 02/17, 05/20	n/a	05/20	01/11; 10/14, 06/20	07/20	02/11;11/14, 03/17, n/a	02/11;12/14; 03/17

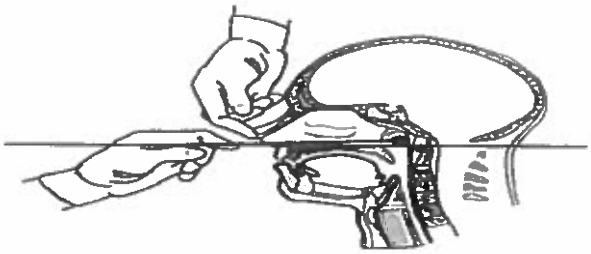

Image: Manual for the Surveillance of Vaccine-Preventable Diseases, 4th ed, 2008

10. Rotate the swab gently for 5-10 seconds to loosen the epithelial cells.
11. Remove swab without touching sides of speculum or nose.
12. Remove the cap from blue-capped specimen container and insert wire swab.
13. Break or cut wire swab handle with clean scissors to fit the specimen container and reattach cap securely.
14. Offer patient facial tissue or using a tissue, wipe any residual nasal secretions from patient's nose.
15. Discard used supplies, remove gloves, and perform hand hygiene.
16. Complete the nurse collectable requisition.
17. Send specimen to the laboratory immediately.
18. Perform hand hygiene.
19. Document collection of specimen in the medical record.

D. REFERENCES:

1. California Department of Public Health. (2010, March). Pertussis: laboratory testing. Retrieved October 26, 2010 from http://www.cdph.ca.gov/programs/immunize/Documents/CDPH_Pertussis
2. Centers for Disease Control and Prevention (CDC). (2009, August 10). Manual for the surveillance of vaccine-prevention disease. (4th e.d.). Chapter 10 pertussis. Retrieved October 26, 2010 from http://www.cdc.gov/vaccines/pubs/surv-manual/chpt10-pertussis.htm
3. Centers for Disease Control and Prevention (CDC). (2010, August 26). Pertussis (whooping cough) diagnostic testing. Retrieved October 26, 2010 from http://www.cdc.gov/pertussis/clinical/diagnostic.html
4. Mosby's Nursing Skills. (2006-2010). Specimen collection: nose throat specimens for culture. Retrieved October 27, 2010 from TCMC intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/91

SUBJECT: Referral to Social Services for Biopsychosocial Assessment

REVISION DATE: 04/09, 01/12, 07/17

POLICY NUMBER: III.D.2

Patient Care Services Content Expert~~Department~~ Approval:	**~~04/17~~04/20**
Clinical Policies & Procedures Committee Approval:	**~~05/17~~05/20**
Nursing Leadership~~Executive Council~~ Approval:	**~~05/17~~06/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/17~~06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) will employ only social workers that have a degree in social work from an accredited school or program. Upon referral from physicians, nurses, staff, family members, community agencies or self-referral by the patient or through high-risk screening criteria, a qualified social worker/social work case manager will conduct an assessment to determine the biopsychosocial needs of the patient/family and develop a **treatment plan.**~~plan of action~~. The social worker/social work case manager will collaborate with and share information with the physician, nurse, and other disciplines as appropriate to the assessed needs of the patient.
2. A biopsychosocial assessment will include, but is not limited to the following:
   a. Mental status of the patient
   b. Coping status of the patient
   c. Emotional status of the patient
   d. Age-specific or culture-specific needs
   e. Relevant psychiatric or substance abuse history
   f. Social support system/family functioning
   g. Home situation
   h. Level of social functioning/rehabilitation potential
   i. Level of understanding of health status and ability to cope
   j. Relevant socioeconomic factors, financial status
   k. Need for discharge planning
   l. Need for referral and linkage to community resources for post hospital care
3. The biopsychosocial assessment is a dynamic process that continues through the course of the patient's hospital admission. The biopsychosocial approach systematically considers biological, psychological and social factors and their intricate interactions in understanding health, illness and the provision of health care. Planned social work intervention will be modified according to the assessed needs of the patient, in collaboration with the other staff involved in the care of the patient.
4. The plan for addressing the biopsychosocial needs of the patient may include, but is not limited to the following:
   a. Supportive counseling and emotional support
   b. Recommendation for psychiatric evaluation
   c. Crisis intervention

d. **Bereavement support, including anticipatory grief.**~~Anticipatory grief~~
e. **Mandated reporting**~~Report to protective agencies/police~~
f. Referrals/transfer to other facilities for continuing care
g. Referral and linkage to appropriate community based resources for post hospital care or social services

5. The assessment and plan are communicated to other appropriate staff in writing via the **electronic health record (**~~EHR~~**her)**~~: Case Management Admission Assessments, Ongoing Social Service Notes),Interdisciplinary Database and Interdisciplinary Progress Notes (Behavioral Health Unit, Women's & Children's Services, and Neonatal Intensive Care Unit) or via PowerChart: Admission Assessment - Patient History Power Form, Clinical Notes,~~ discussion in **Multi**~~Inter~~disciplinary Case Rounds, and timely interpersonal communication by phone or in person.
6. The Clinical Social Worker/Social Work Case Manager will **prioritize**~~interview the~~ patients/famili**es that have been identified as having**~~ within 24 hours of identification of~~ high-risk **needs.**~~problem areas.~~
7. The psychosocial assessment shall be included i**e**n the patient's chart via **the EHR**~~Cerner~~.
8. The Clinical Social Worker/Social Work Case Manager will continue to update progress notes as indicated until patient~~/family~~ is discharged.
9. **Psychoe**~~E~~ducation **and resource referrals made** by Social Services will be documented in **the EHR**~~Cerner~~.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: ~~NEW~~04/16 **SUBJECT: Wound Classification During Surgical Intervention**

REVISION DATE(S):

Patient Care Services Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~06/15~~03/20**
Clinical Policies and Procedures Approval ~~Date(s)~~:	**~~07/15~~03/20**
Nursinge Leadership ~~Executive Committee~~ Approval ~~Date(s)~~:	**~~07/15~~04/20**
Operating Room Committee Approval ~~Date(s)~~:	**~~01/16~~04/20**
Infection Control Committee Approval ~~Date(s)~~:	**~~03/16~~05/20**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~03/16~~06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~04/16~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**04/16**

A. **PURPOSE:**

1. To classify all wounds according to the likelihood and degree of wound contamination at the time of surgical intervention.

~~B. SUPPORTIVE DATA:~~

~~1. The American College of Surgeons' definitions of Surgical Wound Infections (SWI) should be used for routine surveillance because of their current widespread acceptance and reproducibility.~~

~~2. A wound can be considered infected if purulent material drains from it, even if a culture is negative or not taken.~~

~~3. A positive culture does not necessarily indicate infection since many wounds, infected or not, are colonized by bacteria.~~

~~4. Infected wounds may not yield pathogens by culture because the pathogens are fastidious, culture techniques are inadequate, or the patient has been treated.~~

~~5. Wound classification shall be addressed at the end of the case as it may have changed since the start of the case.~~

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

1. **Wound classification shall be reviewed at the conclusion of the procedure and documentation of wound classification shall be updated as necessary.**
2. **The following criteria shall be used to classify surgical wounds:**
   - ~~1.~~**a.** Clean Wound, Class I
     - ~~a.~~**i.** **Clean, ~~U~~u**ninfected operative wounds in which no inflammation is encountered., ~~and neither respiratory, alimentary, genitourinary tracts, nor oropharyngeal cavity is entered.~~
     - ii. **Procedures are free from entry into respiratory, alimentary, or genitourinary tract.**
     - ~~b.~~**iii.** ~~Cases are elective,~~**Wounds are** primarily closed, and if necessary, drained with closed drainage **(e.g., bulb drain)**.
     - ~~c.~~**iv.** Operative incisional wounds that follow non-penetrating (blunt) trauma should be included in this category if they meet the criteria.
   - ~~2.~~**b.** Clean-Contaminated Wound, Class II
     - ~~a.~~**i.** ~~Operative wounds in which the r~~Respiratory, alimentary, or genitourinary tract is entered under controlled conditions ~~and~~ without **evidence of infection or**

contamination, and with no major breaks in technique (e.g., spillage from gastrointestinal tract)~~unusual contamination~~.

~~b. Specifically, operations involving the biliary tract, appendix, vagina, and oropharynx are included in this category, provided no evidence of infection or major break in sterile technique is encountered.~~

~~c. All clean returns to surgery.~~

~~d. Any tube that involves a skin incision.~~

~~3.~~c. Contaminated Wounds, Class III

i. **Wounds are fresh, open, or accidental, or there is gross (i.e., visible) spillage from the gastrointestinal tract, or there is acute non-purulent inflammation present.**

~~a.~~ii. **Major breaks in sterile technique (e.g., unsterile instruments used) during the procedure.**~~Include open, fresh, accidental wounds, a chest tube, operations with major breaks in sterile technique or gross spillage from the gastrointestinal tract, and incisions in which acute, non-purulent inflammation is encountered Including necrotic tissue without evidence of purulent drainage (ie: dry gangrene).~~

~~4.~~d. Dirty Aand Infected Wounds, Class IV

i. **Old wounds with retained, devitalized tissue (i.e., gangrene, necrosis)**

ii. **A wound with existing clinical infection (e.g., purulence)**

~~a.~~iii. **A perforated viscera**~~These include old traumatic wounds with retained devitalized tissue and those that involve existing clinical infection or perforated viscera. This definition suggests that the organisms causing postoperative infection were present in the operative field before the operation.~~

~~5.~~e. ~~Not Applicable~~**No Wound Classification**

~~a.~~i. ~~When t~~There is no wound, **including, but not limited to** ~~i.e. for such~~ procedures **such as:** **closed reductions (with no break in skin integrity), and examination under anesthesia (EUA).**

~~i. Closed reductions (where there is no break in the skin)~~
~~ii. Examination Under Anesthesia (EUA)~~
~~Esophageal Dilatation~~

D. **REFERENCES:**

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

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 6/06

SUBJECT: Wound V.A.C. (Vacuum Assisted Closure), Negative Pressure Therapy Policy

REVISION DATE: 12/08, 06/11; 4/14

POLICY NUMBER: IV.D.1

Patient Care Services Content Expert:	03/20
Clinical Policies & Procedures Committee Approval:	~~06/14~~05/20
Nursing Leadership~~Executive Council~~ Approval:	~~06/14~~06/20
Medical Staff Department or Division Apprval~~ of Family Medicine~~:	n/a
Pharmacy and Therapeutics:	n/a
Medical Executive Committee Approval:	~~08/14~~06/20
Administration Approval:	07/20
Professional Affairs Committee Approval:	~~10/14~~ n/a
Board of Directors Approval:	11/14

A. **PURPOSE:**

1. To define the appropriate procedure for initiation of Wound V~~.~~A~~.~~C~~.~~ therapy and Vacuum Assisted Closure (V.A.C.).
2. To define appropriate assessment, documentation, monitoring, and maintenance of Wound V.A.C. therapy V.A.C. Instillation Therapy Option, **and V.A.C. Prevena incisional management system**.

B. **DEFINITIONS:**

1. Dehisced: the separation of a surgical incision or rupture of a wound closure.
2. Diabetic Ulcer: a wound that has failed to heal as a result of elevated glucose levels that have caused altered nerve function in the lower extremities, commonly located on pressure points of the foot such as the plantar surface and the metatarsal heads.
3. Eschar: black or brown, necrotic, devitalized tissue.
4. Fistula: an abnormal passage from an internal organ to the body surface or between two internal organs.
5. Flap: a layer of skin or other tissue surgically separated from deeper structures for transplantation or to cover an area that has been injured.
6. Graft: a tissue taken from a site and inserted into a new site to repair a defect in structure.
7. Necrosis: localized tissue death that occurs in groups of cells in response to disease or injury.
8. Osteomyelitis: local or generalized infection of bone and bone marrow.
9. Partial-Thickness: tissue damage to the epidermis and part of the dermis. Abrasions, skin tears, and blisters are examples of partial thickness wounds.
10. Full Thickness: Ulceration that extends through the dermis to involve the subcutaneous tissue and if Stage 4, the muscle and possibly down to the bone.
11. Pressure **Injury** ~~Ulcer~~: localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.
12. Suction: dynamic pressure control
13. Therapeutic Regulated Accurate Care (T.R.A.C.) Pad: monitors and maintains target pressure at wound site ensuring consistent therapy is delivered.
14. Tunneling: course or path of tissue damage occurring in any direction from the surface or edge of wound leading to dead space.

15. Undermining: area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.
16. Vacuum Assisted Closure (V.A.C.): negative pressure device used to promote wound healing and stimulate granulation tissue.
    a. V.A.C. Ulta with VeraFlo (instillation therapy system) is indicated for patients who would benefit from negative pressure wound therapy, drainage and controlled delivery of topical wound treatment solutions over the wound bed.
    b. V.A.C. Prevena - incisional V.A.C. therapy placed over an intact surgical incision, usually placed in surgery to help prevent dehiscence and infection. The V.A.C. **Prevena incision management system** is left in place x 7 days ~~post operative~~**post-operative. It will alarm with 3 beeps and turn off after 193 therapy hours. The dressing will become non-compressed.** ~~and usually removed by surgeon.~~ If patient is discharged, unit goes home with patient. **Canister holds 45 mL.**
    c. V.A.C. **Prevena Plus** ~~Via~~ - disposable home unit, sometimes used until patient can get traditional home wound V.A.C. authorized or for short term vac therapy at home. **Canister holds 250 mL and compatible connector with V.A.C. Ultra. Disposable unit**
17. V.A.C. GranuFoam: hydrophobic, black foam. More effective at stimulating granulation tissue and should be used for a wound with drainage.
18. V.A.C. Vers-Foam: hydrophilic, white foam, pre-moistened with sterile water. Used for extremely painful wounds, controlled growth of granulation tissue, and tunneling or undermining wounds. Minimum pressure setting is 125 mmHg.
19. V.A.C. GranuFoam Silver: Hydrophobic, black foam impregnated with silver, allows for continuous delivery of silver into wound protecting against many types of bacteria and fungus.
20. V.A.C. White Foam: hydrophobic foam used for instillation therapy

C. **POLICY**:

1. When a patient has a wound that is difficult to heal and does not respond to therapy, or a complicated dressing change, a referral may be made per physician order to the Wound Nurse for Wound Evaluation and Treatment. The Skin/Wound Team is available for questions at extension 3793 or cell phone number **760-851-9903.** ~~s 760-908-6488 and 760-802-9611~~.
2. Indications for wound V.A.C.:
    a. Acute, chronic, or traumatic wounds
    b. Dehisced Wounds
    c. Diabetic Ulcers
    d. Pressure **Injury**~~Ulcers~~
    e. Grafts
    f. Flaps
    ~~f.~~**g. Full Thickness Wounds**
    ~~g.~~**h.** Enteric Fistulas, in special circumstance
    ~~h.~~**i.** Infected wounds
    ~~i.~~**j.** Venous ulcers
3. Contraindications:
    a. Malignancy in wound – malignant cells should be removed prior to initiation of V.A.C. therapy.
    b. Untreated osteomyelitis – wound should be free of osteomyelitis or receiving concurrent antibiotic therapy.
    c. Non-enteric and unexplored fistula
    d. Necrotic tissue with eschar present – wound should be surgically debrided prior to initiation of V.A.C. therapy.
    e. Do not use V.A.C. Ulta with VeraFlo (instillation therapy) on wounds:
        i. At risk of bleeding
        ii. New flaps and grafts
        iii. Acute enteric fistulas

iv. With unexplored tunnels or unexplored undermining as fluid may enter into unintended cavities
v. Requiring continuous therapy
vi. With unstable structures, such as unstable chest wall or non-intact fascia
vii. With high exudates
viii. Closed incisions
ix. Where hemostatic agents have been used in the wound bed
x. With Granufoam silver because solutions may negatively impact the benefits of the silver dressing

4. Precautions
   a. Active Bleeding
   b. Difficult wound hemostasis
   c. Anticoagulant therapy
   d. When wound V.A.C. therapy is initiated close to blood vessels or organs protective barriers will be used.
   e. Wounds with enteric/non-enteric fistulas require special precautions, initiate dressing per specific physician order or make a referral to Wound Nurse for Wound Evaluation and Treatment
   f. For V.A.C. Ulta with VeraFlo (instillation therapy):
      i. Some irrigants/solutions utilized with instillation therapy may adversely affect bioengineered materials. Refer to manufacturer guidelines
      ii. Use only solutions or suspensions indicated for topical wound treatment according to solution manufacturer guidelines.
      iii. Use solutions that are compatible with V.A.C. dressings and disposable components.
5. A physician order is required to initiate wound V.A.C., ~~and~~ V.A.C. Instillation therapy **and Prevena incision management ~~system~~.**
   a. The primary nurse is responsible for ensuring appropriate orders for the wound V.A.C. are documented in the electronic health record (EHR).
6. Orders should indicate:
   a. Type of wound V.A.C. therapy
   b. Area of placement
   c. Therapy setting (continuous or **dynamic pressure control)** ~~intermittent~~)
   d. Pressure setting for suction (125 mmHg normal preset)
   e. Frequency of dressing change and healthcare provider responsible for performing dressing change
   f. For V.A.C. Ulta with VeraFlo (instillation therapy) include:
      i. Medication and dosage for irrigation
      ii. Instillation infusion time
      iii. Instillation hold and pressure suction cycles
7. All supplies are latex free and obtained from the Sterile Processing Department (see Wound V.A.C. Supply List).
8. Ensure Nutritional Consult has been made on each patient to optimize V.A.C. therapy. If no order exists the nursing staff will make the proper referral.
9. Assessment
   a. Assessment of dressing is done each shift or as needed and documented in the EHR. Dressing should be monitored every 2 hours to ensure dressing is intact and wound V.A.C is maintaining suction.
   b. Assure proper functioning of wound V.A.C. machine. Check power cord, seal check light is on and battery is being charged.
   c. Photograph of wound will be taken upon initiation of wound V.A.C. (except during surgery) and at least weekly (during awound V.A.C. dressing change).

D. **PROCEDURE:**

1. Initiation:
   a. Wound V.A.C. shall be initiated per physician order
      i. V.A.C. Ulta with VeraFlo (instillation therapy) will be initiated by Operating Room (OR), Post Anesthesia Care Unit (PACU), Wound/Ostomy registered nurses (RNs) or specially trained RN.
         1) Instillation (irrigation solutions) will be provided by Pharmacy.
         2) V.A.C. Ulta with VeraFlo (instillation therapy) set-up:
            a) Adjust hanger arm on left side of unit and hang solution bottle.
            b) Prime tubing by spiking solution bottle using adapter with Veralink cassette spike. Clamp off tubing and insert Veralink cassette into left side of machine.
            c) After V.A. C. Veraflo foams applied, secure VeraFlo pad (cut 2.4 cm opening). Connect dressing tubing to canister tubing and VeraFlo tubing to Veralink connection.
            d) Configure therapy settings. Select V.A.C. VeraFlo therapy.
            e) Ensure fill assist is on, set soak time, V.A.C. therapy time, and target pressure/intensity. When complete press OK.
            f) Confirm settings and choose OK after unclamping VeraFlo tubing.
            g) Press start/stop fill assist and observe the wound bed fill with solution. Press stop/start again when volume is sufficient.
            h) Select OK to confirm volume displayed and return to home screen.
            i) If the wound bed is overfilled with solution press "reset" to remove solution and return to fill assist to reset volume.
         3) **V.A.C. Prevena incisional management system**
            a) **Initiation of the Prevena is recommended to be place in OR by the Surgeon or the Wound Team. The sterile dressing is opened and ~~using sterile technique~~ placed along the incisional line using sterile technique.**
            b) **Press firmly around the dressing edges to prevent a leak alert**
            c) **The canister is connected to the portable Prevena unit.**
            d) **The circulating RN will press and hold down on the start button for the count of 15 seconds. This will initiate the 192 hour (eight days) life cycle of the therapy unit.**
            e) **The unit will come on and immediately compress the foam peel and place dressing.**
            f) **When the dressing does not compress, therapy is not at the proper pressure.**
            g) **Assess for leaks: Use Prevena patch strips for peel and place dressings.**
            h) **Often times, the air leak could be coming from around a JP drain that is adjacent to the incision.**
            i) **Close the air leak by placing a patch strip over the edges of the peel and place dressing.**
            j) **If the canister becomes full quickly after surgery. The R~~.~~N~~.~~ can call ~~down to~~ SPD ~~and~~to request a Hospital V.A.C. Ultra unit with a canister.**
            k) **The dressing should not be removed; rather the R~~.~~N~~.~~ should step up the hospital unit and attach the canister. .**
            l) **Turn on the V.A.C Ultra and select Prevena Incision Management System.**
            m) **The R~~.~~N~~.~~ can turn off the disposal unit by pressing and holding to power button for 15 seconds.**

n) **Disconnect the tubing by twisting the tubing at the connection and attaching it to the tubing of the V.A.C. Ultra-Hospital unit.**
o) **Press Start and the unit will immediately compress the peel and place dressing.**
p) **The V.A.C. Ultra has preset settings for the incision management which is 125 mmHg continuous.**
q) **The R.N. can then release the canister and dispose of it in a biohazard red bag.**
r) **The portable unit can then be placed back in the Prevena incision management carrying bag.**
s) **Upon discharge, if the 7 days has not finished, the portable unit can be reattached to the patient.**
t) **The patient can then follow up with care on day seven for removal of the incisional dressing.**
u) **After 192 hours of portable therapy or seven days after the application of therapy the R.N. at the bedside can remove the peel and place dressing. The closed incision can be left open to air unless otherwise indicated by a Physician order.**
v) **Dispose of dressing and unit in a biohazard red bag.**
~~i)~~w) **The Prevena incision management system dressing ~~does~~ contains silver.**

2. Suction:
   a. Suction will be maintained for at least 22 hours of each 24-hour period. If suction is off for more than 2 hours in any 24-hour period (verify by checking therapy history), the dressing must be removed and replaced.
      i. If a V.A.C. dressing is unable to be re-applied, a wet to dry dressing to the site is an alternative dressing until the V.A.C. dressing can be applied. Do not leave a V.A.C. dressing in place with the machine turned off for over 2 hours. Notify Physician.
   b. Suction will be set at 125 mmHg continuous unless otherwise specified by physician. After the first 48 hours V.A.C. pressure settings may be titrated up or down by 25 mmHg in the following situations:
      i. Titrate up (maximum setting is 175 mmHg) in a wound that has an excessive amount of drainage, a large wound, when V.A.C. Vers-Foam is in wound, or difficulty maintaining seal.
      ii. Titrate down (minimum setting is 50 mmHg) in wound that is very painful, or for a patient that is elderly, nutritionally compromised, on anticoagulants, has compromised circulation, or excessive granulation tissue growth.
   c. Intermittent suction therapy should be considered after the first 48 hours of therapy to stimulate granulation tissue quicker. It should not be used for patients who:
      i. Are experiencing significant pain.
      ii. Are experiencing difficulty maintaining seal.
      iii. Have wounds where tunnels or undermining exists.
      iv. Have a large or excessive amount of drainage.
      v. Are using the V.A.C. Ulta with VeraFlo (instillation therapy) option.
3. Dressing change:
   a. Pre-medicate patient per physician's order (if indicated) 60 minutes prior to dressing change for oral medication or 5 - 15 minutes prior for IV medication.
   b. Ensure V.A.C. canister and machine are at bedside.
   c. Gather all supplies for dressing change including
      i. Correct size and type of foam in unopened sterile package
      ii. Scissors
      iii. Sterile Normal Saline

iv. Skin barrier
v. Drape
vi. Gloves
vii. Gown or eye protection if necessary
viii. Wound V.A.C. dressing kit
ix. Biohazard bag

d. Perform hand hygiene and don gloves.
e. Clamp tubing to T.R.A.C. pad and canister and remove old dressing and dispose of in biohazard bag along with gloves.
   i. If there is difficulty removing dressing, use adhesive remover.
   ii. If foam adheres to wound, use Normal Saline or sterile water to saturate the foam before removing.
   iii. If wound is extremely painful and foam is difficult to remove, consider placing a single layer of non-adherent dressing (i.e. Adaptic, mepitel) in the wound bed prior to foam placement. Do not place Xeroform in bed of wound (petroleum based).
f. Perform hand hygiene and don new gloves.
g. Cleanse wound with Normal Saline or per physician order.
h. Clean and dry skin surrounding wound.
i. Apply barrier to intact skin surrounding wound. If a patient has fragile skin, is at risk for breakdown or if breakdown exists, place thin hydrocolloid (i.e. Duoderm) to that area.
j. Assess wound:
   i. Location
   ii. Type of wound
   iii. Measure wound margins and note and measure any tunneling or undermining. including length, width and depth
   iv. Drainage
   v. Surrounding skin integrity
   vi. Odor
   vii. Appearance of wound (i.e., granulation), any tunneling or undermining
   viii. Take photograph at least weekly (during a dressing change) and upload to EHR.
k. Ensure proper foam has been chosen and cut foam to fit gently into wound.
   i. Do not cut foam directly over wound to ensure loose edges do not fall into wound.
   ii. Rub edges after cutting to remove any loose pieces.
   iii. If exposed internal organ or tendon, use a contact layer (i.e. Adaptic, mepitel) before foam application
   iv. If the wound is larger than the largest piece of foam, use more than one piece of foam ensuring that edges of foam are in direct contact with each other for even distribution of negative pressure.
l. Place foam gently into wound.
   i. Do not force foam into wound.
   ii. Foam should be slightly smaller than wound and should never lie on or touch intact skin.
   iii. For a shallow wound, foam may be thinned to accommodate smaller dimensions.
   iv. Fill in all dead space.
   ~~iv.~~**v. Ensure proper count of foam inserted in wound.**
m. Cut drape larger than the wound allowing for a 3 - 5 cm border.
n. Place drape over foam.
   i. Save extra drape, excess drape can be used to reinforce difficult to seal areas.
   ii. If hydrocolloid (i.e. Duoderm) has been placed ensure that the drape covers foam and the hydrocolloid (i.e. Duoderm).
o. Cut a hole into the drape the size of the T.R.A.C. pad, it is not necessary to cut into foam.

p. Apply T.R.A.C. pad directly over the hole in the drape.
   i. Do not cut the T.R.A.C. pad off or insert tubing into the foam, this will cause unit to alarm when turned on.
q. Connect dressing tubing to canister tubing and open both clamps.
r. Time, date, and sign dressing. Document properly.
s. Remove gloves and perform hand hygiene.
t. Place V.A.C. unit on a level surface, hang from the foot of the bed, or secure on an IV pole.
u. Turn on green power switch on left side of V.A.C. unit. Access V.A.C. settings under Therapy on main menu and set per physician order or on 125 mmHg continuous.
v. Press therapy on/off button to activate V.A.C. therapy.
w. In less than one minute the dressing should collapse into wound. If difficulty exists in maintaining vacuum or foam does not collapse, reinforce any air leaks with excess drape or gently press around foam with fingertips.

4. Canister Change
   a. V.A.C. canister should be changed when full, on average 3 - 5 days (unit will alarm).
   b. Turn off therapy and close dressing clamp and canister clamp.
   c. Disconnect canister tubing from dressing tubing.
   d. Remove canister from unit by pressing blue button on front of unit and pulling. Dispose of old canister in biohazard bag.
   e. Insert new canister into slot and connect to dressing tubing. Open both clamps and resume therapy.
      i. V.A.C. Ulta with VeraFlo (instillation therapy) requires more frequent changing of canisters due to the volume of wound irrigation solution and exudate removal.
5. Disconnecting unit for brief periods
   a. If patient needs to be disconnected, ensure V.A.C. therapy is not off for more than 2 hours total in a 24-hour period.
      ~~a.~~**i. Do not turn off or disconnect V.A.C therapy if wound V.A.C. in place to hold down a split thickness skin graft.**
   b. Turn unit off.
   c. Clamp canister and dressing clamp.
   d. Disconnect canister tubing from dressing tubing and cover both ends with gauze or a glove and secure.
   e. To reconnect, remove gauze or glove from both ends and connect.
   f. Open both clamps and turn therapy on. Unit will default to previous settings.
   g. Reconnect V.A.C. unit to battery charger and wall plug. Check screen, battery symbol should be lighted green at all times.

E. **TROUBLESHOOTING:**

1. **Active bleeding**
   a. If active bleeding develops suddenly or in a large amount during V.A.C. Therapy, or if bright red blood is seen in the tubing or in the canister, immediately stop the V.A.C. Therapy.
   b. The R.N. should leave the dressing in place for the physician to remove.
   c. Notify the physician immediately
   d. Take measures to stop the bleeding.

~~1.~~**2.** Audible Alarms
   a. Therapy is not activated.
      i. Machine will alarm every 15 minutes if on when therapy is not activated.
      ii. Press therapy on main screen and turn on.
   b. Canister is full
      i. Change canister.
      ii. Even if canister does not appear to be full, or is new, and alarm goes off, check all connections then change canister, it may be faulty.

c. Leak or difficulty maintaining suction
   i. Check for and listen for leaks in drape
   ii. Reinforce as necessary
d. Tubing blocked
   i. Ensure no kinks in tubing.
   ii. Ensure clamps are open.
   iii. Check that the canister is pushed fully in to the~~at~~ unit.
   iv. Ensure that T.R.A.C. pad is not clogged. Cut out old T.R.A.C. pad. Ensure hole in drape is cut the size of a quarter. Then, replace with new T.R.A.C. pad.
e. Low battery
   i. Check all connections to ensure battery charger is connected to wall plug and to the back of the V.A.C. unit.
   ii. Battery symbol on screen should always be lighted and green.
f. Keep unit on flat surface, unit will alarm if tilted greater than 45 degrees.
g. Question mark at bottom left of main screen has an on-site user guide.
h. A referral may also be made per physician order to Wound Nurse for Wound Evaluation and Treatment. For other troubleshooting tips, the Skin/Wound Team is available at extension 3793 or by cell phone~~s~~ **760-851-9903**~~760-908-6488 and 760-802-9611~~. KCI is available 24 hours a day at 1-800-275-4524

F. **DOCUMENTATION:**

1. Document in the EHR:
   a. Wound V.A.C. therapy
      i. Document wound output in the intake and output section of the EHR per Standards of Care
      ii. For V.A.C. Ulta with VeraFlo (instillation therapy):
         1) Document instillation (irrigation solution) in the electronic medication administration record (eMAR).
         2) Instillation (irrigation solution) will not be calculated in the overall intake
   b. Each dressing change including:
      i. Photograph of wound at least weekly
      ii. Wound assessment
         ~~ii.~~**1) Number of foam pieces removed and number of foam inserted in the wound.**

G. **REFERENCE(S):**

1. **KCI V.A.C Therapy System Safety Information**
2. **V.A.C. Therapy Clinical Guidelines A reference source for clinicians**
~~1.~~**3. Prevena Incision Management System Patient Guide**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 11/94 **SUBJECT: Decorative Material**

REVISION DATE: 03/00; 02/06; 01/09; 09/10; 01/11 **POLICY NUMBER:** 8610-248

Administrative Content Expert~~Department~~ Approval:	**~~10/16~~06/20**
Administrative Policies & Procedures Committee Approval:	**~~10/16~~06/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~01/17~~ n/a**
Board of Directors Approval:	**01/17**

A. **PURPOSE:**

1. The purpose of this policy is to provide for the safety of patients, staff and visitors of the Medical Center by setting forth guidelines for the use of decorative materials within the Medical Center. This policy is in accordance with local and state Fire Codes.

B. **POLICY:**

1. Stairways, corridors, and exit ways shall not be obstructed and decorations shall not be hung in a way as to obstruct exits, exit lights, fire sprinkler heads, fire alarm pull stations, hose cabinets, or fire extinguishers.
2. Decorative materials shall not be hung from the sprinkler heads.
3. All decorative materials need to be approved by the Director of Facilities or the Director of Safety/Environment of Care Officer.
4. Use only materials labeled nonflammable or flame-retardant in your displays (includes artificial trees).
   a. Have documentation (i.e., package labeling) to this effect on file in your department for Fire Department review if necessary.
5. Live trees are prohibited.
6. The Fire Marshall permits electric lights only in the main lobby under strictly controlled conditions. All other areas may use only battery-operated lights.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 04/86

SUBJECT: Fair Treatment For Supervisory and Management Employees

REVISION DATE: 07/09; 08/12; 02/13; 10/13

POLICY NUMBER: 8610 - 427

Human Resources Department Approval ~~Date(s)~~:	**~~11/15~~02/20**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval Date(s):**~~	~~**11/15**~~
Administration Approval:	**07/20**
Professional Affairs Committee:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**12/15**

A. **PURPOSE:**

1. To provide an orderly ~~mechanism~~ **process** for supervisors, managers, directors and above to receive fair treatment in connection with **employment performance issues,** ~~an~~ intent to suspend or terminate their employment.

B. **DEFINITION:**

1. Fair Treatment Process: In the case of corrective actions involving disciplinary final written warning or intent to terminate, supervisors, managers, directors and above with more than 90 days of active employment shall be entitled to follow the process set forth below. A Human Resources representative shall be available to facilitate the Fair Treatment process.

C. **SUPERVISOR/MANAGER LEVEL PROCESS**

1. Step I: Meeting with Management
   a. If a supervisor/manager has received a final written warning or notification of intent to terminate ~~his or her~~ **their** employment, and wishes to initiate the Fair Treatment Process, ~~he or she~~ **they** must contact Human Resources to schedule a meeting with the next level of management, beyond their direct supervisor/manager, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of the suspension or intent to term notification. If the employee fails to contact Human Resources within 5 working days (M-F), ~~his or her~~ **their** opportunity to continue the Fair Treatment process shall end.
   b. The employee's manager, beyond their direct supervisor/manager, and a Human Resources representative shall meet with the employee, and the manager shall respond to the employee within 5 working days (M-F) after the meeting with their decision.
   c. If the Fair Treatment Process has been initiated due to a termination then the date of the letter from the manager to the employee at completion of Step 1 becomes the effective date of the employee's termination. Although the employee has been terminated, ~~he or she~~ **they** may choose to continue the Fair Treatment Process by contacting Human Resources within 5 working days (M-F) of the notification of the manager's decision.
2. Step II: Fair Treatment Form
   a. If the employee still feels after Step I that the decision is unfair, the employee may commence a formal grievance process within 5 working days (M-F) of the decision by the employee's manager in Step I. The formal grievance process begins with the submission to Human Resources of a completed Fair Treatment form, signed by the employee and describing in specific detail the nature of the grievance and the facts

giving rise to it. If the employee fails to submit the completed Fair Treatment form within the above time frame, the Fair Treatment process shall end.

i. A Human Resources representative shall forward a copy of the completed Fair Treatment form to the ~~lead~~ **Head of** Human Resources ~~official~~ within 5 working days (M-F) of receipt of the form.

ii. The ~~lead~~ **Head of** Human Resources ~~official~~, or ~~his or her~~ designee, shall review, investigate, and analyze the matter and shall respond in writing with ~~his or her~~ **their** decision no later than 5 working days (M-F) after concluding ~~his or her~~ **their** analysis. The employee is deemed notified on the date the decision letter is postmarked.

3. Step II: Final Review by Chief Executive Officer

a. If the matter is still unresolved to the employee's satisfaction after Step II, the employee may request review by the Chief Executive Officer. Human Resources shall present the completed Fair Treatment form to the Chief Executive Officer within 5 working days (M-F) of notification of the ~~lead~~ **Head of** Human Resources ~~official's~~ decision. If the employee fails to request review by the Chief Executive Officer within the time frame specified for this Step III, the Fair Treatment process shall end.

b. The Chief Executive Officer~~,~~ **or designee** shall review, investigate, and analyze the matter and render a decision within 5 working days (M-F) after concluding ~~his or her~~ **their** analysis. The employee is deemed notified on the date the decision letter is postmarked. Decisions of the Chief Executive Officer are final and binding.

D. **PROCESS FOR DIRECTORS AND ABOVE**

1. Step I: Meeting with Executive

a. If a Director or above has received a final written warning or notification of intent to terminate ~~his or her~~ **their** employment, and wishes to initiate the Fair Treatment Process, the employee must contact Human Resources to schedule a meeting with the ~~lead~~ **Head of** Human Resources ~~official,~~ **and C Suite member** ~~Chief Nurse Executive, Chief Financial Officer, Chief Medical Officer, Chief Compliance Officer, or the Chief Operating Officer~~, as appropriate based on their reporting hierarchy, to discuss the issue. This initial contact shall be made within 5 working days (M-F) from the date of notification of the intended suspension or termination. If the employee fails to contact Human Resources within this time frame, the opportunity to continue the Fair Treatment process shall end.

b. The appropriate Executive shall meet with the employee and will respond within 5 working days (M-F) with ~~his or her~~ **their** decision.

2. Step II: Fair Treatment Form/Final Review by the CEO

a. If the appropriate Executive does not resolve the employee's complaint to ~~his or her~~ **their** satisfaction, the employee shall complete the Fair Treatment form and Human Resources shall present the written form to the Chief Executive Officer within 5 working days (M-F) of the appropriate Executive's decision.

b. The Chief Executive Officer **or designee** shall review, investigate and analyze the matter and render a decision within 5 working days after concluding ~~his or her~~ **their** analysis. The employee is deemed notified on the date the decision letter is postmarked. Decisions from the Chief Executive Officer are final and binding. If the employee fails to request review by the Chief Executive Officer within the set time frame, the Fair Treatment process shall end.

E. **REFERENCED FORM WHICH CAN BE REQUESTED FROM HR:**

1. Fair Treatment Form

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
INFORMATION TECHNOLOGY

ISSUE DATE: 12/00 **SUBJECT:** Security Controls

REVISION DATE: 05/03; 02/05; 11/08; 05/12; 07~~6~~/12 **POLICY NUMBER:** 8610-612

Information Technology Department Approval ~~Date(s)~~:	~~04/16~~04/20
Administrative Policies & Procedures Committee Approval:	~~06/12~~04/20
Medical Executive Committee Approval:	06/20
Administration Approval:	07/20
Professional Affairs Committee Approval:	~~07/12~~ n/a
Board of Directors Approval:	07/12

A. **PURPOSE:**

1. **The Tri-City Healthcare District (TCHD) is committed to conducting business in compliance with Health Insurance Portability and Accountability Act (HIPAA) Security Regulations. TCHD has adopted this policy to ensure that security violations are prevented, detected, contained, and corrected in accordance with HIPAA Security Regulations, and that the security of Electronic Protected Health Information (EPHI) is protected.**

B. **DEFINITIONS:**

1. **Electronic Protected Health Information (EPHI): Health information protected by law under the Health Insurance Portability and Accountability Act (HIPAA).**
2. **Protected Health Information (PHI): individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD AND**
   - a. **Relates to the past, present or future physical or mental health or condition of an individual; OR**
   - b. **Relates to the provision of health care to an individual; OR**
   - c. **Relates to the past, present or future payment, AND**
   - ~~b.~~d. **Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.**

C. **POLICY:**

1. To assure security and confidentiality of information in TCHD's computer systems, it is necessary to maintain certain security controls. Among these are:
   - a. Limit access rights to certain functions through menu control or logon scripts.
   - b. Provide a secure method for requesting, identifying, distributing and canceling security codes.
   - c. Change security codes on a regular basis.
   - d. Secure the network workstation.
   - e. Provide a mechanism for reporting security breaches.

D. **PROCEDURE:**

1. Limit access rights to certain functions or capabilities through menu control or logon scripts
   - a. All TCHD applications limit access rights to certain functions or capabilities through menu control or logon scripts. Some of these applications are maintained by the Information Technology Department, while a specific department maintains others. In either case, responsibility for the design and implementation of application menus lies with an analyst or systems manager, while responsibility for defining access rights lies with the employee's department director. The Health Insurance Portability and Accountability Act

of 1996 (HIPAA) requires Role Based Access for each employee, Business Associate, or other Authorized User who accesses Protected Health Information (PHI). Role Based Access has been identified for each position within TCHD in accordance with the Worksheet shown at the end of this Policy, and has been forwarded to the TCHD Privacy Officer.

b. When an employee is newly hired or transferred into a new job classification, the employee's department director reviews access rights for that employee, and confirms correct access rights with the analyst or systems manager. The analyst or systems manager then assigns an appropriate menu or login script for that employee.

2. Provide a secure method for requesting, identifying, distributing and canceling security codes.
   a. Access rights are requested and distributed according to specific policies defined for each type of application.
   b. When a login name and password is assigned to a new employee or to an employee who is changing job classification, that employee must obtain the initial login name and password from the Information Technology Department **or approved designated department**. Positive Identification via the employee's picture badge is required.
3. ~~Change security codes on a regular basis.~~**TCHD requires changes for the active directory on a 90-day basis.**
   ~~a. All passwords are expired, and must be changed, on a regular basis.~~
4. Secure the network workstation.
   a. Each network workstation assigned to a specific person must be secured at the close of each workday (signoff/shutdown or comparable procedure)
5. Provide a mechanism for reporting security breaches.
   a. Notification of ~~I~~improper ~~U~~use of ~~E~~electronic ~~I~~information is identified for each type of application.
   b. Each employee is expected to report security breaches.

E. **REFERENCES:**

1. **Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") The complete HIPAA Privacy Rule, Annotated to reflect final modifications dated August 14, 2002, may be viewed at http://www.hipaadvisory.com/**
2. **Title 45 of the Code of Federal Regulations ("CFR") – HIPAA Privacy Rule**

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

1. **Role-Based Access Worksheet ~~– Attachment 1~~**

Tri-City Medical Center

Role-Based Access Worksheet

Type of access

	Create	Edit	Use	Disclose	View	Secure Transport	Destroy
Demographic							
Insurance							
Financial							
Codified							
Clinical							
Complete legal Record							
All							

P=Primary - Required (routine) to do the job.
S=Secondary - Required for the job, but mostly by exception.
I=Incidental - Not required for job, but access may occur.

Type of access
Create: Primary source documentation.
Edit: Changing incorrect data. (According to Policy).
Use: Read and view the information to make decisions appropriate for your position.
Disclose: Conveyance of the information to persons or entities outside TCMC
View: Employee may view certain information, but is expected not to make decisions based on what they know.
Secure Transport: Moving information from one place to another. (Should not view)
Destroy: Final legal disposition of our business records.

What Information:
Demographic: Information to identify a person. (name, address, race, marital status, religion)
Insurance: Information used to identify payors and insured.
Financial: Payment rates, account balances, payor analysis, etc
Codified: Clinical information that is in (alpha) numeric format. (ICD-9CM, CPT, Rev. Codes)
Clinical: Information that describes a patient's health status.
Complete Legal Record: That set of printed information maintained as the legal record.
All: All of the above

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**SUBJECT: Boarders**
REVISION DATE(S):01/06; 02/11	**POLICY NUMBER: 7010-004**
Emergency Department Approval:	**02/20**
Department of Emergency Medicine Approval:	**03/20**
Pharmacy and Therapeutics Approval:	**05/20**
Medical Executive Committee Approval:	**06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	**02/11**

A. **DEFINITIONS:**

1. To define a process for identifying those patients who experience a delayed admission to a Nursing Unit.

B. **POLICY:**

1. Patients who remain in the Emergency Department (ED) greater than two (2) hours after orders to admit are received are deemed a boarder patient. Patients are to receive the same standard of care while awaiting an inpatient bed.

C. **PROCEUDURE:**

1. Implement the documentation and communication criteria to signal the admission process.
   a. ED Physician receives confirmation for admission from admitting Physician.
   b. Admitting Physician **places admission orders into electronic medical record.**~~is contacted for orders.~~
   ~~a.~~**c.** Bed order is communicated to the **Administrative Coordinator via AIONEX by the ED Unit Secretary.**~~ED Assistant Nurse Manager (ANM) or Charge RN.~~
   ~~c.~~**d.** Bed ~~requests~~**Requests: The Administrative Supervisor coordinates with units for all bed assignments.**
   ~~7A – 7P: ED ANM or Charge RN contacts the receiving unit directly and the ANM gives bed assignment.~~
   ~~7P – 7A: ED ANM or Charge RN contacts the Administrative Supervisor for all bed assignments.~~
   ~~d.~~**e.** If a bed is not available within two (2) hours of the orders, the patient is deemed a boarder.
   ~~e.~~**f.** Delays are reported to ED **Management**~~Clinical Operations Manager~~ for intervention.
   ~~f.~~**g.** Continuously monitor opportunities for improvement.

D. **PHARMACIST REVIEW OF PHYSICIANS ORDERS FOR ED BOARDERS:**

1. All medication orders administered in the ED for a boarder patient will be reviewed by the Pharmacist for appropriateness.
2. The following review process will be followed:
   a. When a patient is determined to be an ED boarder patient,~~-~~ **the ED RN will initiate the admission orders if the admitting physician has not already done so. After initiating the admission orders, the ED RN will send an electronic medication request to the Pharmacy for each medication to be administered in the ED.**
   ~~and admission orders are written, the RN will place a check mark by the medication orders to be administered in the ED and fax the orders to the Pharmacy at 4028.~~

b. The Pharmacist will review the orders for appropriateness and **verify the medications on the electronic medication administration reconciliation (EMAR) record.** ~~enter the requested medications into the Cerner Pharm-Net System so the electronic medication administration reconciliation (EMAR) entry will display.~~

~~a.~~**c.** The **ED** RN will perform a nurse review to verify the Pharmacist review of the medications order.

~~b.~~**d.** The **ED** RN will document the medication administration time on the EMAR.

~~c.~~**e.** Once the boarder patient is transferred to an inpatient bed, **all ED orders are to be discontinued and all admission** ~~the pharmacist will discontinue all ED medication orders, re-enter all admission orders and then the~~ orders will be reviewed by the receiving nursing unit RN assigned to the patient.

~~B. **APPROVAL PROCESS:**~~

~~1. Emergency Department Medical Director~~

~~2. Board of Directors~~

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:

SUBJECT: **Release of a Minor Under 18 Years of Age**

REVISION DATE(S): 08/05; 02/11

~~**POLICY NUMBER: 7010-010**~~

Emergency Department Approval:	**02/20**
Department of Emergency Medicine Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	

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

1. To provide guidelines as to releasing a minor under eighteen (18) years of age to a~~n authorized~~ parent or legal guardian.

B. **DEFINITIONS:**

1. **Minor – a person younger than 18 years of age.**
2. **Authorized individual: parent, legal guardian or other person with the authority to consent to medical treatment for the minor per California Hospital Association (CHA) Consent Manual (2017), Chapter 4.**

C. **POLICY:**

1. Minors shall only be discharged to the custody of **an authorized individual.**~~their parent(s) or legal guardian(s) or custodian(s), unless otherwise directed **designated** by the **authorized individual**parent(s), legal guardian(s) or custodian(s)~~.

D. **PROCEDURE:**

1. Prior to the release of a minor to a designated person, that person must complete a receipt or **an** ~~acknowledgement of the release of the minor, CHA form #10-2,~~ Acknowledgement of Release of a Minor.
2. Place the original in the patient's chart and a copy is given to the person who receives the minor.
3. A Department of Health Services (DHS) form is completed and the original forwarded to the DHS within forty-eight (48) hours, with the name and address of the organization to whom the physical custody of the minor is surrendered, unless the surrender is to one of the following:
   a. A parent.
   b. A person who has legal custody or authorization.
   c. A relative by blood or marriage.
   d. An agent of a public welfare, probation or law enforcement agency if the minor comes within Welfare and Institutions Code.
   e. Pursuant to a transfer of the minor to another health facility for further care.
4. The form needs to be completed by the **authorized individual.**~~parent or legal guardian, the person who receives the minor and the medical center~~.

E. **FORM(S)~~RELATED DOCUMENTS~~:**

~~F.~~**1.** Acknowledgement of Release of a Minor

~~G.~~**F. REFERENCES:**

1. **California Hospital Association Consent Manual (2017), Chapter 4**
~~1. 2005 CHA Consent Manual, Title XXII~~
2. ~~2011 CHA Consent Requirements for Medical Treatment of Minors~~

~~H. **APPROVAL PROCESS:**~~
~~1. Emergency Department Medical Director~~
~~Board of Directors~~

FORM 10-2

ACKNOWLEDGMENT OF RELEASE OF A MINOR

I/we have on this date, *(insert date)* _____ received *(name of child)* _____.

I/we understand that the signature below authorizes only the release of this child from the hospital. This is not a consent or relinquishment of this child for adoption.

Date: _____ Time: _____ AM / PM

Signature: _____
(person receiving child)

Print name: _____
(person receiving child)

_____
(organization)

_____
(address)

Signature: _____
(witness)

Print name: _____
(witness)

COMPLETE THE FOLLOWING:

IDENTIFICATION OF PERSON(S) RECEIVING CHILD

Name: _____

Address: _____

_____

Phone Number: _____

Driver's License No: _____ State: _____

Other: _____

Tri-City Medical Center
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS ~~POLICY MANUAL~~

ISSUE DATE: 06/~~19~~99 **SUBJECT: Injury/Illness Prevention Program**

REVISION DATE: 05/~~20~~08, 12/~~20~~11

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**n/a**
Environmental Health & Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/08**

A. **SAFETY POLICY STATEMENT:**

1. Employee safety is a major concern to Tri-City Healthcare District (TCHD). We strongly believe that a clean, safe and healthy environment should be provided for all employees. Every reasonable precaution is taken to provide employees with a safe place to work. Injury prevention is largely an individual responsibility. Therefore, it is ~~every~~ **each** employee's responsibility to think and act safely at all times.
2. ~~We pride ourselves on safety.~~ The TCHD objective is to provide a safe and healthy working environment for our employees and to reduce the likelihood of work-related injuries. If an employee is injured, he/she must report the injury to his/her supervisor **or designee**. ~~In addition, employees who observe an unsafe work condition are expected to report it to their supervisor. This Injury/Illness Prevention Program Policy outlines all the information that is available to employees regarding safety. As additional resources, TCHD has an Environment of Care Manual and an Infection Control Manual. The information in these manuals is there to make employees aware of safe work practices~~

B. **PURPOSE:**

1. To prevent work-related accidents and illnesses by implementing methods and procedures for correcting unsafe work conditions and work practices in a timely manner.
2. To identify, evaluate and correct workplace hazards.
3. To provide an ongoing safety training/communication program designed to instruct employees in safe work practices.
4. To assure compliance with safe and healthy work practices and to promote excellent safety standards among all employees.

~~3.0 MANAGERIAL RESPONSIBILITY~~

~~3.1 It will be the responsibility of the Environment of Care Officer to initiate, implement, maintain and administer the Injury/Illness Prevention Program.~~

~~3.2 The Environment of Care Officer will delegate duties, tasks and assignments to the Committee Environment of Care Committee and Area Safety Representatives.~~

5. ~~3.4 Each Department Director/Manager will be responsible for establishing and supporting departmental safety standards. All performance evaluations include a safety standard~~

C. **SAFETY COMMUNICATION:**

1. ~~4.1~~ It is the policy of Tri-City Medical Center to establish a communication network between staff and the appropriate administrative team regarding safety concerns.

a. ~~4.1.1~~ Employee compliance with safe work practices is assessed through his or her annual performance evaluation.
b. Safety rules and information on occupational hazards are communicated through the following means:
   i. Annual Update
   ii. Department Specific Training
   iii. Net Learning
   iv. "Hot Topics"
   v. Department Staff Meetings
c. Employees are encouraged to report safety concerns to Employee Health Services, the Environment of Care/Safety ~~Officer~~**Manager**, ~~and~~ their Manager or Director

D. ~~5.0~~ **IDENTIFICATION AND CONTROL OF HAZARDS:**

~~5.1 Initial discovery and communication of any and all safety hazards is the responsibility of all TCHD employees.~~

1. ~~5.1.1~~ Employees who wish to ~~submit~~ **report** ~~any~~ safety hazard anonymously may do so by directing their concern ~~in writing~~ to Employee Health Services, the Environment of Care ~~Officer~~**Manager**, their manager, **Risk Manager,** or by calling the Health Care Values Line at ~~800-273-8452~~**844-521-7862**.
2. ~~5.1.2~~ These inquiries will be directed to the Environment of Care Committee and placed on the agenda for discussion and action.

~~1.~~**3.** 5.2The Environment of Care Committee will review and/or investigate accidents, health hazards, and correction on a periodic basis. Environment of Care Committee recommendations will be reported to Patient Care Coordinating Council.

~~2.~~**4.** ~~5.3~~Infection Control – See TCHD Infection Control Manual for detail on identifications, control, and isolation of hospital associated infections.

~~3.~~**5.** ~~5.4Material~~ Safety Data Sheets (~~M~~SDS) – Available to all employees in their departments and through the 3E Company by calling 800-451-8346 for a copy or information. ~~M~~SDS documents inform employees about hazardous substances and materials.

~~4.~~**6.** ~~5.5~~Hazardous Materials – See TCHD Safety Manual for guidelines on the Hazardous Materials Management Program.

E. ~~6.0~~ **UNSAFE WORK PRACTICES:**

1. ~~6.1~~ Unsafe Work Practice – Includes but is not limited to behavior, which may result in injury, or illness caused by:
   a. Carelessness, inattention to duties and tasks.
   b. Failure to follow/obey safety rules.
   c. Failure~~/unwillingness~~ to wear proper safety attire when required.
   d. Failure to store equipment in designated areas or post signs in hazardous areas.
   e. Removal of any safeguard from any tools or machinery.
2. ~~6.2~~ Employees not following safety, policies and procedures, not wearing proper safety attire when required, removing safety devices or any involvement in unsafe work practices may be subject to disciplinary action.
3. ~~6.3~~ Any flagrant misconduct and/or unsafe work practices that are malicious in nature may warrant an immediate intent to terminate.

F. **HOSPITAL PATIENT AND HEALTH CARE WORKER INJURY PROTECTION ACT:**

1. Assembly 1136 amends Title 8 of the California Code of Regulations requiring employers to adopt a patient protection and health care worker back and musculoskeletal injury prevention plan. The plan shall include a safe patient handling policy that requires replacement of manual lifting and transferring of patients with powered patient transfer devices, lifting devices, and lift teams, as appropriate for the specific patient and consistent with the employer's safety policies.
2. See Patient Care Services Manual, Lift Team, IV.J for the Safe Patient Handling Policy.

G. ~~8.0~~ **TRAINING:**

1. ~~8.1~~ Orientation – All employees are required to attend **safety** orientation ~~before~~ **on** the **next scheduled New Hire Orientation during the** first **30** days of scheduled- work unless authorized by the area Vice President. ~~Safety, policies, fire safety, body mechanics, Infection Control, MSDS manuals and other safety awareness items are discussed in orientation. (See AP policy 457)~~
2. ~~8.2~~ Individual training will take place at the department level. No employee is expected to undertake a job until he/she has received instructions on how to do it properly and has been authorized to do that job. No employee should undertake a job that appears to be unsafe.~~; or use chemicals without understanding their toxic properties.~~
3. ~~8.3~~ ~~Periodically~~ **As needed,** the TCHD environment of Care Committee sends a safety ~~"Hot Topic"~~ **bulletin** to the ~~Department Directors and Area Safety Representatives~~ **Facility Leadership** for dissemination to employees.

H. ~~9.0~~ **FIRST AID AND MEDICAL ASSISTANCE**

1. See ~~Administrative Policy & Procedure Manual~~**Employee Health and Wellness** ~~Manual~~ ~~(Refer to Administrative~~ Policy ~~#400~~**:** Employee Occupational Accident or Illness)

I. **EMPLOYEE RESPONSIBILITY**

~~10.1 All employees of TCHD are responsible for following all safety rules, health procedures and recognizing and reporting hazards in his/her work area.~~

1. ~~10.2~~ Employees are not to remove, displace, damage, destroy or tamper with safety devices, safeguards, notices or warnings.
2. ~~10.3~~ Employees are not to interfere with the use of safeguards by others.
3. ~~10.4 Employees are responsible for using proper safety attire when it is required.~~

DELETE – follow no longer needed

TRI-CITY MEDICAL CENTER
Oceanside, California

UNIT SPECIFIC POLICY MANUAL
HOME CARE

ISSUE DATE: 4/04	SUBJECT: Agency Evaluation Indicators
REVISION DATE: 6/05, 6/07, 5/08, 6/11, 7/12	POLICY NUMBER: 105
REVIEW DATE: 7/05, 6/07, 5/08, 3/09, 3/11	APPROVAL: 7/04, 7/06, 8/08, 8/09, 6/11

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/11**

~~A. PURPOSE: Agency evaluation indicators are promulgated by regulatory entities and standards.~~

~~B. POLICY: The Agency will have evaluation indicators promulgated by regulatory entities and standards the Agency deems significant to be evaluated every quarter and annually.~~

~~C. PROCEDURE:~~
~~Each Agency Standard has subsets which are evaluated by various methodologies. These methods include but not limited to tracking reports, patient and personnel chart review, Utilization Review and QI Reports, and logs.~~

~~The document "Total Agency Evaluation /Indicators" describes how each standard is measured, the frequency of the measurement, by whom the standard is measured and the expected outcome of each Standard subset.~~

~~The Standard subsets are reviewed each quarter by the GPP and when the expected outcome or threshold is not met, the GPP will give direction for performance improvement for that Standard subset. The Plan of Action will be developed by the Leadership under advisement of the GPP. The Plan of Action will be presented at the next quarterly meeting of the GPP with the results of that plan.~~

~~The Plan of Action may include but not limited to in service, process change or disciplinary action.~~

~~Indicators will be measured as a 1 form completion for criteria met and 0 for criteria not met.~~

~~The Standards to be met are:~~

~~a. Safety Education~~

- ~~Medical Supplies secured and stored per agency policy has a threshold of 100%. This means that the medical supply room will be locked at all times when supplies are not being obtained by the supply coordinator. The supply coordinator will record compliance each day via a tool and monthly give the tool to the compliance supervisor. Any day the supply room in not locked without attendance a zero (0) score will be given for that quarter.~~

- Emergency and Disaster Plan in place has a threshold of 100%. The emergency evacuation posters and disaster plan are visualized each quarter by the safety officer. If not in place each quarter a zero (0) score will be given for that quarter.

- Safety walkthrough has a threshold of 100%. The safety officer via the Departmental Hazard Surveillance Checklist will log in the Safety manual and give a copy of the completed checklist to the compliance supervisor.

b. Risk Management

- Incident Reports are logged into a database after they are completed by the reporting clinician. Threshold addresses three (3) or more of the same incident by staff. Three or more same staff incidents in a quarter will be given a score of zero (o).

- On call log is maintained daily by the on call clinician and turned into the nursing supervisor weekly. The nursing supervisor views the log for daily completion and gives a monthly report to the compliance supervisor. A score of zero (0) will be given for the quarter when the log is not completed.

- Appropriate disposal of sharps is determined by supervisory/evaluation visits by the nursing supervisor. A log of all appropriate visits will be given to the compliance supervisor every quarter. All clinicians must dispose of sharps according to the infection control policy or a score of zero (0) will be given for the quarter.

- The Performance Improvement Plan will be developed and reported to the GPP annually. The plan for the current fiscal year will be reported in the July, the first month of the fiscal year.

- Urinary tract infections are tracked and an incidence density rate is ascribed per quarter. The accepted rate for the Agency is 1.5. A score of zero (0) is given if the rate is above 1.5 in a quarter.

- Peripheral and central lines are tracked and an incidence density rate is ascribed per quarter. The accepted rate for the Agency is 1.5. A score of zero (0) is given if the rate is above 1.5 in a quarter.

- Chart review is done every quarter using the Utilization Review form. The threshold is 80% for compliance of indicators with a percentage of 90 or better. A percentage below 80 % is a zero (0) score.

- OASIS compliance with lock down and validation reports will be reported quarterly and be below the established thresholds of CMS. The threshold for lockdown is 20% and 10 % for validation for a six (6) month period.

- The organizational chart will be present, complete and accurate for 100% compliance.

c. Record review

- Clinical record review quarterly compliance requires equal amount open and discharged charts. Compliance for this indicator is 80%. Therefore, 80% of the charts reviewed must be equal open and discharged for a score of 1.

- POC and verbal orders signed and returned within thirty (30) days. Compliance of 95% of reviewed records is required for a score of 1.

- Documentation that is timely, clear and complete at SOC is monitored by the case manager via a quality tool/tickler. All items monitored must be a "yes" on the tool for 100% compliance at start of care.

- Care coordination is timely and appropriate at SOC is scored and monitored as above.

- Care coordination is timely and appropriate at Recert is scored and monitored as above.

- Secured medical records are monitored via a tool with 100% compliance meaning the Medical record room is locked when not attended.

- Sixty day clinical record review is done by the Case Manager, reported at case conference and monitored via a coordination/review tool.

d. Human Resources
- Personnel files reviewed quarterly for regulatory compliance

- Performance evaluations are completed per policy

- Supplemental staff contracts meet regulatory requirements

- Regulatory compliance documentation is maintained: license, certificate, driver's license and auto insurance

- Staff meets in-service requirements (CHHA)

- Contract staff files have all components required (same as TCMC personnel)

e. Education
- All employees attend hospital orientation

- All employees complete the orientation check list

- All employees complete visits with preceptor according to calendar

- All employees complete skill validation

f. Group of Professional Personnel
- At least one member of this group is neither an owner nor employee of the Agency and represents the community served. Compliance of 100% is attained when the sign in sheet and minutes reflect this requirement.

- The identified functions of this group must be inclusive in the Group of Professional Personnel to obtain 100% compliance.

- Compliance of 100% is obtained by demonstrating in the minutes the discussion of and recommendations to the committee for indicators falling below the determined threshold.

g. Administrative Personnel
- Compliance for this indicator is evidence of Administrator and designee by the Governing Board.

h. Fiscal
- Budgets, audits, accounting and billing are carried out according to policy

- Contracts are complete and appropriate for services being delivered and meet regulations

i. Quality Management
- The system to review and evaluate appropriate and effective service to the patient includes correction of deficiencies, ongoing plans of action and a Performance Improvement Plan outlining the methodology for agency improvements.

- The review of the records includes the components as written in Title XXII including required sampling numbers and performed quarterly.

j. Patient's Rights
- The patient is informed upon admission of their rights and responsibilities and extent of payment that may be required. Compliance of this indicator is done via quarterly chart review for signed consent. All charts reviewed must have a signed patient consent for 100% compliance. The patient Account representatives will inform the compliance supervisor if the funding form on any chart is missing.

- Compliance regarding complaints is evidenced by completion of the Agency complaint form including investigation and resolution. A complain book and database is evidence for 100% compliance.

k. Organization
- Compliance for Agency Scope of Service is evidenced by the Agency Policy Manual.

- Professional personnel license data is tracked monthly. Compliance of 100% is a list with all licenses current for the month.

- CLIA Waiver, Health permit and Medicare license are all posted and tracked for renewal by a supervisor. Expiration without renewal would result in a zero score for the quarter.

- Health permits are posed and current

- The Medicare license is posted and current

l. Governing Body
- Compliance regarding the Governing Body will be reflected in the minutes of the GPP and Governing Body. This will include budget approval, 3 year capital expenditure plan and action, if any, on Agency reports to the Board.

- ~~A list of current Board members will be available. All above items must be in place annually for 100% compliance.~~

~~m. Review of policies~~

- ~~A review and approval of all policies outlined in the Conditions of Participation will be evidenced in the minutes of the GPP throughout the fiscal year.~~
    - ~~All said policies must be reviewed for~~ 100% compliance.

TRI-CITY Healthcare District
Oceanside, California

DELETE – duplicate policy

UNIT SPECIFIC POLICY MANUAL
HOME HEALTH

ISSUE DATE: 6/04 | SUBJECT: Case Conference

REVISION DATE: 5/07 | POLICY NUMBER: 309

REVIEW DATE: 5/07, 5/09, 5/10, 11/11 | APPROVAL: 7/04, 7/07, 8/09, 10/10, 12/11

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~A. PURPOSE~~

~~To describe the Agency's utilization of multidisciplinary patient case conferencing to ensure effective coordination of care and support the objectives outlined in the plan of care.~~

~~B. POLICY~~

~~All patients are conferenced at the beginning of service, recertification, resumption of care and whenever there is a significant change in patient condition or environment.~~

~~Items of discussion may include, but are not limited to, the type and frequency of service by each discipline involved, changes in the patient's overall status, problems, possible resolutions, and any necessary revisions in the plan of care.~~

~~C. MEMBERSHIP~~

~~Membership is composed of interdisciplinary teams facilitated by the Nursing Supervisor of that patient. All clinicians working with the patient may participate in case conferences.~~

~~D. PROCESS~~

~~Each interdisciplinary team meets once a week. The Nursing Supervisor prepares a patient census that includes date, name, address, date of birth, onset of service and primary physician. A copy is kept in the case conference binder and a copy with acuity rating placed on the disaster clipboard. Members are responsible, when requested, for reviewing the conference census list and care plans of patients they have scheduled for conference and being prepared to discuss their patient's status. Problems that staff or patients are experiencing are discussed along with potential discharge or transfers. Any patient not scheduled for review may be discussed at the request of any member of the interdisciplinary team at any time~~

~~Each member of the team completes an interdisciplinary conference note when appropriate which is filed in the patient's medical record. The case conference note may be signed by the Nursing Supervisor in attendance. The clinical record of case conferences establishes that effective reporting and coordination of patient care does occur. The DPCS or designee maintains overall responsibility for the patient conference.~~

DELETE – follow no longer needed

TRI-CITY Healthcare District
Oceanside, California

UNIT SPECIFIC POLICY MANUAL
HOME HEALTH

ISSUE DATE: 6/04	SUBJECT: Committees
REVISION DATE: 11/06, 4/08, 6/11	POLICY NUMBER: 111
REVIEW DATE: 6/05, 11/06, 2/07, 4/08, 3/11	APPROVAL: 6/04, 2/07, 4/08, 6/11

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/11**

~~PURPOSE: To define the internal committees of Tri-City Home Health~~

~~POLICY: To assure patient safety and quality of care, Tri-City Home Health has internal committees related to various aspects of patient care. Members of the Leadership team participate in all internal committees. The committees carry out Agency functions and deal with professional practice issues.~~

~~PROCEDURE: The following are committees of Home Health that are documented by dated minutes:~~

~~1. Leadership Committee~~
~~a. Meets weekly or at a minimum of two times a month.~~
~~b. Members include: Director of Patient Care Services, Nursing Supervisors, Manager of Quality and Outcomes, Nursing Educator, and Business Development Manager~~
~~c. Leadership committee oversees the functioning of the agency as a whole. Members provide reports from hospital committee meetings.~~
~~d. The committee reviews and revises policies and procedures on a regular basis. The policies are prepared and distributed by the Manager of Quality and Outcomes~~
~~e. Leadership will periodically review operational issues and Home Health procedures~~
~~f. Leadership will review & discuss quality issues and develop plans of corrections reporting to the GPP when needed.~~

~~2. FMEA~~
~~a. Interdisciplinary committee addresses a high risk event every 18 months to determine the process for prevention of untoward occurrences.~~
~~b. Manager of Quality and Outcomes provides education for the interdisciplinary team and facilitates.~~
~~c. The FMEA process is monitored for two quarters to assure compliance.~~

d. The results after that time are reported to the Tri-City Healthcare Safety Committee.

3. Patient Education

a. Interdisciplinary committee reviews, revises and develops educational tools for patient teaching.

b. The committee meets every two months.

4. Ethics

a. This committee reviews and researches all ethical dilemmas presented by staff members and makes recommendations to Leadership if necessary.

b. Functions in a consultative and advisory capacity, not as a decision making body.

c. Committee membership is multidisciplinary.

5. Group of Professional Personnel

a. This committee establishes and annually reviews the Agency's policies governing scope of services offered, admission and discharge policies, medical supervision, plans of care, emergency care, clinical records, personnel qualifications and program evaluation.

b. This committee reviews the agency indicators, financial and outreach and all aspects of the agency.

c. The committee also assists the Agency in maintaining liaison with other health care providers in the community and the Agency's community information program.

d. The annual agency evaluation is a comprehensive review including agency appropriateness, adequacy, effectiveness and efficiency.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 06/04~~	~~SUBJECT: Contracted Services~~
~~REVISION DATE: 1/07~~	~~POLICY NUMBER: 112~~
~~REVIEW DATE: 1/07, 3/09, 7/11~~	~~APPROVAL: 7/04, 11/07, 5/09, 9/11~~

ISSUE DATE: 06/04 **SUBJECT:** Contracted Services

REVISION DATE(S): 07/04, 11/07, 05/09, 09/11 **POLICY NUMBER:** 112

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the use of contracted services within Tri-City Home Health Agency.

B. **POLICY:**
1. It is the policy of Home Health to arrange for another individual or entity to furnish services to the Home Health patient in the event of inadequate staffing or resources not provided by the Agency. -Home Health assures the continuity of patient/family care in the home with the use of contracted services. -All contracted services must have a legally binding written agreement for the provision of arranged services approved by the legal department of Tri-City Healthcare District.

C. **PROCESS:**
1. All contracts with Tri-City Home Health will be individualized and contain fiscal and service responsibilities and written according to all regulatory agencies. All contracts shall be contained in a binder in the Home Health Care office. Contracted services may encompass supportive and clinician services.
2. It is the responsibility of the contracted individual or agency to adhere to applicable agency policies and personnel qualifications.
3. Home Health is responsible for oversight of all activities performed by the contracted individual or agency to assure quality of care and conformance to regulatory requirements. -Home Health retains the professional management responsibility for contracted services and insures that they are furnished in a safe and effective manner and in accordance with the patient plan of care and other state and federal requirements.
4. The Home Health retains financial responsibility for services provided under contract.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 10/09 **SUBJECT: Mileage Expense Reimbursement**

REVISION DATE(S): 02/10, 2/10, 9/11, 1/12 **POLICY NUMBER:** 204

~~**REVIEW DATE: 10/09, 7/11, 1/12 APPROVAL: 2/10, 9/11, 1/12**~~

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

A. **PURPOSE**:
1. To delineate the reimbursement of auto expenses in regards to the use of personal automobile when providing Tri-City Home Health care to patients.

B. **POLICY**:
1. It is the policy of this Agency to reimburse Tri-City employees for any employment related expenses, which include mileage, in accordance with California law.

C. **PROCEDURE**:
1. Employees keep an accurate tally of mileage used on a daily basis.
   a. The published IRS rate is used.
   b. The mileage needs to be entered in the **computer system daily**~~Computer's daily activity record (DAR) section. For those employees not on the computer, the mileage needs to be recorded on the paper DAR~~.
   c. The mileage is started from the office and/or the first home visit and recorded for each trip between patients.
   d. Mileage is not paid for personal errands between visits. Document the actual mileage from one patient to another.
   e. Mileage will not be paid from home to work or work to home.
   f. Mileage is not paid from the last visit to home if not returning to office.
2. Emergent after-hours mileage reimbursement.
   a. When an emergent, after hours, visit is necessary Tri-City Health Care will reimburse mileage from staff's home to patient's home.
   b. Tri-City Health Care will not reimburse from the patient's home, back to staff's home, which is considered a commute.

Tri-City Health Care District	~~Distribution:~~ Home Health Care
PROCEDURE	**~~MOSBY'S~~ELSEVIER CLINICAL INDEX OF NURSING SKILLS**
Purpose	To review or learn procedures to follow in Home Health
~~Supportive Data~~	
~~Equipment:~~	
Issue Date:	07~~8~~/12

A. **PROCEDURE:**

1. ~~A. Mosby's~~**Elsevier's** Clinical **Skills** Index is the resource for the Hospital and Home Health Nurses for proper procedure compliance.
2. Home Health has procedures specific to Home Health, but in the event a patient is admitted with a procedure order that is not common, then the Home Health nurses can access ~~Mosby's~~**Elsevier's** for more information.
3. How to access ~~Mosby's~~**Elsevier's** procedures:
   a. Go to the TCMC employee intranet web site.
   b. Click on 'Policies & Procedures'.
   c. ~~3. Scroll down to 'Patient Care Services', a drop down menu will open, click on Mosby's on the drop down menu~~**Click on the hyperlink in center of page to access Elsevier Online Skills**.
   d. Enter name of procedure you are looking for~~.~~ **in the search bar.**
      i. For Example: If you are looking for a procedure involving Trachs, type in trach, **then enter or** click on ~~'ge'~~**search icon** and a list of trach subjects will open up.
      ii. Then you can look for the procedure you need.
4. **Staff**~~You~~ also have the option to print the procedure if needed.

~~Issued:~~	~~Reviewed:~~	~~Revised:~~	~~Approved:~~
~~8/12~~	~~8/12~~		~~8/12~~
~~S:/HomeCare/Forms/Processes Template~~			

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/20	n/a	n/a	07/20	n/a	07/12

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE:7/1/05~~	~~SUBJECT: Notice of Medicare Non-Coverage for Health Maintenance Organizations (HMO)~~
~~REVISION DATE: 2/08~~	~~POLICY NUMBER: 322~~
~~REVIEW DATE: 2/08, 3/11, 6/12~~	~~APPROVAL: 4/08, 6/11, 2/13~~

ISSUE DATE:	**07/05**	**SUBJECT:**	**Notice of Medicare Non-Coverage for Health Maintenance Organizations (HMO)**
REVISION DATE(S):	**04/08, 06/11, 02/13**	**POLICY NUMBER:**	**322**

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To explain the CMS ruling, regarding the Notice of Medicare Non-Coverage (HMO).

B. **POLICY:**
1. It is the policy of the Agency to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with termination of Medicare-covered services.

C. **PROCEDURE:**
1. Notice Of Medicare Non-Coverage (HMO):
   a. For Medicare HMO beneficiaries, the forms are explained to beneficiary and signed, but not dated, on the SOC visit in anticipation that no further visits will be authorized. These forms are then returned to the ~~Case Manager~~ **office medical records** for inclusion of date upon termination of service, when determined, and then a copy given to beneficiary at the visit prior to the discharge visit. The copy can also be mailed or faxed to the beneficiary, if no further visits are authorized after SOC.
   b. The beneficiary or authorized representative's signature is required on the Medicare HMO Non-Coverage forms. This may be accomplished by mailing or faxing if the beneficiary is not available.
   c. The following information is required for the form:
      i. Beneficiary's name and medical record number
      ii. The date Medicare HMO coverage of services ends
      iii. The type of coverage that is ending (Home Care)
   d. If longer services are needed after a form is delivered and signed, and more services are to be given, the clinician must inform the beneficiary of a new effective date of termination, if known. A new form may be signed in person or the clinician may annotate the original form in the medical record. This is accomplished by the following:

i. Draw a single line though the termination date and write the new termination date above or beside the deleted date.
ii. Write the words "Notice Amended" on the Generic Notice
iii. Date and sign the entry
iv. Verbally notify the beneficiary that the Generic Notice termination date has been amended.
v. Provide or mail a copy of the amended notice to the beneficiary
vi. Place a copy of the amended notice in the beneficiary's medical record.

e. A form does not need to be delivered/mailed to a beneficiary when the beneficiary chooses to terminate Home Care services; the beneficiary is discharged to a higher level of care or in the event of the beneficiary's death.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE:7/1/05~~ ~~SUBJECT: Notice of Medicare Provider Non-Coverage~~

~~REVISION DATE: 2/08, 11/08, 4/11~~ ~~POLICY NUMBER: 321~~

~~REVIEW DATE: 2/08, 12/08, 4/11, 6/12~~ ~~APPROVAL: 4/08, 2/09, 6/11, 2/13~~

ISSUE DATE: 07/05 **SUBJECT:** Notice of Medicare Provider Non-Coverage

REVISION DATE(S): 04/08, 02/09, 06/11, 02/13 **POLICY NUMBER:** 321

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To explain the CMS ruling regarding the Notice of Medicare Provider Non-Coverage for the Medicare beneficiaries.

B. **POLICY:**
1. It is the policy of the Agency to provide Medicare beneficiaries with appropriate forms for an expedited and efficient appeal process when faced with termination of Medicare-covered services.

C. **PROCEDURE:**
1. Notice of Medicare Provider Non-Coverage (Generic form):
   a. The Notice of Medicare Provider Non-Coverage (Generic), must be delivered to all traditional Medicare (Not Medicare/HMO) 2 days prior to the end of the Medicare coverage of All Home Care services. The day of discharge is considered the effective date of termination of services. This form explains to the beneficiaries their right to an expedited appeal process prior to termination of services. In the event that a beneficiary is advised by their physician that they no longer need Home Care, the clinician need not make a visit but may instead phone the patient advising of the discharge and mail the Generic notice the same day with documentation indicating verbal discussion with the beneficiary. This would be done the day the clinician would become aware of the MD discharge.
   b. The beneficiary or authorized representative's signature is required on the Medicare Provider Non-Coverage form. (Generic) This may be accomplished by mailing or faxing if the beneficiary is not available.
   c. The following information is required for the Generic form:
      i. Beneficiary's name and medical record number
      ii. The date Medicare coverage of services ends
      iii. The type of coverage that is ending (Home Care)

iv. The name and phone number of the appropriate Quality Improvement Organization

d. If additional services are needed after a Generic form is delivered and signed, and more services are to be given, the clinician must inform the beneficiary of a new effective date of termination. A new form may be signed in person or the clinician may annotate the original form in the medical record. This is accomplished by the following:
   i. Draw a single line through the termination date and write the new termination date above or beside the deleted date
   ii. Write the words "Notice Amended" on the Generic Notice
   iii. Date and sign the entry
   iv. Verbally notify the beneficiary that the Generic Notice termination date has been amended
   v. Provide or mail a copy of the amended notice to the beneficiary
   vi. Place a copy of the amended notice in the beneficiary's medical record

e. A Generic form does not need to be delivered/mailed to a beneficiary when the beneficiary chooses to terminate Home Care services; the beneficiary is discharged to a higher level of care or in the event of the beneficiary's death.

f. The 2-day rule prior to termination of services does not apply to patients on service fewer than 2 days or when there are unanticipated changes in coverage. However, the notice still needs to be delivered/mailed even though the 2-day rule does not apply.

g. ~~7.~~ Although the Generic Notice must be delivered no later than 2 days before the day of discharge, it can be delivered sooner when the day of discharge is identified. If the discharge date of the Generic Notice changes; please refer to the process outlined in #4.

2. Detailed Explanation of Non-Coverage (Detailed Notice):
   a. The beneficiary has the option to notify the Quality Improvement Organization when he/she feels services should be continued. If this occurs, the Quality Improvement Organization, (QIO) will notify the Home Care Agency. A Detailed Notice must be delivered on the day the Agency is notified by the QIO of the beneficiary's decision to exercise his/her appeal rights and documented that the Notice was given to the beneficiary. The Detailed Notice is also sent the same day to the QIO by mail, e-mail for fax. If a beneficiary states to a clinician that they are going to appeal when they are given the Notice of Medicare Provider Non-Coverage, the clinician may at that time give the beneficiary the Detailed Notice. The Detailed Notice does not require beneficiary signature.
   b. The following are examples of when a Detailed Notice is not required; however, documentation supporting the reason is required for the medical record.
      i. Detailed Notice Not Required:
         1) Beneficiary requests to discontinue care
         2) Unsafe patient situation
         3) Unsafe situation for Agency personnel
         4) Hospitalization
         5) Nursing Home placement
         6) Beneficiary relocation
         7) Beneficiary non-compliance
         8) (Beneficiary non-compliance could include non-compliance with the CMS regulation regarding the physician face to face encounter).
   c. The Quality Improvement Organization (QIO) will be available both to receive a
      i. Beneficiary's request for an expedited determination and to conduct reviews on weekends.

Tri-City Medical Center
Oceanside, California

~~UNIT-SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 6/05~~ ~~SUBJECT: PAIN /SYMPTOM MANAGEMENT~~

~~REVISION DATE: 3/08~~ ~~POLICY NUMBER: 327~~

~~REVIEW DATE: 3/08, 3/11~~ ~~APPROVAL: 11/07, 8/08, 6/11~~

ISSUE DATE: 06/05 **SUBJECT:** Pain /Symptom Management

REVISION DATE(S): 11/07, 08/08, 06/11 **POLICY NUMBER:** 327

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	06/11

A. **PURPOSE:**
1. To delineate the expectations and process for pain and symptom management in the Home Health setting.

B. **POLICY:**
1. It is the policy of the Agency to provide patients with assistance for pain and symptom management under the direction of the patient's physician.

C. **PROCEDURE:**
1. Management of **patient's** pain and symptoms are based on the initial and ongoing assessment of the ~~primary~~ nurse. Pain is managed according to standards of practice and the patient's level of desired relief.
2. The Home Health Team collaborates with the patient's primary physician regarding treatment and expected results of pain and symptom management.
3. Pain is assessed at every home care visit and communicated to the case manager and physician when needed. Pain level assessment is considered the "fifth" vital sign. Pain management is an interdisciplinary process. The patient's pain, symptoms and control of pain are reported at the team care conference when appropriate.
4. Documentation of pain is to be done at every nursing visit. Documentation would include site, intensity, frequency and methods of relief. Type of pain medication and response would also be documented.
5. It is the expectation of the Agency to improve the patient's pain to the desired level with appropriate medication and non-pharmacologic alternatives.
6. Patient Teaching will be done regarding pain management:
   a. Discuss with the patient and family possible physiological causes of pain that might be specific to patient (e.g., mass pressing on nerve, tumor obstructing bowel, etc.)
   b. Teach the patient and family some non-invasive methods which might help prevent or alleviate pain (e.g., distraction, positioning, range of motion, music, meditation, guided imagery, massage therapy, etc.) **Patient's cultural, ethnic, and religious beliefs, shall be considered.**

c. Discuss with the patient and family concepts of pain and pain management (e.g., reality of pain, variability and individuality of pain perception, etc.) teaching them to include self pain assessment, with ability to rate pain on a scale from 0-10, and identify location, aggravating factors and relieving factors.

~~1. All patients or their family (representative) will be provided with a copy of their Bill of Rights during the admission process. The Bill of Rights will contain information on pain management and our philosophy.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Health~~	~~Distribution: Clinical Staff~~
~~Policies: UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~	
~~Subject: SCOPE OF SERVICES / DESCRIPTION OF SETTING~~	
~~Policy Number: 101~~	

ISSUE DATE: 12/98

SUBJECT: Scope of Services / Description of Setting

REVISION DATE(S): 07/04, 04/05, 01/07, 11/07, 04/08, 02/09, 02/10, 03/11, 02/13, 07/13

POLICY NUMBER: 101

Home Health Care Approval:	02/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To describe Home Health territory, location, and services provided.

B. **POLICY:**
1. Tri-City Home Health is a non-profit, hospital based, program of Tri-City Medical Center. The agency is accredited by the Joint Commission on Accreditation of Healthcare Organizations, licensed by the State of California as a Home Health Agency and Medicare Certified.
2. The offices are located adjacent to Tri-City Medical Center at 2095 West Vista Way, Suite 220, Vista, California, 92083. The physical plant consists of a reception area, offices, office and field staff work areas, medical records storage areas, supply areas and a conference room.
3. Tri-City Home Care services are provided to adult patients (18 years of older) living in the Tri-City service area. The geographic borders range north to Camp Pendleton and east to Fallbrook (excludes north east of the Mission Road exit off I-15 and Rainbow), south to Solana Beach, east to Escondido, west of Valley Center Road and west to the Pacific Coast.

C. **SCOPE OF SERVICES:**
1. Home Health provides skilled intermittent care to individuals with compromised functional abilities and an unstable medical condition requiring interventions of a restorative, rehabilitative or palliative nature at their place of residence. Services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Dietitians and Speech Therapists and Physical Therapy Assistants

D. **DISCIPLINES:**
1. **NURSING**
   a. The role of the Registered Nurse is to assess the total health needs of the patient and develop a plan of care and goals approved and directed by the physician to improve the status of the patient. The plan of care reflects the diagnosis, medications, mental and physical status and environment and may include the need for other members of the

health care team. The Licensed Vocational Nurse assists the Registered Nurse in carrying out the plan of care and reports to the Registered Nurse. ~~and or Rehab Services.~~ Nursing services include, but are not limited to, evaluation/assessment, education to the patient and or caregiver and collaboration with the physician and other members of the team.

2. **PHYSICAL THERAPY**
   a. The goals of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning to the best ability of the patient. Physical Therapy Services shall include, but are not limited to, evaluation, development of treatment plans /goals approved and directed by the physician, instruction, treatment and education. Physical Therapy Assistants, under the supervision of a physical therapist, may be utilized executing the physical therapy plan of care.
3. **OCCUPATIONAL THERAPY**
   a. The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skill required for daily living activities. Services include evaluation and treatment, directed by the physician, for impairments of physical, cognitive and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and or cope with disabling conditions.
4. **SPEECH PATHOLOGY**
   a. Speech Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders with direction from the physician. Areas include, but are not limited to, impairment of articulation, language comprehension and expression, cognition, fluency, voice, reading writing and swallowing. Also provided are education and counseling for families of patients exhibiting the aforementioned disorders.
5. **SOCIAL SERVICES**
   a. Social Services include assessment and evaluation of the patient for the functioning and ability of the patient undergoing disruption of their current status. Social Services provide counseling and referral for community resources and assist members of the team and family when a higher level of care needed for the care and safety of the patient. All Social Services are under the direction of the physician.
6. **CERTIFIED HOME HEALTH AIDES**
   a. Personal care is provided to the patient under the supervision of the RN, OT or PT and direction from the physician. These services may include but are not limited to, personal hygiene and assisting with ambulation and or home exercises.
7. **DIETARY**
   a. The Registered Dietitian, under the direction of the physician and in coordination with other team members, evaluates/assesses the dietary needs of the patient and makes recommendations and provides education based on that assessment.

E. **HOURS OF SERVICE:**
1. Office hours are 8:00 am to 5:00 pm Monday through Friday.
2. Nursing services are routinely available 24 hours a day, seven days a week. The ~~RN Case Manager or O~~on-call RN coordinates this and can be reached for phone contact and/or home visits. Physical Therapy, and CHHA services are available 7 days/week from 8 am to 5 pm. Visits will be scheduled according to the Interdisciplinary Plan of Care, and at the request of the patient, family, or caregiver.
3. Occupational and Speech Therapies, and Medical Social Workers, are available Monday through Friday from 8:00 am to 5:00 pm and other hours by arrangement or as patient/family and staff deem appropriate.

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~12/08~~	~~5/04, 1/05, 4/08, 11/08,~~	~~5/04, 1/05, 11/07, 4/08,~~	~~7/04, 4/05, 1/07, 11/07,~~

	~~12/09, 10/10, 3/11, 6/12~~	~~11/08, 6/13~~	~~4/08, 2/09, 2/10, 3/11, 2/13, 7/13~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 8/04~~
~~REVISION DATE: 6/07, 12/08~~
~~REVIEW DATE: 6/07, 12/08, 5/10, 11/11, 2/12, 6/12~~
~~SUBJECT: STAFF SAFETY~~
~~POLICY NUMBER: 203~~
~~APPROVAL: 10/04,7/07, 2/09, 10/10, 1/12, 3/12, 2/13~~

ISSUE DATE: 08/04
SUBJECT: Staff Safety

REVISION DATE(S): 10/04, 07/07, 02/09, 10/10, 01/12, 03/12, 02/13
POLICY NUMBER: 203

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	
Board of Directors Approval:	

A. **PURPOSE:**
1. To outline safety concerns for Home Health Staff.

B. **POLICY:**
1. It is the Policy of Tri-City Home Health to clearly define safety in the workplace for field staff. TCMC Security will assist the clinician when requested.

C. **GENERAL FIELD SAFETY:**
~~1. Attempts will be made to visit patients during the daylight hours only. Patients and their caregivers will be advised to utilize the area's urgent care facilities or call 911 if they require care during nighttime hours or other arrangements as needed.~~
~~2.~~1. When a staff member enters any area or situation they perceive to be unsafe, their first responsibility is to leave the area or situation. They are to be alert and aware of their surroundings and if something doesn't feel right, they should leave the premises. This action must be reported to the supervisor or supervisor on call.
~~3.~~2. Staff members are to immediately leave any situation if a patient or caregiver becomes physically or verbally abusive. This must be reported to the supervisor or **Administrative** Supervisor on call immediately. Physician notification will also be made. The supervisor will investigate all incidents and determine the appropriate follow up. This follow up may include but is not limited to: reports to local law enforcement, telephone contact with the patient or caregiver, reassessment by other agency personnel or discharge from the Agency.
~~4.~~3. Cellular phones are available to all visiting staff for communication and safety.

D. **VISITING STAFF ARE ADVISED TO:**
1. Be familiar with the destination prior to leaving office/home.
2. Carry identification at all times
3. Avoid lingering groups of people on corners or around doors.
4. Carry keys in hand and keep jewelry to a minimum.
5. Never knock on unmarked doors or doors other than the patient's.
6. Never enter a vacant or what appears to be an abandoned house.
7. If necessary, discuss with supervisor the use of an escort.

8. Always be aware of exits and do not allow your access to an exit to be blocked while in the patient's home.

E. **FIREARMS SAFETY:**

1. The Agency recognizes the significant potential danger that firearms present to the Home Health clinician. If firearms are identified to be in the patient's home, the following apply:
   a. The patient/family/caregiver is instructed that the weapon must be removed and not be present during clinician visits or Home Health service to the patient will be discontinued.
   b. It is mandatory that the supervisor or the on-call Administrative supervisor be called when firearms are identified.
   c. The DPCS or designee will contact the patient, family/ caregiver and reiterate the policy on weapons within the next working day.
   d. If weapons are identified on subsequent visits demonstrating non-compliance, the following individuals must be notified immediately:
      i. DPCS or designee, primary physician and administrator on call
   e. The patient will be discharged from service after the primary physician has been notified.
   f. Threatening behaviors involving firearms and other weapons require immediate staff removal, police notification and discharge of patient from Home Health service.

F. **PET SAFETY:**

1. Approach ~~dogs and other~~ pets in a calm and cautious manner. ~~Always ask~~**Ask** the owner ~~if it's okay before you pet an animal~~ **to secure the pet while making the home visit.**
2. If an animal appears aggressive or if you feel uncomfortable, ask that the animal be leashed, caged, or put in another room.

G. **ILLEGAL DRUG USE/MEDICINAL MARIJUANA:**

1. A patient visit will not proceed if medicinal marijuana is being smoked in the clinician's presence. The patient will be asked to not smoke medicinal marijuana just prior to the visit to avoid the presence of second hand smoke.
2. Any evidence of illegal drug use, drug paraphernalia, or methamphetamine production, should be reported to your Supervisor. Do not confront or question anyone in the home, just conclude the visit and leave the area immediately.

H. **AUTOMOBILE SAFETY:**

1. It is recommended that clinicians in the field keep a half a tank of gas or more in their automobiles at all times. This becomes very important in the event of a disaster.
2. Do not talk on cell phones while driving. Use a hands free device or pull over to the side of the road if deemed safe.
3. Follow all the California rules of the road and wear a seat belt.
4. Use an automobile that is in good working order.
5. Lock valuables in the car trunk prior to the first visit.
6. Park as close to the destination as possible in a well lighted area

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF ~~POLICY MANUAL~~

ISSUE DATE: 09/07	**SUBJECT: Unintended Intraoperative Awareness During General Anesthesia**
REVISION DATE(S): 04/17	**POLICY NUMBER: 8710 – 546**

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

A. **PURPOSE:**
1. To establish a process for preventing and dealing with unintended intraoperative awareness during general anesthesia.

B. **DEFINITION(S):**
1. Anesthesia Awareness: Unintended intraoperative awareness occurs when a patient receiving general anesthesia as the primary anesthetic becomes cognizant of some or all events during surgery, or other procedure. Anesthesia awareness does not include the time before the complete induction of anesthesia, or during intended emergence.
2. Background:
   i. The incidence of awareness during general anesthesia is reported to be greater in patients, for whom a smaller-than-usual dose of general anesthetic is necessary to decrease dangerous side effects (e.g., hemodynamic instability). Procedures identified as typically failing into this category are some cardiac, obstetric, and major trauma cases. Because unintended intraoperative awareness during general anesthesia is not always preventable, health care practitioners should be prepared to anticipate, acknowledge, and manage this occurrence with compassion and diligence.
   ii. Monitoring patients during general anesthesia to prevent intraoperative awareness can be challenging. Despite a variety of available monitoring methods, awareness is difficult to recognize while it is occurring. Typical indicators of physiologic and motor response, such as hypertension, tachycardia, or movement are often masked by the use of neuromuscular blocking agents to achieve necessary muscle relaxation during the procedure, as well as the concurrent administration of other drugs necessary to the patient's management, such as beta-blockers or calcium channel blockers.

C. **GUIDELINES:**
1. Prevention:
   a. Equipment Maintenance:
      i. Periodic maintenance of the anesthesia machines and its vaporizers will be performed and documented.
2. Preoperative Identification:
   a. Certain procedures may entail a higher risk of unintended intraoperative awareness and some patients with certain characteristics may be at an increased risk for the occurrence of intraoperative awareness. These include:
      i. Cardiac surgery patients
      ii. Acute trauma patients with hypovolemia

iii. Cesarean section patients under general anesthesia
iv. Patients undergoing emergency surgery
v. ASA Physical Status 4 and 5 patients
vi. Patients with impaired cardiovascular status
vii. Patients with anticipated difficult intubation
viii. Patients with a history of awareness
ix. Patients with a history of heavy alcohol intake
x. Patients with a history of chronic use of benzodiazepines, opioids or both.
1) Patients considered by the anesthesiologist to present significantly higher risk for an awareness experience should be informed of the potential for awareness in preoperative discussions with their anesthesiologists.

3. Reducing the risk of intraoperative awareness during general anesthesia:
a. The appropriate anesthesia techniques and medications are determined by clinical judgment based on each patient's unique circumstances.
b. The anesthesia provider should consider pre-medication with an agent that may reduce the incidence of awareness (e.g. a benzodiazepine or scopolamine) when deemed appropriate.
c. If intubation of the trachea is difficult, consideration should be given to the administration of additional dosages of the induction or amnestic agent.
d. Anesthesia practitioners should realize that certain medications (e.g. beta-blockers, calcium channel blockers, alpha-2 agonists) and neuromuscular blocking agents may mask the homodynamic and physiologic responses to inadequate anesthesia.

4. Managing an Episode of Unintended Intraoperative Awareness During General Anesthesia:
a. When an anesthesiologist learns that a patient may have had unintended intraoperative awareness of surgical or procedural events during general anesthesia, the anesthesiologist should explore, document, and report the experience and provide for any necessary follow-up care. When other personnel learn that a patient may have experienced unintended intraoperative awareness during general anesthesia, the personnel should inform the anesthesiologist of record about the suspected occurrence.
b. If an episode of unintended intraoperative awareness during general anesthesia occurs or is suspected, the anesthesiologist who was responsible for the patient's care, or a qualified designee, should interview the patient and document the details of the patient's experience. If the anesthesiologist determines that unintended intraoperative awareness during general anesthesia has occurred the following steps may serve mitigate serious patient sequelae:
i. Assure the patient of the credibility of his or account and sympathize with the patient's experience;
ii. Explain what happened and why, if a reason can be given (e.g., the necessity to administer light anesthesia in the presence of significant cardiovascular instability);
iii. Offer the patient support, including referral of the patient to a psychiatrist, psychologist, or the Hospital Counseling Services if appropriate;
iv. Document any referrals or treatment provided to the patient;
v. Notify the patient's surgeon and nurse;
vi. Complete an occurrence report concerning the event for the purpose of quality management.

D. REFERENCES:

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~~D.~~3. **Practice Advisory for Intraoperative Awareness and Brain Function Monitoring:A Report by the American Society of Anesthesiologists Task Force on Intraoperative Awareness. (2006, April 01). Retrieved February 3, 2020, from https://anesthesiology.pubs.asahq.org/article.aspx?articleid=1923386**

~~1. ASA. (2004, Dec. 17). Sample of a policy on unintended anesthesia awareness. Retrieved May 10, 2005 from http://www.asawebapps.org/docs/SampleAwarenessPolicy.pdf~~

~~2. JCAHO (2004, Oct. 6). Preventing and managing the impact of anesthesia awareness. Joint Commission on Accreditation of Health Care Organizations Sentinel Alert, Issue 32. Retrieved May 10, 2005 from http://www.jcaho.org/about+us/news+letters/sentinel+event+alert/sea32.htm.~~

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: **INFECTION PREVENTION - NICU**

ISSUE DATE: **04/16**
REVISION DATE(S): **01/18**

Neonatal Intensive Care Unit~~Department~~ Approval:	**~~02/17~~03/20**
Perinatal Collaborative Practice Approval:	**~~10/17~~03/20**
Infection Control Committee Approval:	**~~10/17~~05/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/17~~06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**~~01/18~~ n/a**
Board of Directors Approval:	**01/18**

A. **PURPOSE:**

1. To define infection prevention practices specific to newborns to prevent infection transmission and to comply with current health, infection prevention and control standards.
2. **Reference housewide infection control policies for additional information**
~~1.~~3. **Adhere to Standard Precautions**
~~2.~~4. A CCS and Title 22 Policy Requirement.

B. **POLICY:**

~~1. The initial source of microbial colonization and infection of the newborn is the mother. In the nursery, the infants themselves are the major source of potential pathogens and strategies should be based on the principle that each infant is a potential source as well as recipient of microorganism. Immature host defenses and invasive procedures permit organisms that colonize the newborn to invade.~~

1. General Statements:
   - a. **Personnel working directly or indirectly with infants in the NICU should not work when sick.**
   - b. **Eating or drinking in the unit is prohibited. Breastfeeding mothers are permitted, and encouraged, to drink water from a covered container.**
   - c. **Hand Hygiene should be performed by all individuals in accordance with World Health Organization Guidelines on Hand Hygiene in Healthcare (Refer to Appendix A & B for step-by-step instructions):**
     - i. **Soap & water should be used when hands are visibly dirty or contaminated, with exposure to blood and body fluids, or if exposure to potential spore-forming organisms is suspected/proven and after using the restroom.**
     - ii. **Alcohol-based hand rub is preferred for routine hand antisepsis in all other clinical situations.**
     - iii. **Perform hand hygiene:**
       1) **When entering the NICU**
       2) **Before and after infant contact**
       3) **Before handling an invasive devise for infant care**
       4) **After contact with body fluids or excretions, mucous membranes, nonintact skin, or wound dressings**

5) **When moving from a contaminated body site to another body site during care of the same infant**
6) **After contact with inanimate surfaces and objects in the immediate vicinity of the infant**
7) **After removing sterile or nonsterile gloves**
8) **Before handling medication or preparing breastmilk/formula.**

iv. **Parents/Visitors should be instructed to wash their hands with soap and water or utilize hand gel after touching their cellphone.**

v. **"Foam in, Foam Out": use of waterless hand sanitizer before entering and after leaving infant rooms/bed spaces should be practiced by all**

2. **Staff Dress Code**

~~a. NICU Specific Hand Hygiene:~~
~~i. Emphasize good hand washing technique.~~
~~ii. In addition to Infection Control: Hand Hygiene – IC 8 policy:~~
~~1) Upon initial entry into the NICU, healthcare workers and visitors who will have patient contact will wash hands, wrists, forearms, and elbows with hospital approved soap and water for two minutes.~~
~~2) Fingernails must be short, clean and in good condition. Nail polish, if worn, must be free of chips or wear.~~
~~3) Visitors to the NICU that will not have patient contact will perform hand hygiene with hospital approved soap or the alcohol based waterless product upon entering the unit.~~
~~4) Gloves will be worn when changing diapers.~~
~~b. Avoid sharing of equipment and supplies.~~
~~c.~~a. Each infant should be supplied with its own dedicated stethoscope.
~~d. Invasive procedures should be used cautiously and with appropriate aseptic or sterile technique.~~

~~2. Personnel Health Standards - all personnel will comply with the following policies:~~
~~a. Administrative: Employee Health and Safety – 477~~
~~b. Employee Health & Wellness: Immunization~~
~~c. Employee Health & Wellness: Blood Borne Pathogens Occupational Exposure~~
~~d. Employee Health & Wellness: Guidelines for Reporting Exposures~~
~~e. Employee Health & Wellness: Work Restrictions for Personnel with Infectious Diseases~~

~~2. Staff Dress Code:~~
~~a. In addition to the Administrative: Dress and Appearance Philosophy – 415:~~
~~i.~~a. Scrub attire will be worn by personnel performing patient care.
~~ii.~~b. ~~Long hair (below the shoulder)~~**Hair longer than shoulder length** will be pulled back.
c. Patient care providers **will maintain "bare arms".** ~~may not wear clothing below the elbows.~~ **No clothing or jewelry (such as watches, rings, and bracelets) may be worn below the elbows.** ~~This includes jewelry such as watches, rings, and bracelets.~~ Personnel should not wear large or dangly jewelry while on duty.
d. **Fingernails must be short, clean and in good condition. Nail polish, if worn, must be free of chips or wear. No artificial fingernails or nail jewelry.**

3. **Bedside Environment & Equipment:**

~~Fingernails must be short, clean and in good condition. Nail polish, if worn, must be free of chips or wear.~~
~~3.~~
~~i. Cover gowns will be worn while holding an infant by all personnel inclusive of volunteers. At the nurse's discretion, visitors may be asked to wear a gown while holding an infant.~~
~~4. Bedside Environment:~~

a. All bedside equipment and counter-space shall be disinfected at the beginning of each shift and when visibly soiled, using hospital approved anti-microbial wipes.

b. Shared equipment is cleaned with hospital-grade cleaner per manufacturer recommendation before use by another infant.
c. Each infant should be supplied with its own dedicated stethoscope.
d. Do not stock more than 24 hour's worth of supplies at any infant's bedside.
~~a.~~e. Manufacturer's guidelines for supply use and disposal shall be followed.

4. Infant Management:
   a. Upon admission, all infants are checked for signs of infection and placed on isolation precautions as indicated.
   b. Infants admitted from home or another facility will be placed on Contact Precautions until a known infectious disease process can be ruled out.
5. Family Presence in the NICU
   a. All individuals will be interviewed regarding the following prior to admittance to the NICU:
      i. Exposures: visitors who have had exposure to chickenpox, measles, tuberculosis, or other contagious diseases will not be allowed to visit.
      ii. Signs of infection: visitors with signs of infection, including but not limited to, nausea, vomiting, cough, sneezing, sore throat, conjunctivitis, and draining wounds, will not be allowed to visit for the duration of the illness (signs and symptoms are resolved).
      iii. Fever: No admittance will be granted to the NICU if the visitor presents with a temperature greater that 100.4 degrees Fahrenheit. Re-admittance to the NICU will be allowed when the visitor is afebrile for 24-hours.
         1) Exception: Mothers that are febrile as a result of infections of nontransmissible concern may visit if:
            a) The mother is afebrile times one.
            b) Fever is cleared by OB as being of a non-transmissible origin.
      iv. For the following conditions, parents should adhere to the following guidelines (all others should not visit until completely healed):
         1) Herpes Simplex Virus (Oral Herpes Lesion)
            a) Parents with oral herpes lesions should wear a surgical mask and practice thorough hand hygiene when touching their infant until lesions are completely crusted over.
            b) Parents should not kiss or nuzzle the newborn until lesions have cleared.
         2) Shingles
            a) Parents with shingles must remain home until lesions are dry and crusted over. Lesions should be covered until clear.
         3) Rashes
            a) Parents with an undiagnosed rash will be instructed to see their personal physician for diagnosis and treatment. No admittance will be allowed until cleared by a physician.
         4) Individuals exposed to varicella (chicken pox) without evidence of immunity (documentation of immunization or a history of disease) will not be admitted to the NICU for 21 days. Clearance to return will be determined by the healthcare team in conjunction with the Infectious Disease Department (ID).
         5) Individuals who are diagnosed with measles or rubella will not be allowed to visit until 7 days after the onset of rash.
   ~~B.~~b. Visitation in the NICU will be restricted during cold/flu season per hospital policy.

C. RELATED DOCUMENT(S)~~APPENDICES~~:
1. ~~Appendix A~~Rub Hands for Hand Hygiene! Wash Hands When Visibly Soiled
~~C.~~2. Wash Hands When Visibly Soiled! Otherwise Use Hand Rub

D. **REFERENCES:**

1. American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (2017). Guidelines for perinatal care (8th ed.).
2. 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;51 (No.RR-16:1-45)

~~1. Skin Care:~~
~~a. All skin care will be provided per the NICU: Standards of Care – NICU or as directed by the physician/Allied Health Professional (AHP).~~
~~2. Eye Care:~~
~~a. Reference Patient Care Services: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure.~~
~~3. Transmission Reduction Methods:~~
~~a. Reference Infection Control: Standard and Transmission- Based Precautions – IC5~~
~~b. Airborne, Droplet, and Contact Precautions:~~
~~i. Reference Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11~~
~~ii. Reference Infection Control: Type and Duration of Precautions for Selected Infections and Conditions IC 5-1r11~~
~~c. NICU Methicillian Resistant Staphylococcus Aureus (MRSA) Contact Precautions:~~
~~i. Infants with a positive MRSA screen will remain on contact precautions for the length of their stay.~~
~~ii. Infants transferring to the NICU from another facility will be placed on Contact Precautions until an in house MRSA screen done on admission is resulted.~~
~~d. Infant Readmissions:~~
~~i. Infants readmitted to the NICU from home are to be isolated using Contact Precautions until a known infectious disease process can be ruled out.~~

~~D. RELATED DOCUMENT(S):~~
~~1. Administrative: Dress and Appearance Philosophy – 415~~
~~2. Administrative: Employee Health and Safety – 477~~
~~3. Employee Health & Wellness: Blood Borne Pathogens Occupational Exposure~~
~~4. Employee Health & Wellness: Guidelines for Reporting Exposures~~
~~5. Employee Health & Wellness: Immunization~~
~~6. Employee Health & Wellness: Work Restrictions for Personnel with Infectious Diseases~~
~~7. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11~~
~~8. Infection Control: Hand Hygiene – IC 8~~
~~9. Infection Control: Standard and Transmission- Based Precautions – IC5~~
~~10. Infection Control: Type and Duration of Precautions for Selected Infections and Conditions IC 5-1r11~~
~~11. NICU: Standards of Care – NICU~~
~~12. Patient Care Services: Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure~~

~~E. REFERENCE(S):~~

~~1.~~3. ~~APIC Text Online (2016) Chapter 41 Infection Among Neonates. Http://text.apic.org~~Kimberlin D.W., Brady, M.T., Jackson, M.A., Long, S.S. (Eds.). (2018). *Red book: 2018-2021 report of the Committee on Infectious Diseases* (31st ed.). Itasca, IL: American Academy of Pediatrics
4. World Health Organization (2009). WHO guidelines on hand hygiene in health care: First global patient safety challenge. Clean care is safer care. WHO Press.
~~2. Guidelines for perinatal care 7th edition (AAP/ACOG 2012) chapter 11.~~

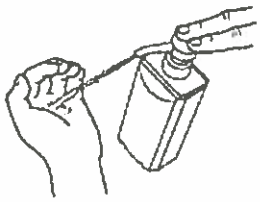
~~3. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings~~

Rub Hands for Hand Hygiene! Wash Hands When Visibly Soiled

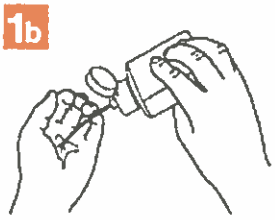
RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a



1b

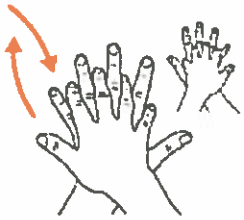


Apply a palmful of the product in a cupped hand, covering all surfaces;

2

Rub hands palm to palm;

3

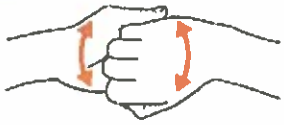


Right palm over left dorsum with interlaced fingers and vice versa;

4

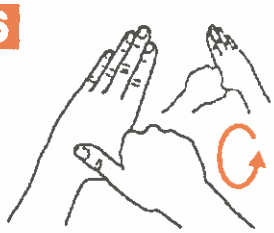
Palm to palm with fingers interlaced;

5



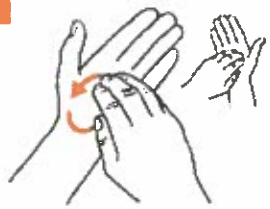
Backs of fingers to opposing palms with fingers interlocked;

6



Rotational rubbing of left thumb clasped in right palm and vice versa;

7



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

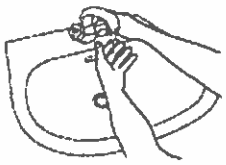
Once dry, your hands are safe.

~~Appendix B~~

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0



Wet hands with water;

1

Apply enough soap to cover all hand surfaces;

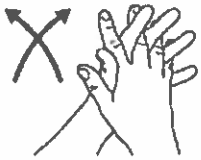
2

Rub hands palm to palm;

3

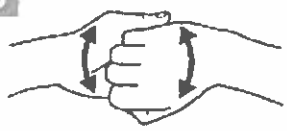
Right palm over left dorsum with interlaced fingers and vice versa;

4



Palm to palm with fingers interlaced;

5



Backs of fingers to opposing palms with fingers interlocked;

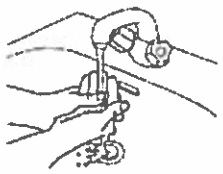
6

Rotational rubbing of left thumb clasped in right palm and vice versa;

7

Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;

8

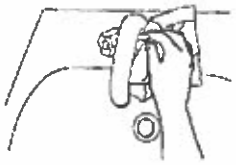


Rinse hands with water;

9

Dry hands thoroughly with a single use towel;

10



Use towel to turn off faucet;

11

Your hands are now safe.

Tri-City Medical Center	Women a **DELETE – no longer perform**
PROCEDURE:	**TRANSPYLORIC TUBE, INSERTION, MAINTENANCE, AND REMOVAL OF**
Purpose:	To facilitate nutrition to infants who are unable to take adequate calories orally or through a nasal/oral gastric tube due to problems related to gastro esophageal reflux, apnea and bradycardia, or assisted ventilation.
Supportive Data:	Nasojejunal feedings are most often used when there is a danger of pulmonary aspiration. The pyloric sphincter and peristalsis of the small bowel provides a barrier that lessens the risk of regurgitation and aspiration.
Equipment:	1. Enteral tube (type and size appropriate for intended purpose) 2. Non-sterile gloves 3. Hydrocolloid dressing or appropriate skin protective barrier 4. Transparent dressing 5. 5-10 ml syringe 6. Stethoscope 7. Water-soluble lubricant or sterile water 8. Syringe feeding pump and extension tubing.
~~Issue Date:11/08~~	**DELETE**

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

~~1. Insertion~~

~~a. Obtain physician or Allied Health Professional order for placement of transpyloric tube and KUB x-ray for confirmation of placement after insertion.~~

~~b. Perform hand hygiene and apply non-sterile gloves.~~

~~c. Assemble appropriate equipment.~~

~~d. Confirm patient identity using two identifier system.~~

~~e. Position patient on right side and head of bed elevated to 30-45 degrees.~~

~~f. Immobilize patient as needed.~~

~~g. Determine the length of tube to be inserted by measuring the tube from the tip of the nose to the earlobe, and from the earlobe to the termination of the xiphoid process, then from the xyphoid process to the right lateral costal margin.~~

~~h. Mark the measured distance on the tube with a small piece of tape or make a note of the pre-printed centimeter measurement on the tubing.~~

~~i. Lubricate the distal end of the tube with sterile water or water soluble lubricant.~~

~~j. Insert the tube gently through the nares, aiming down and back.~~

~~k. If there appears to be resistance, ***do not force***. Try rolling the enteral tube gently. If still unable to pass the enteral tube, remove it and try the other nostril. Do not pass the enteral tube beyond the original mark until further assessment is made. Remove enteral tube at once if there are signs of distress, coughing, gasping, apnea, bradycardia or cyanosis.~~

~~l. Allow the patient to stabilize and resume insertion procedure.~~

~~m. Continue to pass enteral tube until marked position is at the tip of the nostril or at the lip.~~

~~n. After approximately 10 minutes with infant still positioned on the right side, Verify placement of tube by gently aspirating with a syringe. The tube should be correctly placed if the aspirate has no air (snap back) or is bilious (gold or yellow in color).~~

~~o. If tube is not in far enough, retape to give external slack and allow peristalsis to advance the tube to the correct position. Avoid pushing the tube for advancement after initial placement. If the tube does not cross the pyloris within the first 30 minutes of placement it most likely won't and the procedure should be restarted.~~

~~p. Secure tube in place with transparent dressing and obtain x-ray confirmation before use.~~

Department Review	Perinatal Collaborative Practice~~Division of Neonatology~~	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 5/15, 03/20	5/15, 03/20	n/a	8/15, 06/20	07/20	09/15 N/A	9/15

q. Place a small label with insertion centimeter marking and date on enteral tubing just below the hub.
r. Discard used supplies and gloves in appropriate receptacle.
s. Perform hand hygiene.
t. Document the following in the patient's medical record:
    i. Date, time, tube size, tube location, and length of the tube at the mark located at the mouth or nostril.
    ii. Tolerance of the procedure.

2. Maintenance:
a. Ongoing proper placement is verified by:
    i. Measuring the distance from nares to the distal end of the transpyloric tube every shift.
    ii. A "snap-back" upon aspiration of the plunger on a syringe.
    iii. Residuals do not need to be checked when feeding through a transpyloric tube.
b. Refer to physician orders for feedings. Feedings should be delivered at a continuous rate with a pump that can detect obstruction. Infusion duration is never to be less than two hours. NO BOLUS FEEDINGS.

3. Removal:
a. Removal of the transpyloric tube:
    i. Perform hand hygiene and apply non-sterile gloves.
    ii. Remove transparent dressing using warm water or saline prep pad.
    iii. Pull tube out of nose in a steady motion. If resistance is encountered, rotate the tube and again attempt removal. The tube should not be forced out. If resistance continues to be met, location of the tube may need to be verified using x-ray.
    iv. Discard used supplies and gloves in appropriate receptacle.
    v. Document the procedure in the patient's medical record.

B. **REFERENCES:**

1. Gomella, Tricia Lacy, M. Douglas Cunningham, and Fabien G. Eyal, eds. *Neonatology: management, procedures, on-call problems, diseases, and drugs*. 7th. New York: McGraw Hill Education Lange, 2013.
2. MacDonald, M., J. Ramasethu, and K. Rais-Bahrami. *Atlas of procedures in neonatology* (5th ed.). Philadelphia: Lippincott, Williams, & Wilkins. 2012.
3. Merenstein G.G. & Gardner S.L. (2011). Handbook of neonatal intensive care, 7th Ed. St. Louis, MO. Mosby.

Tri-City Medical Center	Women's & Children's Services Manual - NICU
PROCEDURE:	**THERMOREGULATION FOR VLBW AND ELBW INFANTS ≤32 WEEKS AND/OR 1500 GRAMS**
Purpose:	To achieve a core axillary temperature upon admission to NICU of 36.~~5~~6 C to 37.5 C.
Supportive Data:	Protecting VLBW infants ≤32 weeks gestation and/or 1500 grams against excessive heat loss will dramatically reduce their oxygen consumption and improve their chances for survival.
Equipment:	1. Transporter 2. Hybrid isolette 3. Radiant warmer ~~4. Chemical blanket (if using radiant warmer)~~ ~~5.~~4. Polyethylene **wrap**~~sheet or bag (neo wrap)~~ 5. **Thermal**~~Porta~~ mattress 6. **Infant hat**
~~Issue Date: 9/08~~	~~Revision date(s): 6/09, 6/11, 8/12~~

A. **PROCEDURE:**

1. Prior to delivery:
   - a. **Confirm with respiratory care therapist that a** ~~Have~~ pre-warmed transporter **is checked and ready for transport.**~~prepared with polyethylene sheet/bag and porta mattress.~~
   - ~~b. Preheat delivery room radiant warmer. Turn to manual maximum heat.~~
     - ~~i. If needed, turn on chemical blanket set to 102 – 105 degrees and place under one to two layers of blankets.~~
   - **b. Prepare ventilator at the bedside including pre-warming the ventilator circuit with humidity.**
   - ~~c. IAutomatic admission to hybrid isolette if ≤32 weeks gestational age and/or ≤1500 grams.~~ **Prepare hybrid bed with pre-warmed linens, fluidized positioner mattress and sterile water for humidity.** ~~If admitting infant to hybrid isolette, turn it on and DO NOT use chemical blanket.~~
2. ~~Once NICU team is called to the delivery room:~~
   - ~~a. Take pre-warmed transporter with polyethylene sheet/bag (neo wrap) and porta mattress.~~
3. ~~3.~~2. ~~I~~n the delivery room:
   - **a. Prepare hybrid bed with pre-warmed linens, fluidized positioner mattress and sterile water for humidity**
   - **b. Increase delivery room temperature to 23° to 25°C (74° to 77°) for duration of delivery if possible.**
   - **c. Preheat**~~Set~~ radiant warmer **on manual mode at**~~to~~ 100% power.
   - ~~a.~~**d. Activate the thermal mattress at least 5 minutes prior to delivery.**
   - **e.** ~~Lay pre-warmed towels out.~~ Place polyethylene **wrap and infant hat on top of the** ~~sheet/bag and porta~~**thermal** mattress **on** ~~under~~**the preheated** radiant warmer.
   - ~~b.~~**f. Prepare drape to receive infant.** ~~to warm.~~
   - ~~c. Prepare warm dry towels to receive infant. Increase delivery room temperature to 26.0 – 28.0°C for duration of delivery if possible.~~
4. ~~4.~~3. Upon delivery of infant:
   - a. **Place infant directly into polyethylene wrap and apply hat. Apply pulse ox probe, temp probe and EKG leads (if available) to infant and switch radiant warmer to servo mode to help regulate infant's temperature. Drying the body is not necessary.** ~~Lay infant on warmed towels, NOT polyethylene sheet (neo wrap). Dry and~~

NICU Department Review	Perinatal Collaborative Practice	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/20	03/20, 05/20	n/a	06/20	07/20	n/a	09/08, 6/09, 6/11, 8/12

~~stimulate as needed. *If infant is 28 weeks or less, DRYING IS NOT RECOMMENDED, except for the head (always dry the head).~~

b. Monitor infant's temperature in the delivery room and adjust warming measures to ensure ideal core temperature of 36.5°to -37.5°C

~~b. Infant may be wrapped directly in neo wrap after dried.~~

~~c. Place hat on infant.~~

c. Once stabilized, ~~,~~ Pplace wrapped infant **and thermal mattress** in pre-warmed transporter ~~on porta mattress~~

d. **-Position infant in a developmentally supportive position with head midline** and transport to the NICU.

~~5.~~**4.** Admission to NICU:

a. Transfer wrapped infant ~~and~~ without thermal mattress to humidified hybrid bed and place infant on servo mode. ~~Sides of bed should remain up to reduce convection heat loss.~~

b. Close hybrid top if there are no immediate procedures (central line placement, intubation, etc.).

a. Weigh the infant in the polyethylene **wrap.**

~~During procedures such as central line placement, maintain polyethylene wrap to reduce trans epidural water loss and evaporative heat loss. Make an opening in the polyethylene wrap to access umbilical cord.~~

b. Maintain infant in the polyethylene wrap until neutrathermia and desired humidity are achieved.

~~a.~~**c. Continue to monitor infant's temperature every 15 minutes for the first hour of life and then hourly until a neutral thermal environment (NTE) is achieved. Remove plastic wrap and discard after NTE is achieved. If at any time the temperature decreases, consider covering infant from shoulders down with polyethylene wrap.**~~sheet (neo wrap) only. Zero the scale with another polyethylene sheet. If admitted to hybrid isolette, weigh with hybrid scale.~~

~~b. Place infant on either radiant warmer with chemical blanket covered with blankets or directly into pre-warmed hybrid isolette. DO NOT use chemical blanket with hybrid isolette. Remove polyethylene sheet once infant is in hybrid isolette. Always place baby on servo mode in both radiant warmer and hybrid.~~

~~c. When required temperature for chemical blanket is <100 degrees, turn blanket off and remove from under baby. Once chemical blanket is turned off, NEVER leave under the baby. Maintain infant on servo mode. Wean chemical blanket before ambient heat.~~

~~d. Do not forget to remove the chemical blanket before an x-ray is taken.~~

~~**Once in the NICU, M**maintain infant in the polyethylene wrap until neutrathermia and desired humidity are achieved.~~ **If polyethylene wrap becomes soiled, may place infant in new clean polyethylene wrap.** ~~**Monitor temperature hourly until a neutral thermal environment (NTE) is achieved.**~~

~~**Remove plastic wrap and discard after NTE is achieved. If at any time the temperature decreases, consider covering infant from shoulders down with polyethylene wrap.**~~

~~During procedures such as UVC/UAC line placement, **maintain polyethylene wrap to reduce trans epidural water loss and evaporative heat loss. M**make an opening in the middle of the polyethylene **wrap**sheet (neo wrap) to access umbilical cord.~~

~~**Close isolette top as soon as lines are placed and provide relative humidity as ordered.**~~

~~**Perform essential interventions and place the infant in a developmentally supportive position.**~~

d. Isolette should remain in the closed position. The only time the isolette should be in the open position is for procedures including ~~umbilical line placement, PICC insertion,~~central line placement or intubation. All other cares should be performed through the isolette port holes.

i. **During procedures maintain polyethylene wrap to reduce trans epidural water loss and evaporative heat loss. Make an opening in the polyethylene wrap to access umbilical cord**

ii. **Utilize the Air Boost feature on the Giraffe Beds to improve thermal performance when the portholes are opened or after the top has been open and closed.**

~~a.~~ **If able to maintain sterile field, c~~C~~lose the top of the isolette while waiting for X-ray confirmation after the lines are inserted.** ~~**Maintain the sterile field.**~~

e. **In order to maintain the neutral thermal environment, there should be minimal entry into the isolette.**

i. **Provide all routine cares and assessments through the port holes.**

~~b.~~ii. **No more than two people should provide hands-on care at any one time**

Coordinate assessments/exams with all healthcare providers including nursing, respiratory and medical team.

iii. ~~**Temperature decreases when the isolette cover is raised and while providing cares/treatments to the infant. The ultimate goal is to provide and maintain a neutral thermal environment. To achieve this goal, limit the amount of time the isolette cover is in the raised position. Provide all routine cares and assessments through the port holes.**~~

~~e. Always maintain baby on servo control mode.~~

~~f. Utilize warmed normal saline or sterile water for hygiene care needs, i.e., eyes, buttocks, and neck creases.~~

~~2. Rewarming:~~

~~a. In a radiant warmer, set the skin temperature to 36.5C to 37.0C to produce gradual re-warming, and to 1-degree Celsius above the core temperature to produce slow re-warming. 37.0C for extreme preemie less than 28 weeks gestation.~~

~~3.~~2. Use of Humidity:

a. Verify written order from physician for humidity.

b. Infants <32~~0~~ weeks shall be admitted to giraffes and placed in ~~humidity of 70% - 90%~~**80% humidity** for first seven days. **Skin emollients should not be used unless ordered by neonatologist.** ~~Aquaphor is not used during this time unless otherwise ordered by neonatologist or on a localized skin breakdown.~~

c. Use only sterile water in humidifier reservoir and check level each shift.

d. **On day of life 8, d~~D~~ecrease humidity by 10~~to 50~~% every shift until at 50%.** ~~after first seven days of life and continue until infant reaches 28 days of life. Aquaphor~~ **Skin emollients** may be used at this level of humidity if there is evidence of skin breakdown.

~~d.~~e. **At 32 weeks PCA or 28 days of life, humidity may be weaned to 40% and then discontinued after 12 hours if infant temperature is stable.**

~~e.~~f. If rainout occurs, decrease humidity by 5% until no further rainout is present.

~~4. Use of Aquaphor:~~

~~a. Apply Aquaphor every 8 to 12 hours per physician order for seven days if humidity not in use.~~

~~B. EXTERNAL LINKS:~~

~~C.~~B. REFERENCES:

~~1. American Heart Association. (2011). Neonatal *Resuscitation Program, 6th Edition.*~~

1. AWHONN/NANN (2008). Evidence-Based Clinical Practice Guideline Neonatal Skin Care, 2nd Edition.
2. **Beauman, S. S., & Bowles, S. (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th ed.). Chicago, IL: National Association of Neonatal Nurses.**
3. Fanaroff & Martin. (2006). The Thermal Environment of the Newborn Infant. *Neonatal-Perinatal Medicine Disease of the Fetus and Infant.*

4. Nosherwan, A., Cheung, P.-Y., & Schmölzer, G. M. (2017). Management of Extremely Low Birth Weight Infants in Delivery Room. *Clinics in Perinatology*, *44*(2), 361–375. doi: 10.1016/j.clp.2017.01.004
5. Verklan, T., Walden, M. (2015). Thermoregulation (pp 104-105). Core curriculum for neonatal intensive care nursing (5th ed.,pp. 290-299). St Louis, MO: Saunders
~~3.~~6. Weiner, G., Zaichkin, J., & Kattwinkel, J. (Eds.). (2016). *Textbook of neonatal resuscitation* (7th ed.). Elk Grove Village, IL, IL: American Academy of Pediatrics.
~~4. Implementation of Potentially Better Practices for the Prevention of Brain Hemorrhage and Ischemic Brain Injury in Very Low Birth Weight Infants. (2003). *Pediatrics*, 497-503.~~
~~5. Finer, N. (2006). Organize Delivery Room Care of the VLBW as you would NICU Care. *VLBW Tool Kit - Tool Kit CPOCC Best Practices Related to VLBW Delivery.*~~
~~6. World Health Organization, 1997.~~
~~7. Omeda Medical Giraffe OmniBed Product Manual.~~

~~D. **APPROVAL PROCESS:**~~
~~1. Clinical Policies & Procedures Committee~~
~~2. Nurse Executive Council~~
~~3. Medical Executive Committee~~
~~4. Professional Affairs Committee~~
~~5. Board of Directors~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT FORENSIC CLINIC

ISSUE DATE: 3/11

SUBJECT: Age Specific Guidelines

DELETE. No longer needed

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**if affect Medical Staff activities or patient care, if not n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~A. **PURPOSE:** This Guideline has been developed to:~~

~~1. Address the age-specific needs of various groups of patients that may be treated at the Clinic.~~
~~2. Provide optimal age-specific care for the patient population served in the Clinic.~~

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

~~1. The program has been designed to meet the specific medical needs of the adult/ geriatric population.~~
~~2. In the event that a patient from another age group is treated at the Clinic, age-specific guidelines will be utilized to optimize care.~~
~~3. Age-related needs will be considered in the plan of care for each patient.~~
~~4. Equipment and supplies used in the care of patients will be age-specific.~~
~~5. Other resource persons/departments will be consulted as needed to validate and enhance the care provided.~~
~~6. Employee performance appraisals will reflect age-specific evaluation.~~

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

~~1. An age-specific plan of care will be developed for each patient treated at the Clinic.~~
~~2. Age-specific factors/elements of care associated with each age group will be addressed during every encounter by the clinic staff using the tables below.~~
~~3. Appropriate intervention specific to each age group will be identified during the initial visit and reviewed periodically for appropriateness and documented in the medical record.~~
~~4. Physical limitations/impairments, as well as learning or other deficits, will be considered when implementing educational/training measures and documented in the medical record.~~
~~5. The education provided will be given at the level of understanding for each patient.~~
~~6.~~1. ~~Resource materials, persons and departments will be consulted to ensure appropriateness of the~~ treatment plan.

~~Attachment:~~
~~Age Specific Guidelines~~

ADULT (19-65)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Prone to health problems related to an inability to cope with new responsibilities Suicidal tendencies, alcoholism, drug abuse, eating disorders, tobacco abuse may surface Healthcare needs are related to preventative medicine to reduce the occurrence of chronic physical or emotional problems Adjustment to menopause (females) and sexual dysfunction (males) as they approach middle adulthood		Focused on time constraints and only want to learn what is practical for them May be dual caretakers (i.e. parent and children)	Emotional stress due to mate selection, vocational selection, assuming occupational roles, marriage, childbearing, financial pressures, and independence	• Communication: Involve family in patient's care and education. When educating adult patients, explain the benefits of adhering to treatment plan; otherwise, education may not be effective. • Equipment: Refer to manufacturer's instructions.

Attachment 1

GERIATRIC (66 and beyond)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Decreased tolerance to heat/cold Increased wrinkles Declining cardiac/renal function Bones become more prominent/stiff joints Increased susceptibility to infection Increased susceptibility to high blood pressure Shrinkage in intervertebral disc Skeletal changes Skin changes Decreased organ functioning; decreased drug clearance and distribution	Decreased mobility Decreased ability to respond to stimuli Decreased visual acuity Hearing loss Decreased tolerance to pain Hesitant to respond; skills declining	Decrease in memory, slowing of mental functions Slower in learning Drop in performance	Concern for health increases Acceptance of death Decreased authority and autonomy Children leave home; become grandparents; reestablish as a couple Retirement/may pursue second career, hobbies Depression related to decreased physical, motor and cognitive abilities Concern related to limited income	• Patient and Family Education: Explain any instructions well to the patient & family. Don't assume that the patient understands anything. Ask the patient questions to verify understanding. Review important points repeatedly. • Communication: Explain all instructions well. Involve the patient in the examination. Use therapeutic touch as appropriate. • Environment/Safety: Keep room clutter free; orient patient well to surroundings. Frequently assess room temperature to patient comfort. • Use of medical equipment: Refer to manufacturer's instructions.

DELETE- Follow Emergency Operations Procedure Manual General Information

ISSUE DATE: 05/11 **SUBJECT:** Bomb Threat

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. To establish procedure guidelines in the event of a bomb threat emergency.~~

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

~~1. In the event the Clinic has been placed on alert for a threat of a bomb, the personnel will follow hospital emergency shutdown procedures.~~

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

~~1. Guidelines for patient evacuation to the determined safe location will be followed.~~

~~2. California Department of Corrections and Rehabilitation (CDCR) Officers will secure the patients in their wheelchairs and/or those who are ambulatory escort them out of the rear entrance of the building.~~

~~a. During emergent evacuation of the building the patients will remain in the care and custody of the CDCR Officers.~~

~~b. Evacuate the patients following the emergency evacuation route specified for the clinic.~~

~~c.~~a. ~~When appropriate, make contact with the hospital command post to give all names of patients, CDCR Officers, staff, and physicians assigned for a "head count"~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT FORENSIC CLINIC

DELETE -Combined with Outpatient Specialty Services Clinid Policy: Continuum of Care

ISSUE DATE: 03/11

SUBJECT: Collaboration/Continuity of Patient Care

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**04/20**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

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

~~1. To outline the steps taken at the Clinic to provide for individualized patient care while still allowing patients to maintain their California Department of Corrections and Rehabilitation (CDCR) primary care physician (PCP) at the institution the patient came from.~~

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

~~1. All patients will be given an individualized plan of care that will be coordinated with the patient's CDCR PCP, whenever possible.~~

~~2. The clinic physician will communicate with the CDCR PCP (as well as any other physicians/medical agents/agencies involved with patient care) after the initial visit, and periodically as indicated.~~

~~3. Confidentiality of patient medical information will be maintained according to State, Federal, and the California Department of Corrections and Rehabilitation requirements.~~

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

~~1. After the initial evaluation the Clinic physician will document his/her recommendations of care on the Request for Services from the institution and dictate the recommendations and plan of care.~~

~~2. Documentation of the recommendation for care will be addressed in the physician's notes. A copy of all correspondence will be maintained in the medical record.~~

~~3. Physician dictated records from the clinic will be faxed to the CDCR at the institution following HIPAA guidelines/hospital policy.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALTY SERVICES~~FORENSIC~~ CLINIC

ISSUE DATE: 05/11

SUBJECT: Arrival ~~Custody~~ of Justice Involved Patient to Clinic

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish procedure guidelines when ~~custody~~**justice involved** patients arrive and **are** seen in the Clinic.

B. **POLICY:**

1. To ensure the safety of the patients and staff when ~~custody~~**justice involved** patients are entering and exiting the Clinic.

C. **PROCEDURE:**

1. ~~Custody~~**Justice involved** patients will arrive by van accompanied by California Department of Corrections and Rehabilitation (CDCR) Officers at the rear entrance of the Clinic.
2. CDCR Officers will assist the patients from the van into a wheelchair that the patient will be shackled to. For those not requiring a wheelchair they will be escorted by an officer.
3. CDCR Officers will ring the intercom to notify the Clinic staff they have secured the patient and ready to enter the Clinic.
4. Clinic staff will acknowledge the CDCR Officers by the video monitor and release the door for entry.
5. CDCR Officers will transport the patients in their wheelchairs or escort those walking to the waiting area until they are called to the examination room.
6. The CDCR Officer will remain with the patient during the examination.
7. After the physician has seen the patient the CDCR Officer will transport the patient back to the waiting area until all patients have been seen and are ready for discharge.
8. CDCR Officers will transport the patients out the rear entrance of the Clinic and place them back into the van for transportation back to the institution.

Tri-City Medical Center
Oceanside, California

OUTPATIENT FORENSIC CLI

DELETE: Follow Administrative Policies Protected Health Information

ISSUE DATE:

SUBJECT: Data Management

REVISION DATE(S): 03/17/2020

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Effective use and management of patient data is crucial to the service appraisal process and enhancement efforts. Properly managed data can provide vital information about:~~

~~a. The population served~~
~~b. Patient progress/outcomes~~
~~c. Resources utilized~~
~~d. Resources needed~~
~~e. Compliance with plan of care~~
~~f. Efficacy of the treatment plan~~

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

~~1. It is the intent of the clinic to collect and properly manage data to benefit the patients being treated at the Clinic.~~

~~2. Patient information will be handled following all applicable confidentiality regulations, hospital policies, and those of the California Department of Corrections and Rehabilitation (CDCR).~~

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

~~1. The patient information to be included in the patient's chart/Cerner , but is not limited to, is:~~

~~a. Demographics~~
~~b. Referral source~~
~~c. Clinic physician~~
~~d. Primary care physician~~
~~e. Diagnoses~~
~~f. Diabetes information~~
~~g. Wound assessment information~~
~~h. Wound classification~~
~~i. Procedures performed~~
~~j. Insurance information~~
~~k. Acuity of the patient~~
~~l.a. Patient goals~~

Tri-City Medical Cent
Oceanside, California

DELETE. Follow Administrative Policies Protected Health Information

OUTPATIENT FORENSIC CLI

ISSUE DATE:

SUBJECT: Disseminating Medical Information

REVISION DATE(S): ~~03/17/2020~~

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Patient privacy and confidentiality regulations prohibit the arbitrary sharing of medical information to protect the patient from indiscriminate use. This policy outlines the procedure the Clinic follows when disseminating patient information.~~

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

~~1. All applicable State, Federal, and California Department of Corrections and Rehabilitation regulations and hospital policies will be adhered to when disseminating or requesting patient confidential medical data.~~

~~2. Patient information may be obtained without the patient's consent in accordance with the California Department of Corrections and Rehabilitation.~~

~~3. To the extent possible, medical information will be guarded against loss, destruction, tampering, and unauthorized access.~~

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

~~1. Patient information will be faxed by the Medical Records department to the California Department of Corrections and Rehabilitation institution where the patient is currently incarcerated.~~

~~2. Faxed information will be accompanied by a fax cover sheet, which states that information received in error should not be shared with anyone except with those for whom the information was intended.~~

~~3. If it is received in error, it is requested that the Clinic be notified immediately by telephone and return the original message to us at the address on the form.~~

~~4.~~1. ~~Request for any and all clinic records will be handled, per hospital policy.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT FORENSIC CL

DELETE. Follow policy for Emergency Operation Plan

ISSUE DATE: **SUBJECT: Emergency Evacuation**

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. To establish evacuation procedures in the event of a fire, earthquake, bomb threat or any situation that places employees, patients, physicians, and California Department of Correction and Rehabilitation (CDCR) Officers in imminent danger in the Clinic.~~

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

~~1. All staff will be trained in emergency evacuation procedure.~~

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

~~1. Any emergency event of a fire, earthquake, bomb threat, or any situation that requires evacuation of the Clinic employees, patients, physicians, and CDCR Officers the Clinic personnel will:~~

~~a. Calm patients and assure their safety~~

~~b. CDCR Officers will remove the patients who are in immediate danger first.~~

~~c. During emergent evacuation the patients will remain in the care and custody of the CDCR Officers.~~

~~d. Activate the hospital emergency notification system giving the exact location of the event, if applicable~~

~~e. Using the designated emergency exits, evacuate all patients to the designated area, as instructed by the appropriate authority.~~

~~f.~~a. ~~The Clinic Manager, RN, or Medical Assistant will account for all employees, patients, physicians, and CDCR Officers and report to the hospital safety officer or representative and/or fire department staff, if present.~~

Tri-City Medical Cent
Oceanside, California

Delete. Follow Environment of Care Manual Life Safety Management

OUTPATIENT Speciality Services Clinic ~~FORENSIC CLINIC~~

ISSUE DATE:

SUBJECT: Environment of Care

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. In order to provide a safe environment for patients, California Department of Corrections and Rehabilitation (CDCR) Officers, and staff, this policy identifies each aspect of the hospital's safety/EOC program as it relates to the clinic environment.~~

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

~~1. Patients and CDCR Officers to the Clinic can expect a safe and sanitary environment.~~
~~2. Associates of the Clinic will be ensured of a safe and sanitary work environment.~~
~~3. Members of the staff will be competent in the safety/EOC standards set forth by the hospital.~~
~~4. The Clinic manager is responsible for the implementation of the safety/EOC program per hospital standards.~~

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

~~1. All staff members will be knowledgeable of and comply with the safety standards of the hospital.~~
~~2. The Safety/EOC policies and procedures will be readily available to all associates and is located within the Safety / EOC Policy & Procedure manual.~~
~~3. The hospital will provide safety/EOC training during the general orientation program each associate receives in the 30 day period from the date of hire.~~
~~4. A unit specific safety orientation will be presented to the new associate within the orientation period.~~
~~5. Safety/EOC related in services will be presented at the monthly staff meetings.~~
~~6. All associates will complete the annual competency requirements of the safety/EOC program, as required by the hospital.~~
~~7. Safety related incidents will be reported immediately, per hospital Incident Reporting policy.~~
~~8. Topics/issues/plans to be addressed in the safety/EOC presentations include but are not limited to:~~
~~a. Safety management~~
~~b. Disaster~~
~~c. Emergency preparedness~~
~~d. Life safety~~
~~e. Utility management~~
~~f. Bioterrorism preparedness~~
~~g. Bomb threats~~
~~h. OSHA's exposure control plan for bloodborne pathogens~~
~~i. TB control plan~~

j. Electrical power safety
k. Loss of communication
l. Hazardous materials (includes biohazardous)
m. Fire safety

n. Disaster plan
o. MSDS program
p. Infection control plan
q. Emergency codes
r. Security plan
s. Medical equipment

9.1. For more specific information, refer to the hospital's Environment of Care Manual.

Tri-City Medical Center
Oceanside, California

DELETE. Follow Code Red Policy.

OUTPATIENT FORENSIC CLI

ISSUE DATE:

SUBJECT: Fire Alarm/Evacuation Plan

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n.a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

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

~~1. To safely remove patients from Clinic in the event of a fire or fire alarm.~~

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

~~1. When a fire occurs in the clinic the procedure outlined in the policy will be followed.~~

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

~~1. Should evacuation of the patients be necessary, Clinic personnel will:~~

~~a. Inform the California Department of Corrections and Rehabilitation (CDCR) Officers that we must evacuate all patients from the clinic.~~

~~b. Reassure patients and CDCR officers and maintain a calm atmosphere~~

~~c. Assist the CDCR officers to prepare patient(s) for transport to the designated safe location per hospital policy.~~

~~d. During emergent evacuation the patients will remain in the care and custody of the CDCR Officers.~~

~~e. Follow department evacuation procedures and routes according to hospital Code Red procedure – R.A.C.E.~~

~~f. Perform system emergency shut down as indicated.~~

~~g. Upon completion of evacuation of all patients to the designated safe area, the Clinic Manager, RN or Medical Assistant will contact the hospital command center for appropriate head count of patients, CDCR officers and staff and further instruction.~~

~~h. Evacuation Plan Map attached.~~

Tri-City Medical Center
Oceanside, California

DELETE. Covered under Tri Medx.

OUTPATIENT ~~FORENSIC CLINIC~~SPECIALI

ISSUE DATE: 05/11

SUBJECT: Medical Equipment Maintenance

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. PURPOSE:~~

~~1. Due to the potential for injury that medical equipment poses, an effective preventive maintenance and equipment management program must be in place and strictly observed. All patient care equipment used by the clinic will be maintained in good working order and inspected and repaired according to hospital policy.~~

~~B. POLICY:~~

~~1. The Biomedical Department will conduct routine inspection and preventive maintenance (PM) on the Clinic's medical equipment on a regularly scheduled basis, according to hospital policy.~~
~~2. Staff will be trained in the proper and safe use of all medical equipment.~~
~~3. Incidents involving medical equipment will be reported according to hospital policy.~~
~~4. All employees are responsible for reporting unsafe equipment and the Clinic Manager, RN, and Medical Assistant are responsible for the continued observance and monitoring of safe use of equipment.~~

~~C. PROCEDURE:~~

~~1. Prior to use, all electrical devices will be inspected and approved by the Biomed Department.~~
~~2. Staff members will be trained in the proper use of electrical (or mechanical) devices prior to use.~~
~~3. Staff members are required to pull malfunctioning equipment out of use and to notify the appropriate person (biomedical engineer, clinic manager, etc.) for repair.~~
~~4. The manufacturer's operating instructions will be followed when operating medical equipment.~~
~~5.~~1. ~~Annually, or more frequently as indicated, equipment will be inspected per hospital preventative maintenance schedule.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT ~~FORENSIC CLINIC~~SPECIALITY SERVICES CLINIC

ISSUE DATE: **SUBJECT: Patient Record Content**

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. A systematic approach to patient record keeping is necessary:
   a. To provide consistency and orderliness
   b. For ease of use for all staff members

B. **POLICY:**
1. A medical record will be maintained in Cerner on all patients treated at the Clinic and those seen via Telemedicine.

C. **PROCEDURE:**
1. The order and the contents of the patient record will include, but will not be limited to:
   a. Patient Demographics and Information
      i. Admission face sheet
   b. Consents
      i. Conditions of Admission
      ii. Incarcerated Patients Rights & Responsibilities
   c. History and Physical
      i. Documented on the physicians notes and dictated in a medical report
   d. Labs or Radiology
      i. For those diagnostics that are completed at the medical center those are accessed in Cerner under "Labs" or "Radiology" Results.
      ii. For those diagnostics that are faxed to the clinic or brought by the CDCR **or San Diego Sheriff's** Officers those will be scanned in to the patient's encounter.
   e. Physicians Orders
      i. Documented on the physicians notes and dictated in a medical report
   f. Fax
      i. Confirmation of faxes sent and received pertaining to patients will be scanned to the encounter.
   g. Emails
      i. Confirmation of emails sent and received pertaining to patients will be scanned to the patient's encounter.
   h. CDCR **or San Diego Sheriff's Department** Nursing Communication Note
      i. All CDCR **or San Diego Sheriff's Department** Nursing Communication Notes for each patient will be scanned to the patient's encounter
2. All documents will be scanned into Cerner in the patient's medical record according to the date of the encounter.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: **SUBJECT: Registration of Patients**

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Hospital or clinic registration will be completed as a pre-admit or upon admission to the clinic. For pre-admits the registration will be completed upon patient's arrival **by the registration staff**. This document outlines the registration process at the Clinic.

B. **POLICY:**

1. The clerical staff will follow the hospital's procedures for data collection of the patient's information and electronic data entry.

C. **PROCEDURE:**

1. Request for Services (RFS) will be faxed to the Outpatient ~~Forensic~~ **Specialty Services** Clinic from the institution.
2. When an appointment has been scheduled, the clinic staff will enter the appointment on the Forensic Outlook Calendar indicating where the appointment will be, either at the Outpatient Forensic Clinic or another area of the medical center.
3. Upon arrival the Registration staff will complete the registration of the patient.
4. The registration staff will print the face-sheet and patient labels to the Outpatient ~~Forensic~~ **Specialty Services** Clinic's printer.
5. All patients will be admitted to the **Outpatient Specialty Services** Clinic according to hospital policy. The following forms must be signed preceding any exam and/or treatment:
   a. Hospital's "Conditions of Admission"
   b. Incarcerated Patient's Rights & Responsibilities
6. The Original Request for Services (RFS) will be given to the Clinic personnel upon arrival with any additional records from the institutions.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11

SUBJECT: Scheduling and Tracking Appointments

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure the timeliness of requests received from the institutions are scheduled timely and according to the Prison HealthCare Guidelines.

B. **POLICY:**

1. Request for Services (RFS) **and follow-up requests** will be sent to our Fax Server by the institution requesting the appointment. The Fax Server will be checked throughout the day. The appointments will be scheduled according to what is outlined in the Prison HealthCare Provider Manual.

C. **PROCEDURE:**

1. RFS received will be sent to the appropriate specialist or TCMC department as indicated within 24 hours or by the next business day, if the RFS is received on a Friday.
2. The request to the specialist or TCMC department will indicate how soon the appointment needs to be scheduled: per what is outline in the Prison HealthCare Provider Manual:
   a. Routine – must be within 90 days of the request
   b. Urgent – must be within 14 days of the request
3. Routine Appointments will be scheduled within 21 days or sooner to avoid any delays.
4. Urgent Appointments will be scheduled within the 7 to14 days.
5. Once the appointment is provided to us by the specialist office or TCMC department we will notify the institution of the date & time so transportation can be arranged.
6. Any delays in obtaining the appointments – MUST be communicated to the institutions and documented on the CDCR **or San Diego Sheriff's Department** Communication Nursing Note.

~~1. If the specialist office does not respond to the request after 72 hours – the request will be given to the Outpatient Forensic Manager to contact the office to inquire.~~

~~2. If the Outpatient Forensic Manager is not successful in obtaining the appointment – the Outpatient Forensic Medical Director will be contacted to discuss directly with the physician in that office.~~

D. **DOCUMENTATION:**

1. All communications to and from the specialist's offices and TCMC departments will be documented on the CDCR **or San Diego Sheriff's Department** Nursing Communication Note.
2. All faxes, fax confirmations and emails will be kept with the RFS and supporting medical records~~.~~
3. The CDCR **or San Diego Sheriff's Department** Nursing Communication Note, faxes confirmations,emails, RFS, and any supporting medical records that had been received with the RFS, will be sent to Medical Records for scanning to the patient's encounter for that appointment.

~~4. All appointments will be recorded in Excel on the Appointment Log according to Specialty and in Forensic Outlook Calendar.~~

Tri-City Medical Center
Oceanside, California

DELETE. No longer required.

OUTPATIENT FORENSIC CLINIC

ISSUE DATE: 05/11 **SUBJECT:** Staffing Plan

REVISION DATE(S):

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Appropriate and adequate staffing is vital to the success of the multi-service outpatient clinic. A well-planned approach must be taken to accomplish this goal, and several factors for a good staffing plan must be considered. They are:~~

~~a. Acuity of the patients treated~~
~~b. Level of expertise/competency of the staff~~
~~c. Time allotted for each visit~~
~~d. Continuous planning and assessment (daily, weekly, monthly and yearly)~~
~~e. Frequent review and evaluation to seek opportunities to enhance the system to benefit patient care and for good stewardship of financial resources that impact clinic operations.~~

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

~~1. Acuity Classification: The *Acuity Classification* policy has been developed to provide for and validate adequate/appropriate resources for the plan of care for each patient who presents to the Clinic for treatment and to support the requirements for the continuum of care activities.~~
~~a. For more specific information on patient classification, refer to the *Acuity Classification* policy.~~

~~2. Staffing: In general, the type and number of staff members are selected based on qualifications, experience and clinic needs. Clinic needs are determined daily and weekly by the number of scheduled patients, the type and acuity of patients, and the type of service required by the patients. Members of the staff may include:~~

~~a. RN who oversees the day-to-day clinical operations of the clinic. The RN also participates in the decision-making processes related to the selection of the clinic model and the services provided. He/she is accountable for ensuring that the clinic is adequately staffed and makes certain that patient visits are appropriate and timely.~~
~~b. Medical Assistant (MA), under the supervision of the RN and the direction of the RN or Physician performs tasks as assigned. The MA assists other members of the healthcare team while providing direct patient care. As a patient advocate, the MA reports observations and patient responses to care to the RN/MD and assists with maintaining patient privacy/ confidentiality and reports patient complaints of pain to the RN/MD.~~
~~c. Registration will register each patient seen in the Clinic and those who are seen via Telemedicine. The face sheets and patient labels will be printed to the Outpatient Forensic Printer upon completion of each registration.~~

d. Other staff members may include a nurse practitioner/physician assistant/medical assistants, and additional clerical support staff. Competency of clinic staff is based upon:
   i. Education and training
   ii. Years of experience
   iii. Ability to demonstrate the necessary skills to perform the defined duties
   iv. Ability to communicate effectively with the medical staff and patients and their families.

3. Patient Scheduling: Allowing adequate time for each patient visit is necessary for patient satisfaction, convenience, and care needs and is an essential component of an efficient and smooth running clinic. To determine the time required for and between each visit, the following general rules apply:
   a. Increased time is allowed for a new patient visit or for complex cases
   b. Less time is required for follow-up and/or less complex cases
4. Assignments: Assignments are planned by the clinical manager/case manager on a weekly basis and are based upon the number of patients scheduled, assessment of clinical needs of the patient, the complexity of the patient's condition, and the clinical care requirements. Staffing levels may be adjusted to correspond with the anticipated care requirements. In addition, the clinic manager/coordinator reviews the changes in the daily clinic schedule and makes necessary adjustments to staffing levels.

Evaluation of Staffing Plan: The staffing plan is periodically reviewed and evaluated by the Clinic Manager. Opportunities for improvement/enhancement are identified, and changes are made consistent with the needs of the patients and the staff members.

Tri-City Medical Cent
Oceanside, California

OUTPATIENT FORENSIC CLI

DELETE .Follow Administrative New Hire Orientation, Policy #8610-457

ISSUE DATE: **SUBJECT: Unit-Specific Orientation**

REVISION DATE(S):

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

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

~~1. Because of the complexity of the service offered, comprehensive orientation to the processes and protocols of the Forensic Clinic is essential to adequately prepare associates to work in this new environment. This document delineates the responsibilities of the hospital, the OP Forensic clinic and the associate and defines the processes necessary for equipping each employee to safely/effectively perform his/her job duties.~~

~~B. **RESPONSIBILITY:**~~

~~1. The hospital assumes responsibility for the initial and annual orientation programs.~~
~~2. The department is responsible for the unit specific orientation, the unit specific safety and environment of care training and for staff development programs throughout the year that meet the identified needs of the staff and the clinic operations.~~
~~3. The Clinic Manager assumes overall responsibility for the design, implementation and evaluation of the orientation process. The RN oversees the clinical functions and medical assistant's competencies.~~
~~4. The associate, in partnership with the hospital, assumes responsibility for:~~
~~a. Professional education/licensing and certifications~~
~~b. Identifying their own learning needs~~
~~c. Pursuing opportunities to meet their learning needs~~

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

~~1. All employees joining the clinic team will have a unit specific orientation and training.~~
~~2. The orientation/training content will be current, applicable and systematic.~~
~~3. The orientation/training experience is individualized and designed to provide pertinent policy and procedural knowledge to be followed by the new associate.~~
~~4. Instruction will be clear, succinct and administered at the level of the learner.~~
~~5. Competency assessments, where applicable, will be completed before the end of the unit orientation and filed in the associate employment folder in the HR department.~~
~~6. Orientation will be provided during the associates assigned work shift.~~
~~7. Instruction will be didactic and experiential.~~
~~8. Orientees will be acquainted with their new surroundings and receive sufficient orientation and training to become a member of forensic team.~~
~~9. Cross training of an associate may also occur when appropriate. The training will be sufficient in content and duration to prepare the associate for their new position.~~

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

~~1. All associates will receive general hospital orientation.~~

2. Department-specific orientation and training will occur in the initial period of the associate's employment and prior to taking full responsibility for their assigned duties.
3. A job description will be given to each orientee.
4. The duration of the orientation period will be sufficient to prepare the employee for full participation in clinic activity.
5. Each new staff member will be oriented by the Manager and the RN.
6. During the 90-day initial employment period, the new employee will be observed by the Clinic Manager and/or RN for progress and adjustments to the training will be made accordingly.
7. Department-specific orientation schedule includes:
    a. All Clinic staff members
        i. Job descriptions
        ii. Safety
            1. Non-Violent Crisis Intervention Training
            2. CDCR Do's & Don'ts
            3. MSDS
            4. Emergency plans (fire, disaster, etc.)
            5. Hazardous waste
        iii. Infection Control
            1. Standard (Universal) precautions
            2. Personal protective equipment
            3. Biohazardous waste
            4. Handwashing
        iv. Review of abuse reporting policy
        v. Performance improvement program
        vi. Risk management program
        vii. Patient Privacy
    b. Clinical Staff Orientation
        i. Unit orientation
        ii. Clinic policies and procedures
        iii. Clinic flow
        iv. Equipment
        v. Blood drawing/specimens/transporting/storage techniques
        vi. Medical records/documentation
        vii. Supplies/Protective devices
    c. Medical Staff
        i. Unit orientation
        ii. Clinic flow
        iii. Medical records/documentation
        iv. Dictation
        v. Supplies/protective devices
    d. Support Staff
        i. Unit orientation
        ii. Clinic flow
        iii. Medical Records
        iv. Data base
        v. Registration by Access Management staff
        vi. Phone techniques/etiquette
        vii. Equipment
            1. Copier
            2. Fax
            3.1. Computer/printer

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

ISSUE DATE: **SUBJECT: Utilization Management Plan**

REVISION DATE(S): 03/12, 02/16, 11/18

Patient Care Management Department Approval:	~~06/19~~05/20
Utilization Review Committee Approval:	~~08/19~~06/20
Medical Executive Committee Approval:	~~08/19~~06/20
Administration Approval:	~~09/19~~07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/19

A. **INTRODUCTION:**

1. In accordance with the requirements of the Health and Human Services Conditions of Participation, State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Centers for Medicare and Medicaid Service (CMS) guidelines and Standards of the Joint Commission, Tri-City Medical Center Governing Board delineate this Utilization Management Plan. This Plan reflects the actual process of reviewing patient care. The Utilization Management Plan has been developed to be approved by the Quality Assurance Performance Improvement (QAPI), the Medical Executive Committee, and the Board of Directors.
2. The Utilization Management Program applies to all patients regardless of payment source. The program does not include utilization review conducted by members of the medical staff under control with, or via others means of delegation by a third party payer. The Medical Center maintains the authority of decisions regarding review, including appropriate services, at the local level.

B. **AUTHORITY:**

1. The Board of Directors has the ultimate responsibility for review of the quality, appropriateness, and medical necessity of admissions, continued stays, and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive Utilization Management Plan. The authority and responsibility for providing personnel, resources, and equipment has been delegated to the Chief Executive Officer or Designee of Tri-City Medical Center.
2. The Utilization Management Plan is under the direction of the Utilization Committee, and following approval of this Utilization Management Plan, the Utilization Committee shall review and approve the Plan annually for scope and objectives.

C. **GOALS/OBJECTIVES:**

1. All patients, regardless of type of insurance or source of payment, are monitored for over-utilization, under-utilization, and inefficient scheduling of resources. The primary objectives of utilization review are the following:
   a. Assure Care at a Level Appropriate to Patient Needs.
   b. Utilization review monitors the level of care on an ongoing basis to ensure that patients receive care in a facility appropriate for their needs.
   c. A patient in an acute care facility requires the continuous availability of physicians, skilled nursing services, surgical services and/or ancillary services found only in the acute hospital setting.
2. Provide Professional Accountability

a. Utilization review provides professional accountability for the utilization of health care resources to the patient and the person or organization paying for his/her care. It addresses issues of quality and cost controls to ensure the highest quality patient care at the lowest cost.

3. Educate the Medical Staff and Other Health Care Professionals
   a. The ongoing utilization review activity and the identification of problem areas provide continuous education on quality of care and utilization issues to the Medical Staff and other health care professionals.

D. **UTILIZATION MANAGEMENT COMMITTEE**

1. Organization
   a. The Committee shall be a medical staff committee of the hospital; will be composed of five (5) physicians, no less than two (2) physicians who must be either medical doctors or doctors of osteopathy and members of the Medical Staff, representing the admitting services of the medical staff, and assisted by other professional personnel.
   b. The other members may be any of the other types of practitioners as specified in State Operations Manual §482.12(c)(1).
   c. The Physician Advisor will be a member of the Committee.
   d. No person with a direct financial interest in Tri-City Medical Center may participate in reviews conducted by the Committee. No person who is, or has been, professionally involved in the care of the patient whose case is being reviewed may participate in the review.
   e. All members of the Committee must follow the conflict of interest and confidentiality policies of Tri-City Medical Center.
   f. All medical staff committee members shall be appointed by the Chief of Staff. Appointment shall be for one year.
   g. The Director of Case Management will appoint non-medical staff representatives to the Committee annually.
   h. Committee Representatives may include, but are not limited to:
      i. Director of Case Management
      ii. Nursing Administrator or representative
      iii. Medical Records Director or representative as needed
      iv. Case Management / Social Services' representative(s) as needed and may include:
         1) CDI Specialist, and Social Services representative(s) as needed
   i. As per Medical Staff Bylaws, for a quorum, no less than two (2) physician committee members shall attend the Utilization Committee Meetings.
   j. The Committee must meet as often as necessary to accomplish its function, but no fewer than quarterly (4) times per year.
2. Authority
   a. Physician Advisor and Review Personnel
      i. A designated Physician Advisor will be available per contractual agreement, Monday through Friday, to communicate with the Case Managers regarding questionable admissions, quality of care issues, day or cost outliers and continued stay cases. This communication will be in person, via telephone, or via email, as necessary.
      ii. The Physician Advisor has authority to initiate denial of an admission or extension of length of stay (pending QIO review and concurrence when required).
      iii. The Case Managers will seek specific assistance and advice from the Physician Advisor in the following situations:
         1) When the Case Manager has reason to believe that an admission, continued stay, is not medically necessary based on criteria.

2) When the Case Manager is unable to make a decision as to whether there is a medical necessity for acute care, even when the guidelines are met.
3) When there is a question of quality of care being rendered.
4) When the implementation of discharge planning is delayed by either the patient, family and/or attending physician.
5) When under/over utilization and quality concerns are identified, as well as delays in services with the Attending Physician and intervention is necessary.

iv. In most instances, the Physician Advisor shall render a decision within twenty-four (24) hours as to the approval or denial of an admission or continued stay. The Director of Case Management shall oversee review activities. Case Management review shall be conducted by personnel qualified to follow directive of the Utilization Management Committee and to apply clinical guidelines and regulations. Sufficient qualified reviewers will be assigned to meet the requirements of reviews.

b. The Committee has the authority to give notice of non-coverage in accordance with federal and state law and other third party payer requirements.

c. The Committee has the responsibility to:

i. Implement procedures for reviewing all stages of hospital admissions, including but not limited to:
1) Medical necessity for admission, over- and under-utilization of ancillary services, delays in services, quality of care indicators.
2) Adequacy of medical record documentation, lengths of stay and timeliness of discharges.

ii. Report review findings and recommendations to the appropriate Medical Center and/or Medical Staff persons or entities.

iii. Review third-party payer denials, make recommendations and/or take appropriate actions.

iv. Collect and analyze data necessary to carry out its responsibilities.

v. Analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution and/or refer to appropriate entities for resolution.

3. Upon invitation from the Chairperson, other representatives of the Hospital or medical staff may attend meetings. The Chairperson and other designated members of the committee shall serve as Physician Advisor if there is not an appointed advisor available.

4. Chairpersons of all standing committees shall have an open invitation to attend meetings of the Committee; other Medical Center personnel may attend upon invitation from the Committee.

E. **UTILIZATION REVIEW ACTIVITIES:**

1. Utilization Review Staff
   a. The Utilization Review staff consists of qualified non-physician Medical Center personnel including, but not limited to, nurse case managers, social workers, and assistants who function under the direction of Department Director as staff to the Utilization Review Committee.
2. Criteria:
   a. The Case Managers shall use the prescribed and authorized criteria designated by medical staff while reviewing the severity of illness, intensity of service, and discharge screens. InterQual Criteria is utilized at Tri-City Medical Center.
3. Admission Review
   a. All designated admissions shall have an initial InterQual® review performed not later than 24 business hours following admission to TCMC.
4. Concurrent Review

a. The concurrent review process will follow the admission review and will continue throughout the patient's hospital stay.
b. Concurrent reviews shall be provided to payers as requested.
c. Concurrent reviews for Medicare & Medicaid patients should be performed as per department standards throughout the patient's hospital stay.
    i. For duration of stays, review only cases that they (hospital) reasonably assume to be outlier cases based on extended length of stay, as specified in State Operations Manual §412.80 (a)(1)(i); and
    ii. For professional services furnished, including drugs, biologicals, and medical devices, the hospital needs to review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as specified in State Operations Manual §412.80 (a)(1)(ii)
d. In keeping with the "Ten (10) Bed Call List" protocol as determined by the San Diego County office for Medi-Cal, those Medi-Cal or Medi-Cal Pending; CMS or CMS Pending patients who no longer meet an acute hospital level of care and are "awaiting placement" shall be identified as being on the "Ten (10) Bed Call List".
    i. The Case Manager shall discuss case with the treating physician and work to obtain a physician order for the patient to be placed on "Ten (10) Bed Call status".
    ii. The Ten (10) Bed Call List will be maintained by the Case Management department's appropriate support staff member.
    iii. Case Manager shall document "Ten (10) Bed Call" status in the patient's EMR.

5. Outlier Review
    a. The Director of Case Management and Social Work Manager conduct frequent outlier review to ensure the ongoing medical necessity of any patient with an extended stay or high dollar amount of services. Physician Advisor may attend as needed.
    b. Specific outlier cases are discussed in the Hospitalists Stop Light Rounds, and Intensive Care Rounds, outlining clinical condition, discharge barriers, and action plan.
    c. The target indicators for outlier review are:
        i. Length of stay of 10 or more days or
        ii. Total hospital charges of $75,000 or greater
6. Discharge Planning
    a. Discharge planning is a collaborative effort of a multidisciplinary team of individuals performed as an integral component of the direct patient care process.
    b. The concurrent utilization review process is one of several mechanisms designed to identify and refer patients needing discharge Care Coordination.
7. Relationship to Third Party Payers
    a. The Hospital is responsible through the Case Management function for the process of reviewing patients' (beneficiaries') clinical information for the purpose of presenting claims to third parties, including the fiscal intermediary, the basis upon which payment is allowed by the intermediary, the condition under which the intermediary denies claims, and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and the Quality Improvement Organizations (QIO). Information and data shall be protected to ensure confidentiality.

F. **COLLABORATION WITH THE QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) AND/OR THE MEDICAL STAFF:**

1. Case Management is one of the components of a hospital Quality Improvement Program, during the course of concurrent and retrospective review, the Case Managers will screen patient records for quality concerns, including those specific events designated by the Quality Management and Regulatory Compliance Specialist. If concerns are identified through Case Management reviews, they will be documented within Allscripts. Case Management and Quality Improvement functions will be integrated as follows:

a. Quality And Utilization concerns are referred to the appropriate Medical Staff Review Committee:
   i. If a potential quality issue is identified during the review process and is considered to be of immediate need for correction, it will be immediately referred to the Physician Advisor. If the attending physician or Hospital Department Manager is unwilling to correct the problem to the satisfaction of the Physician Advisor, the Chairperson of the attending physician's department, Chief of Staff, or Administration will be immediately notified; the Risk Manager may also be notified.
   ii. If a potential quality issue is identified, however, and correction has already occurred, the case will be referred to the appropriate Medical Staff Committee or Department Manager.
   iii. Problem Diagnosis Related Groups (DRGs) will have Quality Improvement Teams assigned to evaluate the problem, determine the cause, and recommend corrective action.

G. **STANDARD REPORTS TO COMMITTEE:**

1. Standard reports presented at Committee meetings may include at least the following information:
   a. Monthly UR Committee Dashboard: Case Mix Index, Length of Stay, Readmission Reduction
   b. Condition Code 44s per month
   c. Discharge Appeals per quarter
   d. PEPPER Report Analysis quarterly
   e. HSAG Readmission report & HSAG High Risk Medication report (HRM) reported quarterly
   f. Analysis of Observation rates: Observations verses Inpatients & Conversion rates every 6 months
   g. Review of Medicare Specific Inpatient Stays: Chest pain, TIA, Syncope monthly
   h. Physical Advisor Denial Outcomes monthly
   i. Managed Resources Report/Post Appeal Outcomes quarterly

H. **HOSPITAL ADMINISTRATION**

1. The Hospital Administration shall provide the necessary resources to ensure the proper functioning of the Case Management Program. This includes acting as a liaison with all departments, ensuring information is properly assembled, and by providing necessary forms, secretarial assistance, and meeting space. Administration shall be responsible for considering and acting upon decisions and recommendations stemming from the Case Management function with respect to Hospital policy, procedures, and staffing.

I. **REFERENCE(S):**

1. State Operations Manual, Appendix A – Survey Protocol, §482.30(b) Standard: Composition of Utilization Review Committee
2. State Operations Manual, Appendix A – Survey Protocol, §482.30(c) Standard: Scope and Frequency of Review
3. State Operations Manual, Appendix A – Survey Protocol, §482.12(c) Standard: Care of Patients
4. State Operations Manual, Subpart F – Payment for Outlier Cases, §412.80(a)(1) Basic Rule: Discharges occurring on or after October 1, 1994 and before October 1, 1997

Tri-City Medical Center
Oceanside, California

SURGICAL SERVICES
PERI-ANESTHESIA NURSING SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 07/2012

SUBJECT: Discharge of Post Anesthesia and Post Sedation Patients to Inpatient Units

REVISION DATE:

Surgical Services Department Approval:	**03/20**
Department of Anesthesia Approval:	**03/20**
Operating Room Committee Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**06/20**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/12**

A. **DEFINITION:**
1. **ASPAN- American Society of PeriAnesthesia Nurses**

~~A.~~**B. PURPOSE:**
1. To define criteria and processes for discharge of post-anesthesia and post-sedation patients to an inpatient unit.

~~B.~~**C. PROCEDURE:**
1. Recovery: Post Anesthesia **Care Unit (PACU)** ~~R~~recovery is performed according to ASPAN standards ~~of~~ Perianesthesia nursing practice. RNs ~~that~~ **who** have completed PACU ~~or SPRA post-anesthesia~~ competencies may discharge to inpatient unit when the following criteria are met or as ordered by an anesthesiologist:
   - **a.** Modified Aldrete score ≥ 8, **except when** discharge is authorized by anesthesiologist or patient is transferred to critical care, or documented limitations are present prior to anesthesia.
   - **b. Airway:**
     - **i. Patent airway and protective airway reflexes are intact**
   - ~~a.~~**c. Patient is able to cough and deep breathe**
   - **d.** Vital signs are stable **with no significant changes for at least 30 minutes.**
     - i. **Temperature ≥ 36°C (96.8°F)**
     - ii. **Blood pressure within ± 20 mmHg of patient's baseline**
   - **e.** ~~Pain/discomfort~~
   - **f. Pain level meets target pain level or** is appropriate for procedure.
     - i. **Paseo Opioid-Induced Sedation Scale (POSS) score ≤2**
   - ~~b.~~**g. No active emesis and/or acceptable level of nausea.**
   - **h. Post-procedural/operative bleeding controlled or acceptable with procedure**
     - **i. Dressing/surgical site is clean, dry and intact or has mild to moderate drainage with no marked increase**
     - **ii. Patent tubes, catheters and drains**
   - ~~a. Return of reflexes.~~
   - **i. For spinal or epidural block, dermatome level ≥ L3 and patient is able to move toes.**

i. **No evidence of bleeding at puncture site**
j. For regional anesthesia, protection of patient's extremity
~~c.~~k. For obstetrical patients fundus is firm, lochia is small to moderate.
~~d.~~l. If Flumazenil or ~~Narcan~~ **Naloxone** are administered to reverse the effects of sedative ~~medications~~ or opioids **medications**, the patient must be monitored for re-sedation for two hours~~-~~ after administration.

2. The d~~D~~ischarge process and transport will be done according to **PCS Policy Transfer of Patients, Intra-Facility and ASPAN Standards of PeriAnesthesia nursing practice**~~y. TCMC Patient Care Services Policy VI.D Transfer of Patients. Non-licensed staff transporting patients will receive completed TCMC Ticket to Ride form from PACU RN prior to transport.~~
   a. **The** PACU RN ~~will~~ **should** accompany **patients that include, but not limited to:**
      i. **Require evaluation, treatment or are at risk of cardiopulmonary compromise during transport**
      ii. **Require a higher level of care**
      iii. **Have a potential for bleeding**
      iv. **Airway compromise**
   b. **The PACU RN should consider factors when evaluating the patient for transport including, but not limited to**
      1) **Patient stability**
         Higher level of care
      2) **Distance the patient needs to travel**
      3) **Required monitoring**

~~all patients requiring continuous monitoring after PACU discharge, and any patient the primary nurse determines RN presence during transport is necessary due to patient condition.~~

D. **DOCUMENTATION:**
1. **Document the following in the electronic health record (EHR):**
   a. **Vital signs**
   b. **Pain assessment**
   c. ~~**Modified**~~ **Aldrete score**
   d. **Intake and Output**
   e. **Dermatome level (if applicable)**
   f. **Surgical site assessment**
   g. **Presence of nausea/vomiting**
   h. **Additional elements of assessment as indicated by procedure and anesthesia/sedation type**
   i. **PACU Expected Outcomes**
   j. **For patients who have had moderate sedation without anesthesia care, document sedation outcomes.**
   k. **PACU Departure**
2. **Document patient education**
~~2.~~3. **Document all medications given in the eMAR**

~~**QUALIFICATIONS:**~~

~~RNs that have completed PACU or SPRA post anesthesia orientation and annual competencies may discharge patients to an inpatient unit in accordance with the criteria identified in this procedure.~~

E. **RELATED DOCUMENT(S):**
1. **Modified Aldrete Score**

~~C.~~F. **REFERENCES:**

~~American Society of Perianesthesia Nurses.~~

1. **American Society of Perianesthesia Nurses. (201~~6~~18). *Perianesthesia Nursing Standards, Practice Recommendations and Interpretive Statements ~~2017–2018~~2019-2020.* Cherry Hill, NJ: American Society of Perianesthesia Nurses.**

2. **Schick, L., & Windle, P. E. (Eds.). (2016). *PeriAnesthesia Nursing Core Curriculum: Preprocedure, Phase I and Phase II PACU Nursing* (3rd ed.). St. Louis, MO: Elsevier.**

~~1.~~3. ~~Perianesthesia Nursing Standards and Practice Recommendations 2010-2012. Cherry Hill, NJ: ASPAN; 2010.~~

~~Appendix A~~

~~MODIFIED ALDRETE SCORE*~~		
Activity	Moves all extremities voluntarily on command.	2
	Moves two extremities voluntarily on command.	1
	Unable to move extremities.	0
Respiration	Breathes deeply and coughs freely.	2
	Shallow or limited breathing.	1
	Apneic.	0
Circulation	BP ± 20 mm of preanesthetic level.	2
	BP± 21-49 mm of preanesthetic level.	1
	BP ± 50 mm of preanesthetic level.	0
Consciousness	Fully awake.	2
	Arouseable on calling.	1
	Not responding.	0
Oxygen Saturation	Sp02 >92% on room air	2
	Supplemental 02 required to maintain Sp02 >90%	1
	Sp02 <90% with supplemental O_2	0

Tri-City Medical Center	Surgical Services
PROCEDURE:	**DUODENOSCOPE SAMPLING FOR QUALITY CONTROL CULTURING**
Purpose:	To provide protocols for surveillance sampling and culturing of reprocessed duodenoscopes intended as a quality control measure of the adequacy of reprocessing. Duodenoscope sampling is used to identify endoscopes with persistent contamination despite reprocessing. The primary focus of this protocol is for the detection of organisms of concern, some of which have been associated with infectious outbreaks. This protocol is not intended to be used during a suspected outbreak linked to inadequately reprocessed endoscopes, and results after following this protocol cannot be used to certify that an endoscope is sterile. Culturing information may be used to identify systemic errors in reprocessing or damaged endoscopes and equipment. This protocol is designed to identify most organisms of concern that could be present on a duodenoscope, and is not intended to culture all microbes that could potentially contaminate a flexible duodenoscope.
Supportive Data:	Microbial sampling and culturing of duodenoscopes involves sampling duodenoscope channels and the distal end of the duodenoscope (see Appendix B, "Duodenoscope Diagram"), followed by culturing those samples with the goal of detecting contamination that may be present on the duodenoscope after reprocessing. Among all flexible endoscopes, duodenoscopes were selected for sampling because of the national reports of infections associated with this specific type of reprocessed endoscope. Surveillance sampling and culturing is not a substitute for a comprehensive endoscope reprocessing program that includes, but is not limited to, complete adherence to professional guidelines and the manufacturer's reprocessing and maintenance recommendations.
Equipment:	See Appendix A
Issue Date:	NEW

A. **DEFINITIONS: (See diagram Appendix B)**

1. Biopsy port: The entrance to the instrument channel on the endoscope. The biopsy port is where accessory instruments (such as biopsy forceps or guidewires) are introduced into the endoscope.
2. Channels: Duodenoscopes have multiple channels (long, narrow lumens) that have different functions during endoscopy. For example, the instrument channel allows insertion of accessory instruments into the endoscope for biopsy or therapeutic reason.
3. Control Handle: The location of the endoscope that is handled by the physician during an endoscopy procedure. The control handle includes the button and knobs for control of the optics, movement of the distal portion of the endoscope, air insufflation and lens washing.
4. Distal End: The distal end includes the terminal end of the insertion tube that is inserted into the patient during the endoscopic procedure. This location of the duodenoscope also includes the elevator lever and elevator recess.
5. Elevator Lever: Also known as an elevator, the elevator lever is located at the distal end of the duodenoscope. It is a small piece, usually metal, that can pivot. When raised, the elevator lever changes the angles of accessory instruments exiting the instrument channel at the distal end, up to a nearly 90 degree angle.
6. Elevator Recess: The recessed area surrounding the elevator lever. This area has numerous small crevices, making the elevator recess particularly challenging to clean.
7. Instrument Channel: The channel spanning from the biopsy port to the distal end. This channel is used to insert instruments into the endoscope for use during endoscopy. The instrument channel forms a part of the suction channel, which extends from the distal end to the proximal end of the endoscope.

Department Review	Operating Room Committee	Department of Pathology	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/20	03/20	04/20	05/20	n/a	06/20	07/20	n/a	

8. Lowered Position: The position for the elevator lever being parallel to or within the elevator recess relative to the distal end of the duodenoscope.
9. Raised Position: The position of the elevator lever such that it is perpendicular to the distal end of the duodenoscope.

B. **POLICY**

1. Each duodenoscope shall be sampled and cultured quarterly.
2. The sampling protocol is limited to obtaining samples from elevator recess and instrument channel of clinically used and reprocessed duodenoscopes for the purposes of surveillance.
3. Two staff members are required for duodenoscope sampling: one staff member (the sampler) maintains aseptic handling and conducts brushing steps, while the second staff member (the facilitator) opens packages and handles the unsampled portions of the endoscope.
4. Three samples should be collected and combined: distal cap seams (by swab method), instrument channel (by flush, brush, flush method) and elevator recess (by flushing and brushing method).
5. Collection of duodenoscope samples may generate aerosols. Appropriate personal protective equipment (PPE) must be worn and fresh PPE must be utilized with each duodenoscope sampled.
6. The duodenoscope may be used for patient care while culture results are pending.
7. Microbiology/Infection Preventionist shall notify the Director of Surgical Services of culture results and appropriate follow-up action shall be taken.
    a. Negative culture results: no action necessary.
    b. Positive culture results (i.e., results exceed the pre-determined microbial limit):
        i. If duodenoscope culture results exceed the pre-determined microbial limit, the duodenoscope shall be quarantined and reprocessed. A new sample shall be collected from the duodenoscope post-reprocessing and the duodenoscope shall remain quarantined until results of the re-test are obtained.
        ii. Reprocessing practices shall be reviewed and appropriate staff shall be re-educated.
        iii. Sampling and culturing procedures shall be reviewed and appropriate staff shall be re-educated.
8. Duodenoscope sampling records, including culture results, shall be maintained by Infection Prevention for 7 years, then destroyed.

C. **PROCEDURE:**

1. Clean and disinfect the work surface that will be used for duodenoscope sampling.
2. Perform hand hygiene.
3. Label the sterile sample cup with duodenoscope identifying information, including:
    a. Duodenoscope model and serial number (e.g., TJFQ180V, #2619131)
    b. Channels/sites sampled (e.g., Distal cap seams, Instrument Channel, Elevator Recess)
    c. Date
    d. Time
    e. Cerner code of individual collecting the sample
4. Perform hand hygiene.
5. Sampler: Don PPE, including:
    a. Fluid-resistant sterile gown
    b. Fluid-resistant face mask and eye protection
    c. Sterile gloves
    d. Bouffant cap for hair
6. Facilitator: Don PPE, including:
    a. Fluid-resistant face mask and eye protection
    b. Bouffant cap for hair
7. Facilitator: Using aseptic technique, cover work surface with a sterile drape. Place duodenoscope on the sterile drape, taking care to avoid contact with the elevator recess.

8. Sampler: Before sampling the duodenoscope, perform a visual inspection of the distal end for any debris or other concerns using 10x magnification.
   a. If visual debris is present, continue with sample collection, but note the visible debris on the Microbiology requisition. Send the debris for culture (process separately from collected surveillance sample).
   b. Notify the Director of Surgical Services of the duodenoscope reprocessing breach.
   c. The duodenoscope shall be cleaned, inspected, and high level disinfected after sampling.
9. Sample the distal cap seams:
   a. Facilitator:
      i. Open a sterile alcohol wipe package.
   b. Sampler:
      i. Remove sterile alcohol wipe from package.
      ii. Wipe exterior of distal end with alcohol wipe. Ensure the elevator recess and the seams near the elevator recess are not exposed to the alcohol during wiping.
      iii. Wipe away from the elevator recess, taking care to avoid the elevator lever, recess, and the seams between the distal cap and distal end. Allow the alcohol to dry. Refer to Appendix B "Distal Cap Seams Sampling Method".
   c. Facilitator:
      i. Open the sterile swab package.
      ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has moistened the swab in the sterile water).
   d. Sampler:
      i. Remove the sterile swab from the package.
      ii. Moisten the sterile swab in sterile water.
      iii. Swab along the seam between the distal cap and the distal end. Refer to Appendix B "Distal Cap Seams Sampling Method".
   e. Facilitator:
      i. Open the sample collection container and hold the container to allow sampler to break off the tip of the sterile swab into the sample collection container. Sterile scissors may be used to cut off the swab head into the sample collection container.
      ii. Close the sample collection container.
10. Sample the elevator recess:
   a. Facilitator:
      i. Aseptically open the package for the sterile 3mL syringe.
      ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has withdrawn sterile water).
   b. Sampler:
      i. Remove the sterile 3mL syringe from the package.
      ii. Fill the sterile 3mL syringe with 1mL of fresh, sterile water.
   c. Facilitator:
      i. Lower the elevator lever.
   d. Sampler:
      i. While holding the distal end so that it is parallel to or lying flat on the sterile drape or pad, apply 1mL of sterile water into the elevator recess with the sterile 3mL syringe.
      ii. Use the same syringe to draw the fluid up and down five times.
      iii. Suction the fluid into the syringe while the facilitator raises the elevator lever.
      iv. Repeat this step by applying fluid into the recess and drawing the fluid up and down five times.
   e. Facilitator:
      i. Open the sample collection container (close the container after the sampler has added the sample).
   f. Sampler:

i. Use the same syringe to remove fluid from the elevator recess and transfer the fluid to the sample collection container.

g. Facilitator:
   i. Open the package for the sterile elevator cleaning brush.
   ii. Open the sterile water container (loosely place the cap back on the sterile water container after the sampler has moistened the brush in sterile water).

h. Sampler:
   i. Remove the sterile elevator cleaning brush from the packaging and moisten in fresh, sterile water.
   ii. Brush the elevator recess while the facilitator raises and lowers the elevator.
   iii. Place the brush head over the sampling container.
   iv. Use sterile scissors to cut the off the entire head of the bristled portion of the brush and drop it into the sample container.

i. Sampler and facilitator:
   i. With a new sterile 3mL syringe, repeat steps C.10.a through C.10.f.

11. Sample the instrument channel:
   a. Facilitator:
      i. Aseptically open the packages for two 30mL syringes.
      ii. Open the sterile water container.
   b. Sampler:
      i. Remove each 30mL syringe from the packaging.
      ii. Fill each syringe with 20mL sterile water.
      iii. Place the syringes on the sterile drape.
   c. Facilitator:
      i. Don fresh sterile gloves.
      ii. Elevate the control handle of the duodenoscope so the duodenoscope is nearly vertical.
   d. Sampler:
      i. Hand a syringe to the facilitator.
      ii. Hold the distal end of the duodenoscope over the sample collection cup (to collect water flushed through the instrument channel by the facilitator).
   e. Facilitator:
      i. Flush the instrument channel (via the biopsy port) with 20mL sterile water, which sampler will collect in the sample collection container.
      ii. Fill the syringe with air and flush air into the instrument channel. Collect any residual fluid in the sample collection container.
   f. Sampler:
      i. After air has been flushed into the channel, cap the sample collection container and place it on the sterile drape.
   g. Facilitator:
      i. Place the duodenoscope on the sterile drape.
      ii. Open the sterile instrument channel brush package and sterile scissor package.
   h. Sampler:
      i. Remove the sterile instrument channel brush from the packaging.
   i. Facilitator:
      i. Hold the duodenoscope vertically.
   j. Sampler:
      i. Insert the sterile instrument channel brush into the biopsy port.
      ii. Once the brush has been inserted about 3 inches, transfer the brush handle to the facilitator.
      iii. Hold the collection container at the distal end to capture any fluid that exits the channel with the brush, making sure not to touch the distal end.
   k. Facilitator:
      i. Continue to push the brush through the instrument channel.
   l. Sampler:

i. After the brush head exits the distal tip, use sterile scissors to cut the entire bristled portion of the brush and places it into the sample collection container.

m. Facilitator:
   i. Pull the remaining portion of the brush out of the duodenoscope from the biopsy port.
      1) Do not attempt to force the brush handle out through the distal end of the duodenoscope.
   ii. Discard the brush handle in the trash.

n. Sampler and facilitator:
   i. Repeat steps C.11.c through C.11.f.

12. Complete a Microbiology Requisition form for each sample collected, including:
    a. Duodenoscope model and serial number (e.g., TJFQ180V, #2619131)
    b. Channels/sites sampled (e.g., Distal cap seams, Instrument Channel, Elevator Recess)
    c. Reason for collecting the sample (i.e., Surveillance Monitoring)
    d. Date
    e. Time
    f. Cerner code of individual collecting the sample
13. Send the collected sample(s) and accompanying Microbiology Requisition(s) to Microbiology department immediately.
14. Clean, high level disinfect, dry and return the duodenoscope to storage per manufacturer's instructions for use (IFU) and Patient Care Services Procedure: High Level Disinfection.

D. **REFERENCES:**

1. Duodenoscope Surveillance Sampling & Culturing: Reducing the Risks of Infection. Department of Health and Human Services Collaboration (2018).

APPENDIX A

EQUIPMENT

a. Fluid-resistant sterile gown
b. Fluid-resistant face mask and eye protection
c. Sterile gloves
d. Bouffant cap for hair
e. Fluid-resistant sterile drape
f. 10x magnifying glass
g. Sterile specimen cups
h. Specimen labels
i. Sterile water (approximately 50mL)
j. Sterile alcohol wipes
k. Sterile cotton-tip swabs
l. 3mL syringes x 4
m. Sterile brush for elevator recess (i.e., Olympus Single Use Combination Cleaning Brush Model #BW-412T, sterilized according to manufacturer's instructions for use)
n. Sterile scissors
o. Sterile brush for instrument channel (i.e., Olympus Single Use Combination Cleaning Brush Model #BW-412T, sterilized according to manufacturer's instructions for use)
p. Large Back Table

APPENDIX B

DUODENOSCOPE DIAGRAM

Figure 1: Duodenoscope diagram

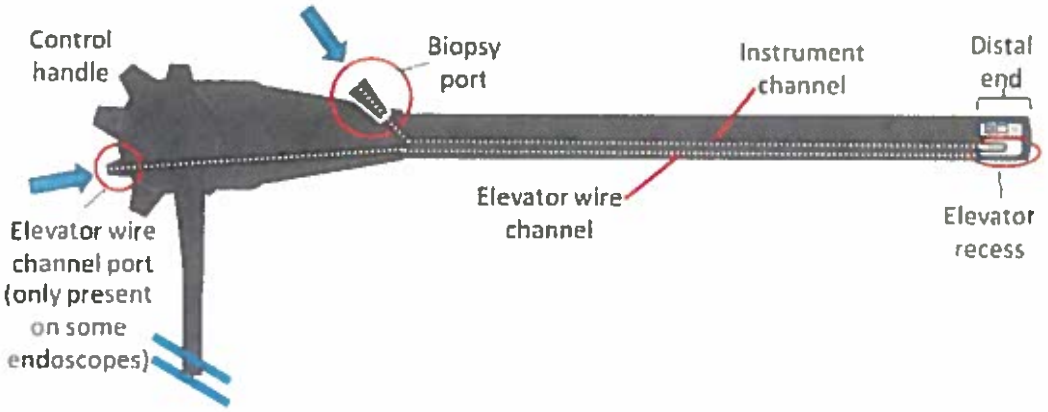
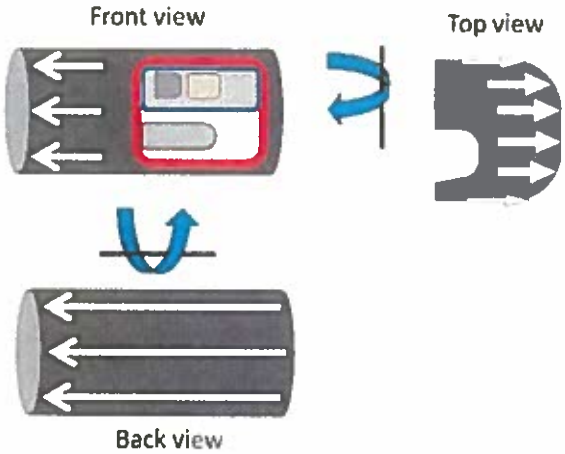


Image retrieved from Department of Health and Human Services Collaboration:
Duodenoscope Surveillance Sampling & Culturing, 2018.

DISTAL CAP SEAMS SAMPLING METHOD



White arrows represent location and direction of alcohol wiping of the exterior of the distal end.
Red box identifies the location of seams to swab for sampling.
Image retrieved from Department of Health and Human Services Collaboration:
Duodenoscope Surveillance Sampling & Culturing, 2018.

Tri-City Medical Ce
Oceanside, Californi

DELETE – no longer needed

TELEMETRY ~~UNIT SPECIFIC MANUAL~~

SUBJECT: ~~Assistant Nurse Manager (ANM), Relief~~ Charge Nurse, Duties and Responsibilities

POLICY NUMBER: 6150-103

ISSUE DATE: 02/05

REVISION DATE(S): 06/06, 03/07, 09/10, 12/10, ~~0~~

Department Approval:	~~01/16~~06/20
/Division of Cardiology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/11

~~A. PURPOSE:~~

~~1. To outline the shift duties and responsibilities for Registered Nurses (RN) assigned to the role of Telemetry ANM and Relief Charge Nurse.~~

~~2. The duties and responsibilities outlined in the policy are not inclusive. for the ANM.~~

~~B. POLICY:~~

~~The Relief Charge Nurse will perform the clinical and administrative duties and responsibilities identified in the Charge RN Orientation Skills Checklist and unit specific relief charge nurse task list.~~

~~1. Additional duties and responsibilities include but are not limited to the following:~~ANM or Relief Charge Nurse assigned to 2E and 2W

- ~~Collaborates with Bed Coordinator/Administrative Supervisor in patient placement to facilitate admission/transfers.~~
- ~~Obtains pertinent information on patients and staffing during shift hand off~~
- ~~Communicates discharges and transfers to bed coordinator during the day shift and to the Administrative Supervisor during the night shift using the electronicic bed system and during the bed meeting.~~
- ~~Communicates staffing needs to Staffing Resource Representative~~
- ~~Assist with bedside procedures as needed~~
- ~~Assist/delegates transporting patients requiring continuous monitoring as needed~~
- ~~Ensures narcotic counts are completed every week Wednesday per TCMC policy by night shift.~~
- ~~Reviews the following logs to ensure they are check per TCMC's policies and procedures:~~
  - ~~Crash Carts (verifies all items on the checklist are checked i.e., no blank boxes or spaces) per policy~~
  - ~~Transport defibrillators~~
  - ~~Available telemetry transmitters i.e., telemetry boxes~~
  - ~~Blanket warmers~~
- ~~Attends all overhead pages for Rapid Response, Dr. Strong, codes STEMI, Blue, and Stroke on Telemetry~~
- ~~Ensures a staff RN assumes the role of recorder during a code blue and the code blue record is complete per hospital policy~~
- ~~ProvidesAssist with break relief for all staffthe Monitor Technician (MT)~~

- Assist with all staff breaks as needed
- Attends shift bed meeting
- Assists with resolving patient, physician, and staff complaints/issues or contacts the appropriate nurse leader per the hospital's chain of command
- Ensures patient care boards and hourly rounding boards are updated
- Provides/initiates shift huddles

a. Directly communicates discharges and transfers to staffing coordinator during the day shift and to the Administrator Coordinator during the night shift.
b. Directly communicates staffing needs to (i.e., sick calls)
c. Ensures weekly narcotic counts are completed every Wednesday per TCMC policy
d. Assures patients' assignments are completed and properly assigned
e. Ensures patient assignments are completed using the Synergy Model
f. Breaks 2E and 2W when a break relief nurse is not available
g. Breaks monitor tech
h. Obtains pertinent information on every unit
i. Completes and verifies acuity report
j. Verifies Assignment Book is updated and Crash Cart is checked daily **Is this done by the Relief CN or the PRN or Both**
k. Complete or delegates the completion audits i.e. hand hygiene, restraints, CAUTI
l. Completes or ensures narcotic counts are completed every Wednesday per TCMC policy
m. Attends shift bed meeting
n. Updates clinical manager
o. Serves as a resource to all staff
p. Provides/initiates shift huddle topics
q. Completes daily productivity tool
- Assist/delegates transporting patients requiring continuous monitoring

r. to other departments

2. ANM or Relief Charge Nurse assigned to 3E, 4E, and 4W

a. Breaks 3E, 4E and 4W when break nurse is not available
b. Attends huddles and received updates from 2E/W ANM and/or Relief Charge Nurse
c. Provides report/update to ANM or Relief Charge Nurse on 2E and 2W (i.e., transfers, discharges, transports etc).
d. Transports and/or delegates patients as necessary
e. Complete and/or delegates audits
f. Completes and/or delegates weekly narcotic counts
g. Ensures weekly narcotic counts are completed every Wednesday per TCMC policy
h. Relief RN when staffing crisis arises
i. Verifies Assignment Book is updated and verifies Crash Cart is checked daily
j. Ensures patient assignments are completed using the Synergy Model
k. Serves as a resource to all staff
l. Assist/delegates transporting patients requiring continuous monitoring to other departments
m. Assist with bedside procedures

APPROVAL PROCESSRELATED DOCUMENT(S):

- **Blanket Warmer Policy, TCMC Patient Care Services Manual**
- **Emergency Cart Policy, TCMC Patient Care Services Manual**
- **Nursing Administration Relief Charge Nurse Skills Checklist, TCMC Patient Care Services Manual**
- **Plan for Nursing Care, TCMC Patient Care Services Manual**
- **Pyxis Medstation System, TCMC Patient Care Services Manual**

3.1. TCMC Nursing Administration: Relief Nurse Skills Checklist, TCMC Patient Care Services Manual

Tri-City Medical Center
Oceanside, California

TELEMETRY ~~UNIT-SPECIFIC POLICY MANUAL~~

ISSUE DATE:	**02/05**	**SUBJECT:**	**Bed Flow**
REVISION DATE(S):	**06/06, 03/07, ~~12/10~~, 02/11**	**~~POLICY NUMBER: 6150-104~~**	
Department Approval Date(s):		**~~11/15~~06/20**	
Division of Cardiology Approval Date(s):		**n/a**	
Pharmacy and Therapeutics Approval Date(s):		**n/a**	
Medical Executive Committee Approval Date(s):		**n/a**	
Administration Approval:		**07/20**	
Professional Affairs Committee Approval Date(s)		**n/a**	
Board of Directors Approval Date(s):		**02/11**	

A. **PURPOSE:**

1. To outline patient bed flow on the Telemetry **Units and to ensure Telemetry monitored beds are available and ~~used~~ assigned appropriately.**
   - ~~Cardiac Telemetry patients will be assigned beds on 2-East, 2-West, 4-East or 4-West.~~
   - ~~Medical or surgical Telemetry patients will be assigned beds on 3 Pavilion (3P).~~
2. ~~1.~~ **To provide guidelines to determine admission, discharge, and triage of hospitalized patients requiring cardiac monitoring on the Telemetry Unit.**

B. **POLICY:**

1. **It is the policy of Tri-City Medical Center (TCMC) to screen and triage all Telemetry patients daily for potential discharge or transfer to the appropriate level of care.**
2. **A patient may be admitted or transferred to Telemetry by order of a physician or his/her designee.**

C. **BED ASSIGNMENT VIA ELECTRONIC BED SYSTEM:**

1. Telemetry's ~~he Assistant Nurse Manager (ANM)/ or r~~**Relief** ~~C~~charge **Registered N**~~n~~urse **(RN)** is the first point of contact **for all admissions or transfers to the Telemetry units.**
2. **The ~~ANM/relief~~ charge nurse ~~RN~~ will assign patient beds based on the criteria identified in Telemetry's Admission and Discharge Criteria policy and bed availability.**
3. **Administrative Supervisors (AS) will inform a Telemetry ~~ANM/relief~~ charge ~~RN~~ of patients requiring Telemetry level of care. The Telemetry ~~ANM/ relief~~ charge ~~RN~~ will determine bed placement and inform the Administrative Supervisor.**
4. **Once a request for a Telemetry bed is received~~quired~~, the Telemetry ~~ANM/relief~~ charge ~~RN~~ will determine bed availability and assigned ~~provide the Telemetry unit and~~ a bed.**
   - ~~Patients with admission or transfer orders written by a cardiologist or cardiovascular surgeon will be assigned a room on 2E, 2W, 4E or 4W~~
   - ~~Patients with admission or transfer orders not written by a cardiologist or cardiovascular surgeon will be assigned a room on 3P.~~
   a. **Patients on ventilators will be assigned a bed on 2 East (2E) or 2 West (2W)**
   b. **Patients ~~or~~ requiring Bi-level Positive Airway Pressure (BiPAP) will be assigned a bed on ~~on~~ any Telemetry unit based on bed availability. ~~Cardiac Telemetry. Medical-Surgical-Teleson 3P BiPAP will be initiaed and transferred to cardiac Telemetry when bed is available.~~**

~~Nephrology patients with critical lab values, newly diagnosed or per the discretion of the Telemetry ANM/relief charge RN will be assigned a bed on Cardiac Telemetry.~~

c. **Telemetry overflow patients assigned to 4 Pavilion (4P) will have their care provided by a Telemetry staff RN.**

d. The ~~ANM/relief~~ charge **nurse** ~~RN~~ nurse is responsible for **requesting beds through the electronic bed system** ~~AIONEX~~**. Task may be delegated to the Unit** ~~Coordinator/Unit~~ **Secretary (US)** ~~contacting the ANM/relief charge nurse on other nursing units for bed requests for patients transferring to Acute Care Services (ACS) or the Intensive Care Unit (ICU).~~

e. **The Emergency Department (ED) will enter request in** ~~AIONEX~~**the electronic** ~~is~~ **bed system.**

~~1. Day Shift Monday through Friday:~~

~~a. The department requesting a bed shall call the ANM/relief charge nurse at 760-594-6082 for bed assignments.~~

~~b. If the call is not answered, the requesting department shall leave a message providing but not limited to the following information:~~

~~i. Name of department (Emergency Department (ED) please include station letter~~

~~ii. Patient name, age, admitting/transferring physician, and diagnosis~~

~~iii. Patient special needs i.e. ventilator/BiPAP, isolation/infection status, mental status~~

~~iv. Safety requirements i.e. restraints, psychological holding status~~

~~v. Presence of vasoactive or antidysrhythmic IV infusions~~

~~1. Night Shift and Weekends~~

~~c. The Administrative Supervisor shall contact the ANM/relief charge nurse at 760-594-6028. If no answer, contact 760-594-7421~~

~~2. For ED patients, the ANM/relief charge may enter the bed assignment into FirstNet with either "ready" or "not ready" status to inform the ED, the Telemetry ANM/relief charge is aware of their bed assignment need but accommodations are not available.~~

~~3. The ANM/relief charge nurse shall decide where patient will be placed on the Telemetry unit.~~

~~2.~~5. The ~~ANM/relief~~ **charge nurse** ~~RN~~ **or staff nurses** from ~~the~~ sending or receiving unit **will** ~~shall~~ not ~~notify or~~ request a bed assignment from ~~the~~ Telemetry staff nurses or ~~Unit Coordinators/US.~~ ~~monitor technician for a bed assignment~~.

~~3.~~6. ~~Staff nurses from the sending unit may not contact Telemetry staff nurses for bed assignments.~~;

~~4. The ANM/relief charge nurse on 3E, 4E, or 4W shall:~~

~~a. Notify the 2E/2W ANM/relief charge nurse of changes in patient's status, discharges, transfers, and room accommodations.~~

~~b. Make periodic calls to update the 2E/2W ANM/relief charge nurse of changes in census as soon as possible but prior to the deadline for staffing the unit for the next shift.~~

D. RELATED DOCUMENT(S):

1. **Telemetry** ~~'s~~ **Policy: Admission and Discharge Criteria,** ~~#6150-100~~

~~C.~~E. REFERENCE(S) ~~LIST~~:

1. **Plan for Nursing Care, TCMC Intranet**

~~American Heart Association (AHA). (2004). An american heart association scientific statement from the councils on cardiovascular nursing, clinical cardiology and cardiovascular disease in the young. Retrieved October 13, 2010, from http://www.circ.ahajournals.org~~

~~1.~~2. **American Association of Critical Care Nurses (AACN). (nd). Progressive care fact sheet. Retrieved January 2010 from http://www.aacn.org**

Tri-City Medical Center	Telemetry ~~Unit Specific Procedure Manual~~
PROCEDURE:	**MONITORING TELEMETRY PATIENTS USING THE DASH 3000**
Purpose:	To outline the nursing management for Telemetry patients requiring cardiac **monitoring** or **patients with arterial catheters requiring continuous blood pressure (BP) monitoring** ~~invasive line monitoring~~ utilizing the DASH 3000
Supportive Data:	The DASH 3000 is used to perform Basic Bedside Monitoring for Telemetry patients
Equipment:	1. DASH 3000 2. Monitoring cables for cardiac monitoring, blood pressure monitoring, invasive SpO2 monitoring, and invasive line monitoring if needed 3. Transducer Holder (if monitoring invasive line) 4. Electrodes 5. Pressure Bag 6. **Normal saline**~~Heparin Flush Solution~~ 7. Level
Issue Date:	2006

A. **POLICY:**

1. ~~All~~ Telemetry patients **with arterial catheters** requiring **continuous** ~~invasive~~ **BP**~~blood pressure (BP)~~ monitoring will be monitored using the DASH 3000 until the **arterial catheter is discontinueds or as ordered by a physician or Allied Health professional.** ~~invasive line is discontinued.~~
2. **The DASH 3000 may also be used for monitoring cardiac rhythms, heart rate, BP, respiratory rate, and oxygen saturation for patients without arterial catheters.**
3. **The DASH may not be used as a vital sign machine for routine vital signs on multiple patients.**

~~The DASH may also be used for cardiac monitoring for Telemetry patients who do not require invasive line monitoring.~~

~~1.~~

~~2.~~**4.** Only ~~Telemetry~~ Registered Nurses (RNs) **hired for the Telemetry unit and** ~~, Resource Nurses with ICU experience or~~ Intensive Care Unit (ICU) staff **will**~~shall~~ be assigned patients with invasive line.

~~3.~~**5.** Patients **will**~~shall~~ be monitored using standard monitoring leads in V1 or Lead II. Secondary lead **will**~~shall~~ be based on patient pathology.

6. The primary nurse **will**~~shall~~ verify the patient's rhythm can be viewed on the DASH 3000, the ~~nursing~~ **cardiac monitoring screen and the central monitoring station.** ~~ECG monitor, and by the monitor technician (MT) ECG monitor within 10 minutes of applying the monitor~~

~~1.~~**a. See the Management of Telemetry Patients Policy**

~~4.~~**1.** The DASH may also be used for cardiac monitoring for Telemetry patients who do not require invasive line monitoring.

~~5. The DASH may also be referred to as the monitor or bedside monitor.~~

~~6. The DASH may not be used routine shift vital signs.~~

B. **PROCEUDRE:**

1. Admitting a patient:
   a. Examine DASH to ensure the necessary monitoring equipment is present.
   b. Notify **Monitor Technician** (MT) patient will be monitored using the DASH 3000.
   c. Explain purpose for using DASH 3000 to patient.
   d. Apply telemetry box to patient.
   e. Turn on DASH by depressing the Green Power button.

Department Review	Division of Cardiology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/10;2/11, 01/16, 06/20	n/a	n/a	n/a	07/20	n/a	02/11

f. Close initial window using the trim knob located in the lower ~~right hand~~**right-hand** corner of the machine. Turning the trim knob left or right identifies all options. Selections are accepted by depressing the trim knob.
g. Select More Menus.
   i. If the previous patient's name is on the screen, select ECG Source, select Discharge Patient, then select both.
h. Select Admit Menu.
i. Select the Set Unit Name
   i. Select "A Care Unit".
   ii. Scroll down until the arrow points the appropriate unit (IMC 2, IMC 3, or IMC 4).
j. Select the patient's bed number.
k. Select the ECG Source
   i. Number located on the telemetry box.
   ii. Verify correct telemetry box number.
l. Select the Admit Patient button (patient's name, room number, and rhythm will automatically appear on the main screen).
m. If the telemetry box is missing:
   i. Call the MT and use the DASH.
   ii. Admit the patient using the steps outlined a-j.
   iii. Select ECG Source, then select monitor.

2. Monitor Setup:
   a. Waveforms On/Off:
      i. Select main menu or use the trim knob and scroll to ECG.
      ii. Select ECG Display Lead (If the lead displayed is not II or VI).
         1) May select a maximum of three cardiac waveforms which the following lead selections.
            a) I, II, III, VI, AVR, AVL, AVF.
         2) Waveforms may be aligned by selecting "Align Waveforms".
         3) The size of a waveform may be increased by selecting "ECG Size".
            a) The options include: 0.5X, 1X, 2X, and 4X.
         4) Other options include:
            a) Display lead.
            b) ECG size.
            c) Detect Pacemaker Mode.
            d) ECG limits.
            e) View all ECG.
            f) Relearn.
         5) Select Main Menu or Previous Menu for other options.
   b. Parameters:
      i. Select More Menus.
      ii. Select Parameters On/Off.
      iii. Turn off the Parameters not being used. i.e., Arterial Line (Art1, Blood Pressure (NBP), SP02, and respiratory rate (RR). You cannot manually turn off the ECG.
   c. Setting and Reviewing Alarms:
      i. Do not pause alarms~~or change internal settings. for alarms~~.
      ii. Default alarm parameters may be altered at the discretion of the primary ~~RNRegistered Nurse (RN).~~.
      iii. Modified alarm parameters will be reset to default settings once patients ECG is within default settings range. ~~Inform the MT for alarms adjustments for arrhythmias.~~
         ~~i.~~**1) Communicate to MT alarm parameter changes and provide instructions when to notify primary RN~~alarm parameter range for notifying RNs~~.**
      ~~i.~~**iv.** Review alarms history.

~~ii.~~v. Adjust alarm volumes. Never turn off alarms.

d. Patient Data:

i. Patient Data includes reviewing information on patient vital signs, alarm history, and dose calculations. Telemetry will not use the dose calculation options.

ii. Vital Signs:

1) The vital signs option may be used to select time specific intervals for monitoring non-invasive BP, view recent or older vital signs.
2) To view vital signs in a graph format, select graph setup.
3) Select main menu or previous menu to select more options.

iii. Non-Invasive Blood Pressure (NBP) monitoring:

1) Select main menu or use the trim knob to scroll to NBP.
2) Select desires options.
   a) NBP Auto (use this option to set specific time intervals for automatic BP). ~~Time intervals are available~~
   b) NBP Stat.
   c) Review NBPS.
   d) Cuff Size.
3) Select NBP intervals.
4) Select initial inflation pressure.
   ~~4)~~**a)** ~~to i~~Increase the **systolic BP** (SBP) pressure **above default setting** for patients with **SBPs**~~ blood pressures exceeding~~ 160.
5) Select Main Menu or Previous Menu for other options.

iv. Respiratory Rate Monitoring:

1) Select RR limits, ~~make adjustments~~**adjust** as needed.
2) Select RR sensitivity, ~~make adjustments~~**adjust** as needed.
3) Select Main Menu or Previous Menu for other options

v. SPO2 Monitoring:

1) The following options are available:
   a) Waveform size.
   b) Rate, may select on or off.
   c) Rate Volume.
   d) SPO2 Limits.
2) Select Main Menu or Previous Menu for other options.

3. **Continuous BP Monitoring for Patients with an Arterial Catheter**

~~3.a. Attaching the Transducer for Invasive BP Management and Monitoring (Arterial Line~~**catheter** ~~Monitoring):~~

~~a.~~**b.** Verify orders and attach the tele box (follow all the steps outlined in Admitting a Patient).

~~b.~~**c.** Attach transducer holder to an **intravenous pole** (IV)~~ pole.~~

~~c.~~**d.** Attach the ART Line cable (Red tipped cable) to the DASH in position 1.

~~d.~~**e.** Attach the ART line cable to the transducer.

f. Place transducer into the transducer holder

~~e. i.e. the firm portion of the transducer tubing leads to the patient and the soft portion of the transducer tubing is attached to the heparinized bag.~~

~~f.~~**i.** ~~Ensure the heparinized bag is placed into a pressure bag and inflate to 300 mm HG (300 millimeters of Mercury).~~

4. Calibrating **(Leveling Arterial Air-Fluid Interface), Troubleshooting, Monitoring and Discontinuing Arterial Catheter:**~~Arterial Line:~~

a. See Clinical Skills Arterial Catheter Insertion (Assisting), Care and Removal procedure.

~~a. Calibrating or zeroing to the atmospheric pressure equipment ensures accuracy of hemodynamic pressure readings. After the initial calibration, recalibrate PRN.~~

~~b. Positing the patient.~~

~~i. Position the patient according to the physician orders or supine no higher than a 60 degree angle.~~

~~c. The Phlebostatic Axis is a physical reference point of the chest used as a baseline for consistent transducer height placement.~~
~~i. It is the approximate level of the left atrium (Urden, Stacy, & Lough, 2010).~~
~~ii. It is a reference point for both arterial and central venous pressure transducers.~~
~~1)~~b. ~~The phlebostatic axis is a theoretic line drawn from the fourth intercostal space where it joins the sternum to a midaxillary line on the side of the chest.~~
~~2) The midaxillary line is one half of the anterioposterior depth of the later chest wall.~~
~~d. Locate the patient's phlebostatic axis and mark the phlebostatic axis with a skin marker.~~
~~e. The purpose is to line up the air fluid interface with the left atrium to correct for changes in hydrostatic pressure in blood vessels above and below the level of the heart.~~
~~f. Leveling the Transducer of secure to the patient's phlebostatic axis with tape.~~
~~i. Place the transducer on an IV pole.~~
~~Level the transducer to the patient's phlebostatic axis.~~
~~ii. If available, a carpenter's level may be used to make a straight line between the transducer and the patient's phlebostatic axis.~~
~~iii. Move the transducer holder up or down until the transducer is leveled to the patient's phlebostatic axis.~~
~~iv. When there is a change in the patient's position, the transducer must be leveled again (Urden, Stacy, & Lough, 2010).~~
~~v. Calibrating or Zeroing the Transducer to the atmospheric pressure.~~
~~1) Turn the three way stopcock nearest to the transducer to open the to air.~~
~~vi. Close the stopcock to the patient i.e the firm tubing leads to the~~
~~g. Select Zero Art on the DASH using the trim knob. A zero (0) should display on the DASH.~~
~~h. Flush the transducer by slowly opening the air valve. Do not remove the cap. Pull the flush tab and close the stopcock to atmosphere and open the stopcock to the patient. The following will appear on the monitor:~~
~~i. A square waveform (called a square wave test) then~~
~~i. A waveform with an invasive BP (see one of the following: Critical care nursing: Diagnosis and management or and AACN Procedure manual for critical care.~~
~~5. Troubleshooting Invasive lines:~~
~~a. Critical care nursing: Diagnosis and management or AACN Procedure manual for critical care.~~
~~6. Blood Draws:~~
~~a. See Attachment A~~
~~7. Discontinuing Arterial Line:~~
~~a. See Arterial Sheath Removal, Femoral Procedure~~
~~b. See Femostop Compression Device~~
~~8.~~5. Temporarily Off unit (Pause the DASH when a patient leaves the unit for procedures of diagnostic test):
a. Select More Menu
b. Select Alarm Control
c. Select Display Off-Alarm Pause
d. Select monitor/central pause
e. Disconnect patient (the screen will go blank)
~~9.~~6. Returning to Unit from Procedure:
~~(1)~~a. Reconnect patient to the DASH
~~(2)~~b. Push trim knob and the patient's cardiac rhythm will appear
~~ii.~~c. Check monitor at nurse's station to verify patient's rhythm can be viewed by the MT.
~~10.~~7. Changing (Discharging) a patient from the DASH 3000 and continuing monitoring using the Telemetry Box:
a. Select More Menu
b. Select Admit Menu

c. Select Discharge Patient
d. Select Monitor ONLY (this selection changes the monitor to the telemetry box)

~~11.~~8. Discharging a patient from both the DASH 3000 and the Telemetry Box:
a. Select More Menu
b. Select Admit Menu
c. Select Discharge Patient
d. Select Discharge from both

~~12.~~9. Monitoring the patient:
a. Monitor the patient per physician orders
b. Notify the physician as ordered

~~13.~~10. Patient Education:
~~a.~~ Instruct patient and family on **the purpose of monitoring patient using the DASH 3000.** ~~therapeutic use of hemodynamic or cardiac monitoring.~~
~~b.~~a. Instruct patient on activity and positioning restrictions.
~~c.~~b. Instruct patient to notify nursing for complaints of chest pain, shortness of breath, numbness, tingling, or cool extremities distal to sheath site.
c. Inform the patient of the signs of bleeding.
d. **Document education provided in the Electronic Health Record.**

C. **RELATED DOCUMENT(S):**
~~C.~~1. **Management of Telemetry Patients Policy**
2. **Arterial Sheath Removal, Femoral Procedure**
~~1.~~

D. **EXTERNAL LINK(S):**
1. **Clinical Skills:** ~~Mosby's Skills Manual:~~ Arterial Catheter Insertion (Assisting) Care, and Removal.

E. **REFERENCE(S)** ~~**LIST:**~~
~~1. (2010). *Critical care nursing: Diagnosis and management.* Canda: Elsevier~~
~~2. Edwards Lifesciences. (2010). Pressure monitoring: Edwards vamp system in-service bulletin. Retrieved from http://www.edwards.com/Edwards.web/printerForm.aspx~~
~~3.~~1. GE Medical Systems Information Technologies (n.d.). Clinical education and development: Basic bedside monitoring-adult non-invasive parameter.
~~4. Mosby's Procedure Manual~~
~~Urden, L. D., Stacy, K. M., & Lough, M. E. (2014). *Critical care nursing: Diagnosis and treatment.* Mosby's Inc., St. Louis: MO~~
~~Wiegand, D.L. (2011). *AACN procedure manual for critical care* (6th ed.). Philadelphia: Saunders~~

Tri-City Medical Center
Oceanside, California

TELEMETRY

ISSUE DATE: 10/96	**SUBJECT:** Nursing Responsibilities for Admissions
REVISION DATE(S): 04/00, 02/02, 05/05, 06/06, 03/07, 09/10, 02/11	
Department Approval:	~~06/15~~06/20
Division of Cardiology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/11

A. **DEFINITION(S):**

1. Core Telemetry **Direct Patient Care Providers:**~~Staff:~~ Registered Nurse (RN) s, ~~-or~~ Advanced Care Technicians (ACT)~~s~~, **and Lift Team Technicians I (LTT)** hired as staff for the Telemetry unit ~~and/or resource staff identified by the Telemetry Assistant Nurse Manager (ANM).~~
2. Five Rights of Delegation: A list of decisions a RN must consider based on the scope of practice of other RNs, or ACTs prior to delegating task. The Five Rights of Delegation include:
   a. Right task
   b. **Under the** ~~R~~right circumstances
   c. **To the** ~~R~~right person
   d. **With the** ~~R~~right direction **and** /communication
   e. **Under the** ~~R~~right supervision **and evaluation**~~provided~~

B. **PURPOSE:**

1. The purpose of this policy is to outline nursing responsibilities for patients admitted to the Telemetry Unit.
2. All patients admitted to Telemetry shall have a RN assigned to manage their care.
3. Components of the admission process and patient care may be delegated to ~~an~~-ACT **and LTTS**.

~~1. Components of the admission process may be delegated to the Telemetry LTTift Team Staff~~

C. **POLICY:**

1. A core Telemetry RN shall review the patient's admission information and **will** use the Synergy Model prior to assigning the patient to the following:
   a. RNs floating from another TCMC patient care area other than the Intensive Care Unit (ICU)
   ~~a. Resource RN~~
   b. Nursing registry RN
   c. RN traveler
2. All patients admitted to Telemetry shall be assessed by a RN upon arrival to the unit per the Standards of Patient Care **for Adults**.
3. All patients transferred from other nursing units to Telemetry shall be assessed by a RN on arrival to the unit per the Standards of Patient Care **for Adults**.
4. All post cardiac catheterization, ~~-and~~ **post cardiac surgery** patients admitted **or transferred** to the Telemetry, **ventilator, BiPAP, patient's requiring intravenous therapy for the management of a cardiac rhythm, rate, blood pressure or medications that may be only be administered on the Telemetry unit or higher level of care, and skills identified as**

specific for Telemetry Competency Skills checklist ~~shall~~ be assessed by and assigned to the following:

a. Core Telemetry RN
b. ICU RN
c. Core Telemetry ACTs
~~b. Resource RN who has successfully completed the Telemetry Annual Skills Lab or the ICU Annual Skills Lab.~~

D. **PROCEDURE:**

1. The following summarizes the primary nurse's responsibility. Many of the interventions listed below may be delegated to RNs floating to Telemetry~~,~~ and ACTs per their scope of practice:
   a. Review admission orders; **per the Physician/Provider orders policies**~~scan orders to pharmacy and implement STAT and/or NOW orders~~.
      ~~b.~~**i.** ~~Assist patient to bed, apply a gown and telemetry box.~~
   b. Verify patient's cardiac rhythm is visible on the telemetry monitor. **See the Management of Telemetry Patient Policy.**
   c. Obtain vital signs, height (may be stated) and weight. Please reference Telemetry Unit Specific Procedure Weighing Telemetry Patients.
   d. Orient patient, their family, or significant other to the unit.
   e. Instruct patient on the use of bed controls, television remote, bedside lights, and call button.
   f. Instruct patient to use urine collection container.
   g. Encourage patient, their family, or significant other to review the Patient Handbook.
      i. Review the process for implementing a Condition H with patient and their family.
      ii. Review the process for contacting regulating agencies as listed in the Patient Handbook.
   h. Apply appropriate patient identification bands i.e. allergy or fall risk.
   i. Update the patient education board.
   j. Document patient rounding per unit practice.
   ~~i.~~**k.** Post and interpret admission cardiac rhythm tracing **per policy**.
   ~~j.~~**l.** Review the admission orders with patient, their family, or significant other.
2. The Primary RN must ensure the following is completed and documented:
   ~~a. Completion of the Admission Assessment: History and Admission Assessment.~~
   ~~b. Pertinent information is entered on the Patient Information Tab( ) ???~~
   ~~c.~~**a.** Establish a Privacy Code and document the code in **Electronic Health Record (EHR)** ~~Cerner~~ and place a copy of the Privacy Code in the patient's chart.
      i. Ensure the patient and/or their family spokesperson receives a copy of the Privacy Code Patient Education sheet.
   b. Completion of the following per the Standards of Care:
      i. Admission Assessment
      ii. Admission Assessment-Patient History
      ~~i.~~**iii. Medication History**

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

1. **Patient Care Services Management of Telemetry ECG Strips**
2. **Patient Care Services: Standards of Patient Care, Adult**
3. **Telemetry Policy: Management of Telemetry Patients**~~, Telemetry Manual~~
4. **Telemetry Procedure: Weighing Telemetry Patients**~~, Telemetry Manual~~

F. **REFERENCE(S):**

~~1. California Code of Regulation Title 16. Retrieved from http://ccld.ca.gov/PG555.htm.~~
1. ~~California Code of Regulation Title 22. Retrieved from .~~**California Board of Registered Nursing. (N.D.) Understanding the role of the registered nurse and interim permittee**

according to the nursing practice act, the California code of regulations, and selected sections of title XXII. Retrieved from http://www.rn.ca.gov

2. American Nurses Association (ANA). (n.d.) Joint statement on delegation. American nurses association (ANA) and the national council of state boards of nursing (NCSBN)

Tri-City Medical Center
Oceanside, California

TELEMETRY

ISSUE DATE: 10/96 **SUBJECT: Orientation of Registry Staff**

REVISION DATE(S): 04/00, 10/02, 01/04, 05/05, 06/06, ~~POLICY NUMBER: 6150-110~~ 08/10, 02/11

Department Approval:	06/15
Division of Cardiology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	07/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/11

A. **PURPOSE:**

1. The purpose of this policy is to assist temporary nursing staff with written answers to the most frequently asked questions.

B. **POLICY:**

1. Patient Assignments:
   - a. Each unit will be **staffed according to** ~~assigned three (3) licensed nurses per~~ TCMC staffing practices~~ and Advanced Care Technician(s) (ACT)s per unit staffing guidelines~~.
   - **b.** Each unit **will**~~shall~~ have an **identified**~~assigned~~ Resource ~~Nurse~~ Registered Nurse (RN).
   - **c. Registry RNs** ~~Nurses~~ **who have completed a class in ECG rhythm recognition may interpret cardiac tracing (strips)**
     - **i. Inform the charge nurse**~~Resource Nurse~~ **at the beginning of the shift if you have not completed an ECG rhythm recognition class or need assistance**
   - **d. Electrocardiogram (ECG) tracings (strips) will**~~shall~~ **be posted**
     - **i. The primary RN will**~~shall~~ **record a six (6) second ECG tracing (strip) at the beginning of their shift.**
     - **ii. The strip will**~~shall~~ **be measured,** ~~interpreted~~**interpreted, and posted in the patient's EHR within a timely manner and as needed.**~~PRN~~**.**
     - **iii. The heart rate, the lead interpreted and measurements of following wave forms, if present, will be documented in the medical record; PR interval, QRS interval, and QT interval**
     - ~~a.~~**iv. Each RN nurse will**~~shall~~ **document their assigned patient's rhythm every four hours and as needed**~~PRN~~ **with any significant rhythm or rate changes in the medical record.**
2. **Telemetry Monitors**~~E~~**:**
   - ~~b.~~**a.** All patients **will**~~shall~~ be monitored in leads II and V1. A ~~m~~**Monitor T**~~t~~**echnician** ~~(s)~~**(MT)** is located on **3 Pavilion.**~~2 East~~.
   - **b. Telemetry patients will**~~shall~~ **have cardiac monitoring per physician order.**
   - **c. Telemetry monitoring may be interrupted for transport to tests/procedures with a physician order.** ~~Please review Telemetry's Admission Discharge or~~**Criteria.** ~~Or consult with the Resource RN or Assistant Nurse Manager (ANM)/relief Charge RN~~
   - **d. All Telemetry patients requiring cardiac monitor will**~~shall~~ **have a patent intravenous (IV) access at all times unless otherwise ordered.**
   - **e. Admissions, transfers, and patients returning to the unit from test/procedures will be placed on a cardiac monitor immediately upon arrival to the unit. Review the**

Management of Telemetry Patient Policy and consult with the Resource RN, Clinical Nurse Manager or ~~ANM/relief~~ Charge RN. ~~Exceptions:~~

~~l. Primary RN or relief RN present in patient's room and assessing patient's stability.~~
~~Prior to leaving the patient's room, the primary RN or relief RN will ensure the cardiac rhythm is visible to the Monitor Tech (MT).~~
~~A diagram of proper lead placement is located on the telemetry box.~~

~~f.~~ ~~Patients who have their cardiac monitor interrupted or disconnected from the view of the central monitoring station for any reason shall be placed back on the cardiac monitor immediately once identified or notified by the MT. See the Management of Telemetry Patients policy for examples and additional information.~~

g. Telemetry box batteries will~~shall~~ be maintained in working order at all times and changed as indicated.

h. The patient's telemetry box will~~shall~~ be removed during hygiene care or for transport as ordered.
   i. Notify the MT at extension 3466 or 3467 if you are removing the telemetry box from the patient for other reasons.
   ii. It is the primary RN's responsibility to ensure the telemetry box is removed, cleaned and properly stored when a patient is discharged or their accommodation is changed to a medical, surgical unit ~~conventional care (CC)~~ or Medical Monitored.
   iii. Clean telemetry box and lead wires with the appropriate disinfectant.
   iv. Consult with the ~~resource~~ RNs or primary Telemetry ACT.

3. Documentation:
   a. Document the following in the Electronic Heath Record (EHR) in a timely manner:
      i. Delays in placement of cardiac monitor not related to direct patient care being provided
      ii. Patient's status during delay in cardiac monitoring or visualization of cardiac rhythm

~~a. Admissions and transfers to the unit shall be placed on a cardiac monitor within 5 minutes of arriving to the unit.~~

~~b. The primary RN must verify the patient's cardiac rhythm is visible on the cardiac monitor by printing a cardiac rhythm strip.~~

~~c. Patients returning from procedures shall be placed on a cardiac monitor within 15 minutes of arriving to the unit.~~

~~d. Patient's cardiac rhythm shall be documented every four hours in the medical record thereafter:~~
   ~~i. Nurses who have completed a class in ECG rhythm recognition may interpret cardiac strips.~~
   ~~ii. Inform the Resource Nurse at the beginning of the shift if you have not completed an ECG rhythm recognition class or need assistance.~~

~~e. Cardiac rhythm Strips shall be posted and interpreted once a shift and PRN.~~

~~f. The primary nurse is responsible for ensuring patient's arriving to the unit or returning from procedures are placed back on the cardiac monitor.~~
   ~~i. A diagram of proper lead placement is located on the telemetry box.~~

~~g. When notified by the monitor technician (MT), RN, or ACT on the unit to replace a patient's leads, replace electrodes or replace the battery, immediately.~~

~~h. The patient's telemetry box shall be removed during hygiene care or for transport as ordered.~~
   ~~i. Notify the monitor tech at extension 3466 or 3467 if you are removing the telemetry box from the patient for other reasons~~

~~i. It is the primary nurse's responsibility to ensure the telemetry box is removed, cleaned and properly stored when a patient is discharged or their accommodation is changed to conventional care (CC):~~
   ~~i. Notify the MT~~

~~ii. Remove the monitor from the patient's room~~
~~iii. Clean the telemetry box with the correct solution and place it in the storage compartment for telemetry boxes.~~

~~3.~~4. Vital Signs:
   a. Routine Telemetry vital signs are every four (4) hours while awake.
   b. Vitals should be taken **as needed**~~PRN~~ based on clinical judgment and/or orders.
   c. Routine recommended Telemetry vital sign times are 0700-0800, 1200, 1600, 2000, and 2400 while awake and/or as ordered.

~~4.~~5. Intake **and**~~&~~ Output:
   a. All Telemetry patients are on measured intake ~~&~~**and** output.
   b. Ensure the correct urine collection device~~s in the patient's room~~ **is available in patient room**.
   c. **Intravenous**~~V~~ Infusion pumps **will**~~shall~~ be zeroed and documented at every twelve hours (12) 0600 and 1800. See Standards of Patient Care.
      i. See the Telemetry unit specific procedure: Weighing Telemetry Patients for fluid restriction requirements.

~~3.~~6. **Weights:**
   a. All patients **will**~~shall~~ be weighed in kilograms on admission using a chair scale unless contraindicated stated weights are not acceptable.
   b. See Telemetry unit specific procedure: Weighing Telemetry Patients Weighing for more information on the patient population requiring daily or weekly weights.
   c. All patients **will**~~shall~~ have their height assessed and documented on admission.

~~4.~~7. **Documentation of Patient Acuities:**
   a. Acuities **will**~~shall~~ be documented every shift and **as needed**~~PRN~~.
   b. See: Patient Care Services Policy Manual, Subject: Documentation, Policy Number VII.A

~~5.~~8. **Physician Orders and Chart Checks:**
   a. Registered Nurses are responsible **for** reviewing and verifying orders per TCMC policy. See
      i. PCS: Physician Orders.

~~6.~~9. **Communication**~~HAND-OFF~~**:**
   a. Healthcare providers **will**~~shall~~ communicate new, changes or updates in patient information throughout a shift.
   b. Prior to transferring patients to another healthcare provider' care.
      i. See PCS: Hand-off, Communication and Telemetry Shift-to-Shift Hand-off Policy

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

3. **Management of Telemetry Patients. Telemetry Manual**
~~1.~~4. ~~PCS:~~ Documentation **in the Medical Record, Patient Care Service Manual**~~, Policy Number VII.A~~
5. ~~PCS:~~ Hand-off, Communication**, Patient Care Service Manual**
~~2.~~6. ~~PCS:~~ Physician's Orders**. Patient Care Service Manual**
~~3.~~7. Standards of Patient Care, **Patient Care Service Manual**
8. Telemetry Shift-to-Shift Hand-off Process. **Telemetry Manual**

Tri-City Medical Center
Oceanside, Californ

DELETE – no longer needed

TELEMETRY ~~UNIT-SPECIFIC POLICY MANUAL~~

SUBJECT: Staff Meetings **POLICY NUMBER: 6150-117**

ISSUE DATE: 10/96
REVISION DATE(S): 04/00, 10/02, 05/05, 06/06, 03/07, 11/09, 08/10, 12/10, 02/15

Department Approval:	**08/15**
Division of Cardiology Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee ~~Approval:~~	**n/a**
Board of Directors Approval:	

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

~~1. To provide a forum for intradepartmental communication and the dissemination of information.~~

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

~~1. Telemetry unit-based staff meeting operates under the shared governance model.~~

~~Telemetry staff meetings are held twice **once** a month; one scheduled in the morning and one scheduled in the evening for a total of four**two** a month.~~

~~2. The times of the staff meeting will be posted on the unit.~~

~~A preliminary agenda is posted for the staff to add items for discussion prior to the meeting.~~

~~3. The final agenda will be distributed during each meeting.~~

~~4. A Telemetry Assistant Nurse Manager **(ANM or the Manager** shall chair the meeting.~~

~~5. The Critical Care Secretary shall record minutes and post a copy of the minutes in the Practice Education Book.~~

~~All Telemetry staff members are required to **attend 75% of the meeting annually and/or read the**read the minutes **of all meetings.**.~~

~~**Staff may also participate in a meeting via conference call when available.**~~

~~**In addition to participating in the meeting conference, can also view the meeting presentation online.**~~

~~6. **Conference meeting information will be emailed to staff, prior to the schedule meeting date.**~~

~~C. **APPROVAL PROCESS**~~

~~1.~~

Tri-City Medical Center	Distributi

DELETE – follow Patient Care Services Policy: Hand Off Communication

PROCEDURE:	**TELEMETRY SHIFT-TO-SHIFT HAND-OFF**
Purpose:	To identify Telemetry's Shift-to-Shift Hand-off communication processes a Registered Nurse (RN)) and/or Advanced Care Technician (ACT) shall implement to communicate new, changes or updates in patient information throughout a shift.
Supportive Data:	2008 National Patient Safety Goals Hospital Program: Goal 2E Hand-Off, Communication and PCS Policy IV.F
Equipment:	The following equipment is optional: Kardex Patient Chart Hand-Off report forms i.e. SBAR Nursing Hand-Off Form, Patient Census Task List eMAR Electronic documentation devices i.e., tablet or desk top computer
Issue Date: 7/08	Revision Date(s): 8/08, 12/08, 1/09, 7/10, 12/10; 2/11

A. **DEFINITIONS:**

1. Shift-to-shift hand-off communication: a process for communicating patient information between the on-coming and off-going nursing shifts as both nurses review and discuss pertinent patient information while observing the patient.

a. Telemetry shift-to-shift hand-off communication process includes a verbal hand-off (report) presented by the off-going licensed nurse to the on-coming licensed nurse In certain circumstances hand-off may take place outside of the patient's room

2. Rounds: a process by which patients are observed by the off-going and on-coming RNs or ACTs at the patient's bedside during or after verbal shift-to-shift hand-off communication.
3. Health Care Team: RNs, ACTs, secretaries, and Lift Team Technicians (LT) assigned to a nursing unit.
4. Shift Team Update: A brief verbal communication between the health care team assigned to a unit to provide pertinent information regarding individual patient assignments. Shift Team Updates shall also be known as "post hand-off huddle".

a. Shift team updates shall be initiated by the on-coming healthcare team after shift-to-shift hand-off communication

b. Shift Team Updates shall continue throughout the shift as needed to improve communication between all members of the health care team.

B. **POLICY:**

1. Shift-to-shift hand-off communication shall be accurate, complete, and include information about the patient's care, current condition, recent or anticipated changes, treatments, and services.
2. Shift-to-shift hand-off communication shall begin after shift huddles and end in approximately 30 minutes seven days a week on all Telemetry units.
3. The nursing staff shall prepare the units for shift-to-shift hand-off communication prior to 0700 and 1900.
4. Shift-to-shift hand-off communication shall consist of a verbal report and rounds.
5. ACTs, secretaries, and LT shall answers the telephones and patient call lights during the RN shift-to-shift hand-off to decrease interruptions.
6. At the completion of shift-to-shift hand-off, the on-coming nurses shall meet and provide each other brief shift team updates on their assigned patients.

a. Shift team updates may occur at the nurses' station or in the break room.

7. ACTs shall receive hand-off from as outlined in the Telemetry: Advanced Care Technician Shift Routine Policy.
8. ACTs shall receive updates, clarify duties and shift task with the RN assigned to the patient after the completion of the RN hand-off.
9. Copies SBAR Nursing Hand-Off Forms are located on the unit.

Department Review	Division of Cardiology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/20	n/a	n/a	n/a	07/20	n/a	

a. Documentation of the shift-to-shift hand-off communication on the SBAR Nursing Hand-Off form is not required; however the components of SBAR shall be discussed during hand-off communication.

10. To promote patient/family centered care; information communicated during shift-to-shift handoff may be discussed in the presence of the following with the consent of the patient or their spokesperson:

a. Patient's spouse
b. Patient's children
c. Patient's significant other
d. Patient's friends

C. **PATIENTS ASSIGNMENTS:**

1. Patient assignments shall be a collaborative effort with contributions from the off-going shift using the following as guidelines:

a. Acuity
b. Synergy Model Nursing Model
c. Maintaining continuity of care
d. Admissions, transfers, and discharges

2. Assignments shall be divided among the health care team.
3. The resource nurse/designee shall inform the ANM/ relief charge nurse of the assignments prior to the start of the on-coming shift.
4. The ANM/ relief charge nurse may adjust the assignments after consulting the resource nurse/designee or designee.
5. The assignments shall be posted on the unit prior to the start of the on-coming shift.

D. **SHIFT TEAM UPDATES (Post Hand-off Huddle):**

1. Shift team updates shall take place every shift after the completion of shift-to-shift hand-off.
2. All members of the healthcare team shall participate in shift team updates.
3. RN Shift Team Updates

a. Shift team updates shall not include a head-to-toe assessment.
b. The following information may be communicated during shift team updates:

i. Current condition/status (do not provide patient history)
ii. Code status
iii. Isolation status
iv. Level of consciousness
v. Cardiac rhythm and rate
vi. Cardiac drips, TPN, infusing blood products (mainline electrolyte solutions do not need to be discussed)
vii. Respiratory i.e., vent settings or oxygen administration type and liters
viii. Diet information if NPO or fluid restriction
ix. Safety issues and/or mobility limitations
x. Scheduled diagnostics (current critical lab values may be discussed, do not discuss normal labs or provide detail information on normal diagnostic results).

4. ACTs Shift Team Updates

a. ACTs shall receive shift team updates during the RN's shift team updates (post hand-off huddle).
b. ACTs may use the Telemetry ACT/CNA Shift Report Handoff Tool to document pertinent information communicated during shift team updates (post hand-off huddle).
c. ACTs shall document the following information discussed during shift team updates on their report hand-off tool

i. Current condition/status (do not provide patient history)
ii. Code status
iii. Isolation status
iv. Level of consciousness
v. Respiratory i.e., patient on vent, BiPAP and oxygen administration type and liters
vi. Diet information if NPO or fluid restriction
vii. Diabetic
viii. Safety issues and/or mobility limitations

5. Shift team updates shall be communicated among the health care team throughout the shift.

Other pertinent patient information may be communicated to the health care team as needed

E. **PREPARING THE UNIT FOR PATIENT HAND-OFF:**

1. After informing the patient and their family prepare the unit by completing the following:
a. Place patient's bedside table, call button, cup, pitcher, telephone, and other personal items within patient's reach.
b. Assist or delegate patient with toiletry needs prior to hand-off.
c. Close unit doors near the following rooms (optional):
i. 227 A/B, 237, 242, 252 A/B, 327 A/B, 337, 427A/B, 437, 442, and 452 A/B
d. Do not close center doors located near the following areas:
i. ANM office on 2 East and 4 East
ii. Nurses' station on 2 East, 2 West, 4 East and 4 West
iii. Soiled utility closet on 3 East
2. Once shift-to-shift hand-off is completed open unit doors.

F. **PATIENTS/FAMILY PREPARATION AND EDUCATION FOR PATIENT HAND-OFF:**

1. Inform patient and/or family shift-to-shift hand-off communication is:
a. A method used to provide patient information to the on-coming nurse
b. Occurs twice a day beginning after shift huddles.
c. A process which may take approximately 45 minutes
2. Inform the patient's spouse, children, family, or significant others may remain in the patient's room during shift-to-shift hand-off only with the permission of the patient.
a. Ask visitors in double patient rooms to leave the unit during hand-off or obtain permission from both patients' to have family/friends present during hand-off.
3. Inform patient and/or family patient's doors may be closed during shift-to-shift hand-off to provide privacy for the other patients on the unit.
4. Inform the patient and/or family the main entrance to each unit will be closed during patient shift-to-shift hand-off.

G. Shift Huddles

1. Shift huddles shall be conducted prior to every shift to convey information to the staff. The information shared during shift huddles shall include but is not limited to the following:
a. Staffing concerns
b. Education updates
c. In-services
2. Shift huddles shall occur at the beginning of every shift beginning at 0700 & 1900.
3. Shift huddles shall be initiated by the off-going ANM/relief charge nurse

Nursing Hand-Off Form

Patient Name:
Age:
Physician Date:
Admission Process Completed: Daily Interventions:
Admission Med Reconciliation: Y or N Turn Q2 hrs: Y or N

S

SITUATION: Inpatient Observation Medicare Important Message on Chart Y or N
Admit Dx: Core Measure: PN/Flu (Vaccine given Y or N)
MI (ECHO, ACE/ARB, Beta-blocker)
Current Dx: HF (ECHO, ACE/ARB, Diuretic)

B

BACKGROUND:
Med Hx:
Allergies:
Code Status/Treat Orders:
Interventions/Responses:

Problems/Concerns/Resolutions:

A

ASSESSMENT:
Neuro: A/O, confused, forgetful VS (include pain):
alzheimer/dementia
Respiratory: (include Bipap/Vent settings) Accucheck Insulin given Y or N
Cardiac: (rhythm/rate) CVS Patients: Pacer wires AV or V
Isolated or Attached
Cardiac Cath: Site Temp pacemaker mA rate sen
Site Closure: Manual hold, Femostop,
Perclose, Angioseal Aline: Y or N Diagnostic Abnormal Results:
GI/GU:
Musculoskeletal: IV site/type/solutions:
ADLib or Assist
Ambulate, Cardiac Chair, Bedside Chair
Lift Team Y or N Skin: (Decub or wound vac)
Psychosocial: Drains:

R

RECOMMENDATIONS:
Goals:
Consults:
Test/Treatments: (example dressing changes)

Discharge Needs/Support System:
D/C: Home/SNF/B&C/Hospice

Admission History/Short Stay: Y or N Oral Care: Y or N

~~Admission Assessment: Y or N Falls Risk: Y or N >/= 45 bracelet applied Y or N~~
~~Care Plan initiated/updated: Y or N Restraints: Y or N (type) _____~~
~~Orders noted: Y or N Chart Checks Completed: Y or N~~

A.

Tri-City Health Care District
Oceanside, California

~~CENTER FOR~~ WOUND CARE CENTER~~&~~
HYPERBARIC CLINIC~~MEDICINE~~
~~POLICY MANUAL~~

ISSUE DATE: 06/07

SUBJECT: Patient ~~HBOT~~ Instructions

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. The Patient Instructions provides the patient and family/caregivers with a clear guide to understanding the physician's instructions for care after the clinic visit.
1. **Guidelines for documenting physician orders for patient use.**

B. **POLICY:**

1. All patients receiving ~~treatment at the Center~~**hyperbaric oxygen (HBO) therapy** will receive clear **and** verbal and written instructions for aftercare/home care.

C. **PROCEDURE:**

1. The Center/**hyperbaric** physician will write physician orders using the approved physician order form after each visit/**treatment, if applicable**.
2. The licensed/**HBO** staff will transcribe orders for patient use on the approved "Patient Instructions" form, **if applicable**.
3. The Center/**HBO** staff will also provide verbal instructions for clarity and to assess patient understanding.
   a. **For complex instructions (such as complicated dressings), the Center staff will assist with patient instructions.**
4. The next appointment date and time will be included on the instruction sheet.
5. A copy of the instructions will be given to the patient.
6. The patient will sign the form, indicating receipt and **their** understanding of **the** instructions.
7. The form will remain a permanent part of the medical record.
8. The patient's compliance with instructions and understanding of instructions will be assessed ~~with~~**on** each visit.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBA
POLICY MANUAL

DELETE – follow Patient Care Services Policyies: Outpatient Specimen Transport to TCMC Main Laboratory & Specimen Labeling

ISSUE DATE: 06/07 **SUBJECT: Specimen Transport**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
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 Center 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., deep 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 Center 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 Health Care District
Oceanside, California

~~CENTER FOR~~ WOUND CARE CENTER~~&~~
HYPERBARIC CLINIC~~MEDICINE~~
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Unit Specific Orientation**

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Because of the complexity of the services offered, comprehensive orientation to the processes and protocols of the wound care and hyperbaric medicine center is essential to adequately prepare associates to work in this new environment. This document delineates the responsibilities of the hospital, the wound care center and the associate and defines the processes necessary for equipping each employee to safely/effectively perform his/her job duties.

B. **RESPONSIBILITY:**

1. The hospital assumes responsibility for the initial and annual orientation programs.
2. The department is responsible for the unit-specific orientation, the unit-specific safety and environment of care training and for staff development programs throughout the year that meet the identified needs of the staff and the clinic operations.
3. The clinic manager assumes overall responsibility for the design, implementation and evaluation of the orientation process.
4. The associate, in partnership with the hospital, assumes responsibility for:
   a. Professional education/licensing and certifications
   b. Identifying their own learning needs
   c. Pursuing opportunities to meet their learning needs

C. **POLICY:**

1. All employees joining the clinic team will have a unit-specific orientation and training.
2. The orientation/training content will be current, applicable and systematic.
3. The orientation/training experience is individualized and designed to provide pertinent policy and procedural knowledge to be followed by the new associate.
4. Instruction will be clear, succinct and administered at the level of the learner.
5. Competency assessments, where applicable, will be completed before the end of the unit orientation and filed in the associate employment folder in the HR department.
6. Orientation will be provided during the associates assigned work shift.
7. Instruction will be didactic and experiential.
8. Orientees will be acquainted with their new surroundings and receive sufficient orientation and training to become a member of wound care team.
9. Cross training of an associate may also occur when appropriate. The training will be sufficient in content and duration to prepare the associate for their new position.

D. **PROCEDURE:**
1. All associates will receive general hospital orientation.
2. Department-specific orientation and training will occur in the initial period of the associate's employment and prior to taking full responsibility for their assigned duties.
3. A job description will be given to each orientee.
4. The duration of the orientation period will be sufficient to prepare the employee for full participation in clinic activity.
5. Each new staff member will be assigned to a resource person(s) by the clinic manager.
6. During the 90-day initial employment peiord, the new employee will be observed by the clinic manager and/or designee for progress, and adjustments to the training will be made accordingly.
7. Department-specific orientation schedule includes:

E. **ALL CENTER STAFF MEMBERS:**
1. Job descriptions
2. Safety
   a. **Safety Data Sheets (MSDS)**
   b. Emergency plans (fire, disaster, etc.)
   c. Hazardous waste
3. Infection Control
   a. Standard (Universal) precautions
   b. Personal protective equipment
   c. Biohazardous waste
   d. Handwashing
4. Review of abuse reporting policy
5. Performance improvement program
6. Risk management program

F. **CLINICAL STAFF ORIENTATION:**
1. Unit orientation
2. Clinic policies and procedures
3. Clinic flow
4. Equipment
   a. Doppler
   b. Glucometer
   c. Photography
5. Case management (RN)
6. Blood drawing/transporting/storage techniques
7. Medical records/documentation
8. Supplies/Protective devices

G. **MEDICAL STAFF:**
1. Unit orientation
2. Clinic flow
3. Medical records/documentation
4. Dictation
5. Supplies/protective devices

H. **SUPPORT STAFF:**
1. Unit orientation
2. Clinic flow
3. Medical Records
4. Data base

5. Billing/Reimbursement/Registration
6. Phone techniques/etiquette
7. Equipment
    a. Copier
    b. Fax
    c. Computer/printer

Tri-City Health Care District
Oceanside, California

DELETE – duplicate policy

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07

SUBJECT: Patient HBOT Instructions

REVISION DATE(S):

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**07/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. Guidelines for documenting physician orders for patient use.~~

~~B. **POLICY**~~

~~1. All patients receiving hyperbaric oxygen therapy will receive clear and verbal and written instructions for aftercare/home care.~~

~~C. **PROCEDURE**~~

~~1. The hyperbaric physician will write physician orders using the approved physician order form after each treatment, if applicable.~~
~~2. The HBO staff will transcribe orders for patient use on the approved "Patient Instructions" form, if applicable.~~
~~3. The HBO staff will also provide verbal instructions for clarity and to assess patient understanding.~~
~~4. For complex instructions (such as complicated dressings), the Center staff will assist with patient instructions.~~
~~5. The next appointment date and time will be included on the instruction sheet.~~
~~6. A copy of the instructions will be given to the patient.~~
~~7. The patient will sign the form, indicating their understanding of the instructions.~~
~~8. The form will remain a permanent part of the medical record.~~
~~9.~~1. ~~The patient's compliance with instructions and understanding of instructions will be assessed on each visit.~~

ADMINISTRATION CONSENT AGENDA
August 13th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Advance Healthcare Directives	3 Year Review, Practice Change	Forward To BOD For Approval
2. Alcohol Withdrawal Symptom Management	3 Year Review	Forward To BOD For Approval
3. Child Passenger Restraint System Education Policy	DELETE	Forward To BOD For Approval
4. Code Status / Do Not Resuscitate (DNR) / Withholding or Withdrawing Life Sustaining Treatment	3 Year Review, Practice Change	Forward To BOD For Approval
5. Code Triage Alert, Emergency Department Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
6. Continuous Passive Motion (CPM) Machine Procedure	DELETE	Forward To BOD For Approval
7. Determination of Brain Death	3 Year Review	Forward To BOD For Approval
8. Epicardial Pacing Wires Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
9. Interpretation and Translation Services Policy	3 Year Review, Practice Change	Forward To BOD For Approval
10. Meals, Patients - Times, Menus, Substitutions, & Nourishments Policy	3 Year Review, Practice Change	Forward To BOD For Approval
11. Nursing Students in Patient Care Areas Policy	3 Year Review, Practice Change	Forward To BOD For Approval
12. Percutaneous Tracheostomy Assist Procedure	Practice Change	Forward To BOD For Approval
13. Rapid Response Team and Condition Help Policy	3 Year Review, Practice Change	Forward To BOD For Approval
14. Safe Patient Handling, Bariatric	NEW	Forward To BOD For Approval
15. Spiritual Care for Family of Critically Ill or Deceased Infant	DELETE	Forward To BOD For Approval
16. Spiritual Care of the Patient Policy	3 Year Review, Practice Change	Forward To BOD For Approval
17. Thinning of Patient Record Policy	DELETE	Forward To BOD For Approval
Administrative Policies & Procedures/Pay Practices		
1. Disclosure of Unanticipated Adverse Outcomes to Patient Family Policy 275	3 Year Review, Practice Change	Forward To BOD For Approval
2. Equal Employment Opportunity - 418	3 Year Review, Practice Change	Forward To BOD For Approval
3. Coaching and Counseling for Work Performance - 424	3 Year Review, Practice Change	Forward To BOD For Approval
4. Leave of Absence - 435	3 Year Review, Practice Change	Forward To BOD For Approval
Jury Duty - 435.02	3 Year Review, Practice Change	Forward To BOD For Approval
6. Flex.Float to Activity - 437	3 Year Review, Practice Change	Forward To BOD For Approval
7. Reduction in Work Force - 448	Practice Change	Forward To BOD

ADMINISTRATION CONSENT AGENDA
August 13th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
		For Approval
8. Diversity - 471	3 Year Review, Practice Change	Forward To BOD For Approval
9. Benfit Eligibility Matrix - 472.01	DELETE	Forward To BOD For Approval
10. Premium Specialty Pay - 473	3 Year Review, Practice Change	Forward To BOD For Approval
11. Charge Pay - 473.01	DELETE	Forward To BOD For Approval
12. Holiday and Holiday Premiums - 473.02	DELETE	Forward To BOD For Approval
13. Interpreter Premium - 473.03	DELETE	Forward To BOD For Approval
14. On-Call and Call-Back - 473.04	DELETE	Forward To BOD For Approval
15. Report In Pay - 473.06	DELETE	Forward To BOD For Approval
16. Special Pay Practices - 473.08	DELETE	Forward To BOD For Approval
17. New Hire Pay Rates - 475.03	DELETE	Forward To BOD For Approval
18. Staff Requests Not to Participate in Care - 480	3 Year Review, Practice Change	Forward To BOD For Approval
19. Step Progression - 481	DELETE	Forward To BOD For Approval
20. Hiring and Employment; Screening Current Employees - 485	3 Year Review, Practice Change	Forward To BOD For Approval
21. Hiring and Employment; Pending Charges against Current Employees - 486	3 Year Review	Forward To BOD For Approval
22. Hiring and Employment; Conviction/Exclusion/License Revocation of Current Employees - 487	3 Year Review	Forward To BOD For Approval
23. Hiring and Employment; Employee Requirements to Report Changes in Certification - 488	3 Year Review	Forward To BOD For Approval
24. Procedure DevApproval - 775	DELETE	Forward To BOD For Approval
Unit Specific		
Cardiac Rehab		
1. Contraindication to Cardiac Rehab Exercise	3 Year Review	Forward To BOD For Approval
2. Exercise Prescription	3 Year Review	Forward To BOD For Approval
3. Exercise Protocol, Phase II	3 Year Review, Practice Change	Forward To BOD For Approval
4. Exercise Protocol, Phase IV	3 Year Review	Forward To BOD For Approval
5. Patient Discharge Criteria	3 Year Review, Practice Change	Forward To BOD For Approval
6. Patient Enrollment	3 Year Review, Practice Change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
August 13th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
7. Patient Referral	DELETE	Forward To BOD For Approval
8. Scope of Practice	3 Year Review, Practice Change	Forward To BOD For Approval
Emergency		
1. Deaths of Pediatric Patients Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
2. Leave Without Treatment (LWOT), Against Medical Advice (AMA) or Elopement	3 Year Review, Practice Change	Forward To BOD For Approval
3. Notification Patient Follow Up Policy	3 Year Review, Practice Change	Forward To BOD For Approval
4. Pediatric Patients, Care of Policy	3 Year Review, Practice Change	Forward To BOD For Approval
5. Transfer of Pediatric Patients Procedure	3 Year Review, Practice Change	Forward To BOD For Approval
Home Care		
1. Care Coordination	3 Year Review, Practice Change	Forward To BOD For Approval
2. Critical Lab Values	3 Year Review, Practice Change	Forward To BOD For Approval
3. Late Entry Documentation	3 Year Review	Forward To BOD For Approval
4. Medical Record Security	DELETE	Forward To BOD For Approval
5. Procedure for Use of Home Care Nursing Bag	3 Year Review, Practice Change	Forward To BOD For Approval
Medical Staff		
1. Credentialing Standards for Vertebral Augmentation 8710-534	3 Year Review	Forward To BOD For Approval
2. Criteria for Granting Moderate and Deep Sedation/Analgesia Privileges to Non-Anesthesiologists 8710-517	3 Year Review	Forward To BOD For Approval
3. Election Process of Member(s) at Large for Medical Executive Committee 8710-531	3 Year Review	Forward To BOD For Approval
4. Focused Professional Practice Evaluation - Proctoring 8710-542	3 Year Review	Forward To BOD For Approval
5. Quality Review Process for Teleradiologists 8710-525	3 Year Review, Practice Change	Forward To BOD For Approval
NICU		
1. Cue Based Feeding	3 Year Review, Practice Change	Forward To BOD For Approval
Outpatient Specialty Clinic		
1. Continuum of Care	3 Year Review, Practice Change	Forward To BOD For Approval
2. Diagnostic Tests	DELETE	Forward To BOD For Approval
3. History and Physical	DELETE	Forward To BOD For Approval
4. Hospital Admission from the Outpatient Forensic Clinic	3 Year Review,	Forward To BOD

ADMINISTRATION CONSENT AGENDA
August 13th, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
	Practice Change	For Approval
5. Medical Emergencies	DELETE	Forward To BOD For Approval
6. Medical Record Review	3 Year Review	Forward To BOD For Approval
7. Patient Instructions	3 Year Review, Practice Change	Forward To BOD For Approval
8. Physician Orders / Request for Services	3 Year Review, Practice Change	Forward To BOD For Approval
9. Receiving of Patients into the Clinic	3 Year Review, Practice Change	Forward To BOD For Approval
10. Scope of Services	3 Year Review, Practice Change	Forward To BOD For Approval
11. Standards of Care and Practice	3 Year Review, Practice Change	Forward To BOD For Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/91**	**SUBJECT:**	**Advance Health Care Directive**
REVISION DATE:	**02/92, 08/92, 11/96, 06/97, 10/00, 06/01, 08/01, 05/03, 08/06, 01/10, 06/11**	~~**POLICY NUMBER: 8610-354**~~	

Patient Care Services Content Expert Review:	~~**10/17**~~**05/20**
Clinical Policies & Procedures Committee Approval:	~~**08/15**~~**11/17**~~**06/20**
Nursinge Leadership~~**Executive Council**~~ **Approval:**	~~**09/15**~~**12/17**~~**07/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**09/15**~~**01/18**~~**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	~~**10/15**~~ **n/a**
Board of Directors Approval:	**10/15**

A. **PURPOSE:**

1. To ensure that when a patient is admitted for care through Tri-City Healthcare District (TCHD) or visits an outpatient setting, each patient's ability and right to participate in medical decision-making is recognized and maximized **regarding health care directives**. This policy reflects compliance with the Joint Commission, **California Probate Code,** and the Federal Patient Self-determination Law ~~and the California Code~~.
   a. Advanced~~d~~ directives prepared by military lawyers are exempt from State requirements as to form, substance, or recording.

B. **DEFINITION(S):**

1. For purposes of this policy, the following terms shall be interpreted in accordance with their respective definitions as set forth below.
2. Advance Directive or Advance Healthcare Directive:— **Either an individual health care instruction or a power of attorney for health care.** ~~**is a document that may authorize another person to make health care decisions for a patient when the patient is no longer able to make health care decisions for himself or herself. An Advance Directive may be in the form of either written or oral individual health care instruction, a power of attorney for health care. an individual healthcare instruction or a Power of Attorney for Healthcare. [Probate Code Section 4605]**~~
3. Individual Healthcare Instruction or Individual Instruction:— A patient's written or verbal direction concerning a healthcare decision. ~~**[Probate Code Section 4623].**~~
4. **Agent:— ~~means a~~An individual designated in a power of attorney for health care to make a health care decisions for the patient, regardless of whether the person is known as an agent or attorney-in-fact, or by some other term.** ~~**An agent may include a successor or alternate agent. [Probate Code Section 4607].**~~
5. **Power of Attorney for Health Care "PAHC," (previously known as "Durable Power of Attorney for Health Care" or "DPAHC"):; aA written instruction designating an agent to make health care decisions for a patient.**
6. **Capacity:— ~~means a~~A person's ability to understand the nature and consequences of a decision and to make and communicate a decision, and includes in the case of proposed health care, the ability to understand its significant benefits, risks and alternatives ~~[Probate Code Section 4609]~~.**
7. **Conservator:— ~~means a~~A guardian appointed by a judge to protect and manage the financial affairs and/or the person's daily life due to physical or mental limitations or old**

~~agea court appointed conservator having authority to make a health care decision for a patient [Probate Code Section 4613].~~

~~3.~~8. **Health Care Decision:**— ~~means a~~**A decision made by a patient or the patient's agent, conservator, or surrogate, regarding the patient's health care, including the following:**
   a. **Selection and discharge of health care providers and institutions;**
   b. **Approval or disapproval of diagnostic tests, surgical procedures, and programs of medication;**
   c. **Directions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation ~~[Probate Code Section 4617]~~.**

~~1. Medical Decision-Making - decisions regarding authorization for treatment, the withholding of treatment or the withdrawal of treatment (including life-sustaining procedures) obtained from the patient or, in the event of the patient becomes incompetent, from the patient's surrogate decision-maker.~~

~~4.~~9. Life-Sustaining Procedure:— a**A**ny medical procedure or intervention, including the administration of fluids and nutrition by artificial means, that when administered to a patient, will serve only to prolong the process of dying or prolong a permanent unconscious condition.

~~5.~~10. Permanent Unconscious Condition:— a**A**n incurable and irreversible condition that within reasonable medical judgment renders the patient in an irreversible coma or a persistent vegetative state.

~~6. Power of Attorney for Health Care: means a written instrument designating an agent to make health care decisions for the principal (the patient) (Probate Code Section 4623).~~

~~7.~~11. Terminal Condition:— a**A**n incurable or irreversible condition that without the administration of life-sustaining treatment will within reasonable medical judgment result in death within a relatively short time.

~~8.~~12. Agent or Surrogate: ~~Decision-Maker — means a~~**An adult, other than a patient's agent or conservator, authorized under the Health Care Decisions Law (HCDL) to make a health care decision for the patient ~~[Probate Code Section 4643]~~. ~~This is a person who has been designated orally by a patient. In contrast, an agent is designated in writing in an advance directive. someone who acts in the patient's stead (substitutes in judgment for the patient) to determine what the patient would likely have decided if he/she were able to decide for him/herself. This agent may be formally appointed (through the Health Care Decisions Act or through conservatorship or guardianship proceedings) or, in the absence of a formal appointment, may be informally authorized by virtue of a relationship with the patient (i.e., the patient's next of kin or in the absence of next of kin, close friend).~~**

~~9.~~13. Conscience Objection:— o**O**bjection to a particular course of treatment or care based on an individual's moral ethical and/or religious beliefs or affiliations.

~~10.~~14. ~~DNR (~~Do Not Resuscitate~~)~~ **(DNR)** Order:— a**A** physician **or ann's/Allied Health Professional's (AHP)** order to the effect that in the event of respiratory or full cardiopulmonary arrest, no basic or advanced life support will be administered.

~~11.~~15. Pre-hospital DNR:— This is a pre-hospitalization ~~Do Not Resuscitate (~~DNR~~)~~ or no-code request from the patient, agent or surrogate ~~decision maker~~ to emergency medical service providers. The request may be made on a completed, approved Emergency Medical Services Pre-hospital DNR Form, an approved DNR medallion or bracelet, or a valid DNR order from the patient's medical record from a long term care facility where the patient resides.
   a. If a patient requests assistance initiating a Pre-hospital DNR, **one should** enter a referral for a Social Services consult in the **electronic** (EHR).

~~12.~~16. **Physician Order for Life-Sustaining Treatment** (POLST) Form:— ~~Physician Order for Life-Sustaining Treatment~~**POLST ~~Form means~~** a**A** request regarding resuscitative measures that directs a healthcare provider regarding resuscitative and life-sustaining measures. ~~(POLST)~~
   a. If a patient requests assistance initiating a POLST, enter a referral for Social Services consult in the EHR.

C. **POLICY:**

1. It is the policy of TCHD to recognize and respect patient self-determination. Patients are

encouraged to be active participants in decision-making regarding their care through education and inquiry. **TCHD supports an individual's right to participate in healthcare decision-making and supports communications during healthcare decision making if a patient is incapacitated. Advance Directives and a POLST will be honored in both inpatient and outpatient settings. The patient's wishes will be respected as documented either by an Advance Directive or POLST.** ~~It is hoped that such E~~education and inquiry about advanced directives will~~, in turn,~~ motivate patients to communicate their preferences and values ~~in that regard,~~ in advance~~,~~ to their loved ones and to health care providers. Thereafter, the patient's expressed wishes will guide surrogates/agents and health care providers in medical decision-making for the patient if that patient becomes temporarily or permanently incompetent, or incapacitated.

2. It is the policy of TCHD to treat a patient in accordance with a POLST form ~~(See Patient Care Services Policy: Physicians Orders for Life Sustaining Treatment [POLST])~~. **This is a standardized form that complements an advance directive by taking the individual's wishes regarding life-sustaining treatment, and converting them into a physician order.**

~~2.~~3. As an institution, TCHD supports and encourages patient self-determination and, to the best of its ability, acts in support of a patient's Advance Directive as long as the directive is within the legal parameters of sanctioned medical practice. TCHD does not support the practice of physician-assisted suicide. TCHD may decline to comply with an instruction or decision that requires medically ineffective healthcare or healthcare contrary to generally accepted healthcare standards.

~~3.~~4. If a patient arrives at TCHD Emergency Department experiencing respiratory or cardiac arrest and the patient has with them a pre-hospital DNR Form, an approved DNR medallion or bracelet, or a valid DNR order from the long term care facility where the patient resides, no chest compressions, assisted ventilations, intubation, defibrillation or cardiotonic medications are to be initiated, unless the patient or surrogate decision maker instruct the staff to do otherwise. The Emergency and attending physicians/**AHPs** will be notified of the existence of the DNR request and a copy of the form or request will be placed in the patient's medical record. Documentation to the patient's medical record regarding patient's DNR status will be completed.

~~4.~~5. It is the right of any physician/**AHP** ~~or health care provider~~ to withdraw from care of a patient based on the provider's own conscience or moral objection to a particular treatment, or withdrawal of treatment, plan. If this occurs, it is the responsibility of the physician/**AHP** and/or the hospital staff to assist the patient/family with identifying a new physician/**AHP** ~~or health care provider~~.

~~5.~~6. Inquiry and Documentation Regarding Advance Directive - As soon as reasonably possible during the admission process, patient registration, Emergency Department patient registration or nursing staff member will inquire of all patients, 18 years of age or older, whether or not the patient has completed an Advance Directive for health care. If patient lacks capacity, the patient's surrogate ~~decision maker~~/agent, will be asked during every admission whether or not the patient has completed an Advance Directive for health care.

a. Review document for special requests.

~~6.~~7. The patient's nurse will be responsible for accurately completing the Advance Directive screen in the ~~electronic health record (~~EHR~~)~~, as part of the admission process.

~~7.~~8. A copy of the Advance Directive, if available, will be placed in the patient's medical record.

~~8.~~9. If the Advance Directive is unavailable at the time of admission, reasonable efforts will be made to obtain a current copy for the patient's medical record.

~~9.~~10. If a patient revises their Advance Directive during their hospital stay the following needs to occur:

a. Place revised~~,~~ Advance Directive in the patient's medical record.
b. Update the EHR to reflect that the Advance Directive has been revised.
c. The revised Advance Directive will be scanned into the patient's EHR by the Medical Records Department.

~~10.~~11. Upon readmission to an inpatient status and Advance Directive status of "Yes, on file TCMC" or "Copy placed on paper chart", the Medical Records department will locate the paper Advance

Directive and scan into the EHR and update Advance Directive Status to "Scanned into EHR."

~~11.~~12. If a patient decides to complete a formal, written Advance Directive document after admission, but during their hospital stay, the staff member assisting the patient with the Advance Directive information will have the responsibility of ensuring that a copy of the completed ~~a~~Advanced ~~d~~Directive is placed in the patient's medical record and that the Advance Directive screen in the EHR is updated to reflect the change in Advance Directive status.

13. The patient may revoke an existing Advance Directive verbally, at any time.
    a. **An oral directive is effective only during the course of the treatment or illness during the hospitalization.**

~~12.~~14. Provide Patient Rights Information
    a. As part of the admission process, the patient~~,~~ or if the patient lacks capacity, the patient's surrogate ~~decision-maker~~/agent, will be given written information regarding an individual's rights to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment, even if that treatment is life-sustaining. Such information shall be consistent with that promulgated and/or required by the California Department of Public Health. ("Your Right to Make Decisions about Medical Treatment" is the brochure used to provide this information.)
    b. If the patient lacks capacity at the time of admission, the required written information about Advance Directives and patients' rights to make decisions about medical treatment will be provided to the family, significant other and/or surrogate ~~decision-maker~~ if applicable.
    c. If, during his or her hospital stay, a patient who lacks capacity regains his or her ability to understand advance directive and patient rights information, hospital staff must provide the patient with this information as soon as practicably possible.
    d. Patients or families may file a complaint with the California Department of Public Health, Licensing and Certification District Office at 1-800-824-0613 concerning non-compliance with their Advance Directive. ~~Tri-City Healthcare District~~**TCHD** staff is to provide patients/families with this number upon request or complaint.

~~13.~~15. Provide Policy Information
    a. At the time of admission, or thereafter, information about Advance Directives shall be offered to each patient/agent and the offer of information shall be made a part of the admission record. Provisions of care shall never be conditional upon a patient's completion of an Advance Directive.
    ~~a.~~b. **If the patient or family member would like more information regarding making an Advance Directive, he or she will be provided with detailed information, including how to contact a patient liaison for assistance.**
    ~~b.~~c. Information, provided to patients and families includes:
        i. Any limitations the Medical Center may have on honoring specific requests based on conscience objection.
        ii. Any differences between ~~Tri-City Healthcare District~~**TCHD** - conscience objection policies and those that may be raised by individual physicians/**AHPs**.
        iii. The legal authority, which supports the hospital's conscience objections.
        iv. The range of medical conditions or procedures affected by the conscience objections.

~~14.~~16. Educate Patient and Surrogate ~~Decision-Maker~~/Agent - To the extent the patient or his surrogate ~~decision-maker~~/agent requests additional information about Advance Directives, or TCHD's policies regarding Advance Directives, such requests should be referred to the attending physician/**AHP**, nurse, social worker, chaplain, patient representative, Ethics Committee or Administration as appropriate, depending upon the kind of information sought. Any such inquiries or requests, and the answers or referrals offered in response, as well as any follow-up action undertaken for such a referral, should be documented within the patient's medical record.

~~15.~~17. Educate Staff - In order to assure that questions from the patient and/or surrogate ~~decision-maker~~/agent regarding Advance Directives are appropriately referred and answered and, more importantly, in order to assure that patient participation in medical decision-making is

maximized, and that care is provided consistent with patient values and directives (though not in any way conditioned upon the existence of such directives), educational information about Advance Directives and TCHD's policies will be provided (this may be in written form or through in service education programs) to the medical, allied health professional and hospital staff during hospital orientation.

18. Educate Community - In order to assure the community served by ~~Tri-City Healthcare District~~**TCHD** is aware of Advance Directives, written materials are available at the Medical Center.
19. **Requirements for Written Advance Directive (by patient):**
    a. **Dated**
    b. **Signed by the patient or in the patient's name in patient's presence and at the patient's direction (if the patient cannot sign) and**
    c. **Acknowledged before a notary public or signed by at least two adult witnesses. Neither witnesses may be:**
        i. **The patient's health care provider or an employee of the patient's health care provider or**
        ii. **The patient's agent (if the Advance Directive includes a power of attorney for health care)**
    d. **Advance Directives that fail to meet the above witness/notary requirements, where patient has written an Advance Directive but does not meet all of the requirements described above, the health care provider may still rely on the Advance Directive document as evidence of the patient's wishes regarding health care treatment unless he or she has reason to doubt that the document was prepared by the patient.**
20. **Written Advance Directives from other states:**
    a. **A written Advance Directive or similar document signed in another state in compliance with the laws of that state or with those of California, is valid and enforceable in California. In the absence of knowledge to the contrary, a physician or other health care provider may presume that a written Advance Directive or similar document, whether signed in another state or in California is valid.**
21. **Emergency Exceptions:**
    a. **The HCDL does not affect the laws governing the securing of consent in an emergency. However, if a patient is incompetent to give consent and treatment is immediately needed to prevent the patient's death or serious disability, or to alleviate severe pain, efforts should be made to contact a known agent if there is time to do so before treatment must be provided.**
22. **Priority of Agent:**
    a. **Unless a court order or the power of attorney indicates otherwise, an agent who the health care provider knows is reasonably available and willing to make health care decisions has priority over all other persons, including conservators, to make health care decisions for the patient. However, the agent has the authority only when the patient is not competent to and cannot give informed consent. In addition, if the patient designates a "surrogate" orally or by a temporary Advance Directive, that surrogate has priority over an agent identified in an earlier written Advance Directive, for that hospitalization.**
    b. **Revocation of An Advance Directive**
        i. **A health care provider, agent, conservator or Surrogate who is informed of a revocation of an Advance Directive must promptly communicate the fact of the revocation to the Supervising Health Care Provider and to any health care institution where the patient is receiving care.**
        ii. **A patient having capacity may revoke the designation of an agent only by a signed document or by personally informing his or her Supervising Health Care Provider. If the patient informs a hospital employee who is not the Supervising Health Care Provider of his or her desire to revoke the**

designation of agent, the Supervising Health Care Provider should be contacted immediately. The Supervising Health Care Provider should then talk to the patient about his or her expressed desire to revoke the designation of an agent.

c. A legally recognized health care surrogate~~decision maker~~ may execute, revise, or revoke the POLST form for a patient only if the patient lacks decision making capacity.

i. If the POLST form conflicts with the patient's previously-expressed health care instructions or advance directive, then the most recent expression of the patient's wishes govern.

ii. For any conflicts or ethical concerns about the POLST orders, appropriate hospital resources (e.g., ethics committees, care conference, legal, risk management, or other administrative and medical staff resources) may be utilized to resolve the conflict.

iii. The POLST form may be revised at any time by the patient or the patient's legally recognized healthcare surrogate~~decision maker~~. Initiate a referral to Social Services for assistance in revising the form.

iv. Discussions about revising or revoking the POLST shall be documented in the medical record, and dated and timed. This documentation shall include the essence of the conversation and the parties involved in the discussion.

v. To void the POLST form, draw a line through sections A through D and write "VOID" in large letters. Sign and date this line.

1) If a new POLST form is completed, a copy of the original POLST marked "VOID" shall be kept in the medical record directly behind the current POLST.

D. **OUTPATIENT SETTINGS:**

1. Any patient who comes to the hospital for outpatient care will be presumed to desire full resuscitative efforts, in the event of an arrest. Outpatients will not be asked if they have an advance directive, nor will information about advance directives be offered to outpatients.
2. Exceptions:
   a. A patient who volunteers information about his or her advance directive, and provides a copy of a valid advance directive or DNR at the time of outpatient care, may request that outpatient staff honor his or her advance directive. Such requests will be honored.
   b. A patient who requests assistance in formulating an Advanced Directive will be referred to appropriate resource.
   c. Outpatient surgery patients shall be treated as inpatients.
   d. Outpatient chemotherapy patients shall be treated as inpatients.
   e. Emergency department patients shall be treated as inpatients.

~~**FORM(S):**~~

~~**Physician Orders for Life-Sustaining Treatment (POLST) Form - Sample**~~

~~**Pre-Hospital Do Not Resuscitate (DNR) Form – Sample**~~

~~**E. FORMS/RELATED DOCUMENTS:**~~

~~1. Physician Order for Life-Sustaining Treatment Form - Sample~~

~~2. Pre-Hospital Do Not Resuscitate (DNR) Form – Sample~~

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

1. The Comprehensive Accreditation Manual, (2015), The Joint Commission
2. California Hospital Association Consent Manual – Advance Healthcare Directives 2019~~5~~
3. **Health Care Decisions Definitions, Cal. PROB §§ 4605 – 4643 (1999).**
4. **Cal. PROB §§ 4651, 4676, 4684, 4685, 4695, 4696, 4711.**

Physician Orders for Life-Sustaining Treatment (POLST) Form - Sample

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a lega
not completed
POLST comp
is not intende

Patient Last Name:	Date Form Prepared:
	Patient Date of Birth:
:	Medical Record #: *(optional)*

A *Check One*

CARDIOPULMONA *If*

no pulse and is not breathing.
w orders in Sections B and C.

☐ Attempt Resusc

☐ Do Not Attempt

ecting Full Treatment in Section B)

B *Check One*

MEDICAL INTERVE

th a pulse and/or is breathing.

☐ Full Treatment –
In addition to treatm
advanced airway in

ctive means.

used Treatment, use intubation,
s indicated.

☐ Selective Treatm
In addition to treatm
IV fluids as indicate
intensive care.

iding burdensome measures.
lical treatment, IV antibiotics, and
y pressure. Generally avoid

cannot be met in current location.

☐ Comfort-Focuse
Relieve pain and su
treatment of airway
with comfort goal.

ygen, suctioning, and manual
lective Treatment unless consistent
nnot be met in current location.

Additional Orders ___

C *Check One*

ARTIFICIALLY ADM

mouth if feasible and desired.

☐ Long-term artificial
☐ Trial period of artifi
☐ No artificial means

D

INFORMATION AND

Discussed with:

zed Decisionmaker

☐ Advance Directive dat
☐ Advance Directive not
☐ No Advance Directive

f named in Advance Directive:

Signature of Physic
My signature below indicates

Physician/NP/PA)
tient's medical condition and preferences

Print Physician/NP/PA Na	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signatu	Date:

Signature of Patient
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: *(write self if patient)*
Signature: *(required)* / Date:	Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.
Mailing Address (street/city/state/zip): / Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

DELETE Sample

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician | n signing Physician/NP/PA)

Name: | Phone #:

Additional Contact

Name: | Phone #:

Completing POLST

- **Completing a POLST form is v** lowed by healthcare providers and provides immunity to those v will be assessed by a physician or a nurse practitioner (NP) or a p physician, who will issue appropriate orders that are consi
- **POLST does not replace the A** irective and POLST form to ensure consistency, and update
- POLST must be completed by a dical indications.
- A legally recognized decisionmak agent designated in an Advance Directive, orally designated surro or closest available relative, or person whom the patient's physic st interest and will make decisions in accordance with the patient s
- A legally recognized decisionmak apacity or has designated that the decisionmaker's authority is effec
- To be valid a POLST form must physician assistant acting under the supervision of a physician an patient or decisionmaker. Verbal orders are acceptable with follow ty/community policy
- If a translated form is used with p LST form
- Use of original form is strongly e s are legal and valid. A copy should be retained in patient's m

Using POLST

- Any incomplete section of POLS

Section A

- If found pulseless and not breath ors) or chest compressions should be used on a patient who

Section B

- When comfort cannot be achieve n "Comfort-Focused Treatment" should be transferred to a setting
- Non-invasive positive airway pres), bi-level positive airway pressure (BiPAP), and bag valve mask (B
- IV antibiotics and hydration gene
- Treatment of dehydration prolong ent" or "Full Treatment."
- Depending on local EMS protoco mented by EMS personnel.

Reviewing POLST

It is recommended that POLST be re

- The patient is transferred from or
- There is a substantial change in t
- The patient's treatment preferenc

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

DELETE Sample

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Pre-Hospital Do Not Resuscitate (DNR) Form – Sample

CAA PUBLICATIONS 1(800) 882-1262 www.caasrr.org

EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

I, _____ as herein described.
(print patient's name)

I understand DNR means that if my cal procedure to restart breathing or heart functioning will b

I understand this decision will **not** p al care by prehospital emergency medical care personnel a my death.

I understand I may revoke this direc ing any "DNR" medallions.

I give permission for this informatio ersonnel, doctors, nurses or other health personnel as necessary t

I hereby agree to the "Do Not Resus

DELETE Sample

_____ _____
Patient/Legally Recognized Health Care Decisio

_____ _____
Legally Recognized Health Care Decisionmaker

By signing this form, the legally recognized heal suscitative measures is consistent with the known desires of, and with the best interest o

I affirm that this patient/legally reco formed decision and that this directive is the expressed wish of th naker. A copy of this form is in the patient's permanent medical r

In the event of cardiac or respirator ns, intubation, defibrillation, or cardiotonic medications are to be

_____ _____
Physician Signature

_____ _____
Print Name

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

White Copy: To be kept: by patient
Yellow Copy: To be kept: in patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/16

SUBJECT: Alcohol Withdrawal Symptom Management

REVISION DATE(S):

Patient Care Services Content Expert~~Department~~ Approval~~-Date(s)~~: ~~04/16~~06/20
Clinical Policies and Procedures Approval~~-Date(s)~~: ~~05/16~~06/20
Nursinge Leadership~~Executive Committee~~ Approval~~-Date(s)~~: ~~05/16~~07/20
Medical Staff Department/Division Approval~~-Date(s)~~: n/a
Pharmacy and Therapeutics Approval~~-Date(s)~~: n/a
Medical Executive Committee Approval~~-Date(s)~~: ~~06/16~~07/20
Administration Approval: 08/20
Professional Affairs Committee Approval~~-Date(s)~~: ~~07/16~~ n/a
Board of Directors Approval~~-Date(s)~~: 07/16

A. **DEFINITION(S):**
1. Alcohol Use Disorders Identification Test (Audit-C): ~~is a~~**A** 3-item alcohol screen that can help identify **patients**~~person~~ who are hazardous drinkers or have active alcohol use disorders. Generally, the higher the Audit-C score, the more likely it is that the patient's drinking is affecting their health and safety.
2. Clinical Institute Withdrawal Assessment Scale for Alcohol Revised (CIWA-Ar): a**A** 10-item scale for assessment and management of alcohol withdrawal. A summation of the scores correlates to the severity of alcohol withdrawal.

B. **POLICY:**
1. All patients shall be screened for alcohol use on admission.
   a. If a patient is identified on admission as currently consuming alcohol which puts them at risk for experiencing alcohol withdrawal symptoms during hospitalization, the nurse will discuss with physician and obtain orders for management of withdrawal symptoms.
2. Patients shall be assessed each shift for signs/symptoms of alcohol withdrawal.
   a. If patient exhibits signs/symptoms of alcohol withdrawal, the patient will be assessed using the CIWA-Ar scale.
      i. Based on the CIWA-Ar score, the nurse will contact physician and obtain orders for management of withdrawal symptoms.
         1) If patient is pregnant or lactating, review appropriateness of medications with physician.
3. If a patient has a CIWA-**Ar** score of greater than or equal to 8, the patient requires ~~a~~ more frequent monitoring and a higher level of care (ie: Telemetry or Intensive Care Unit).

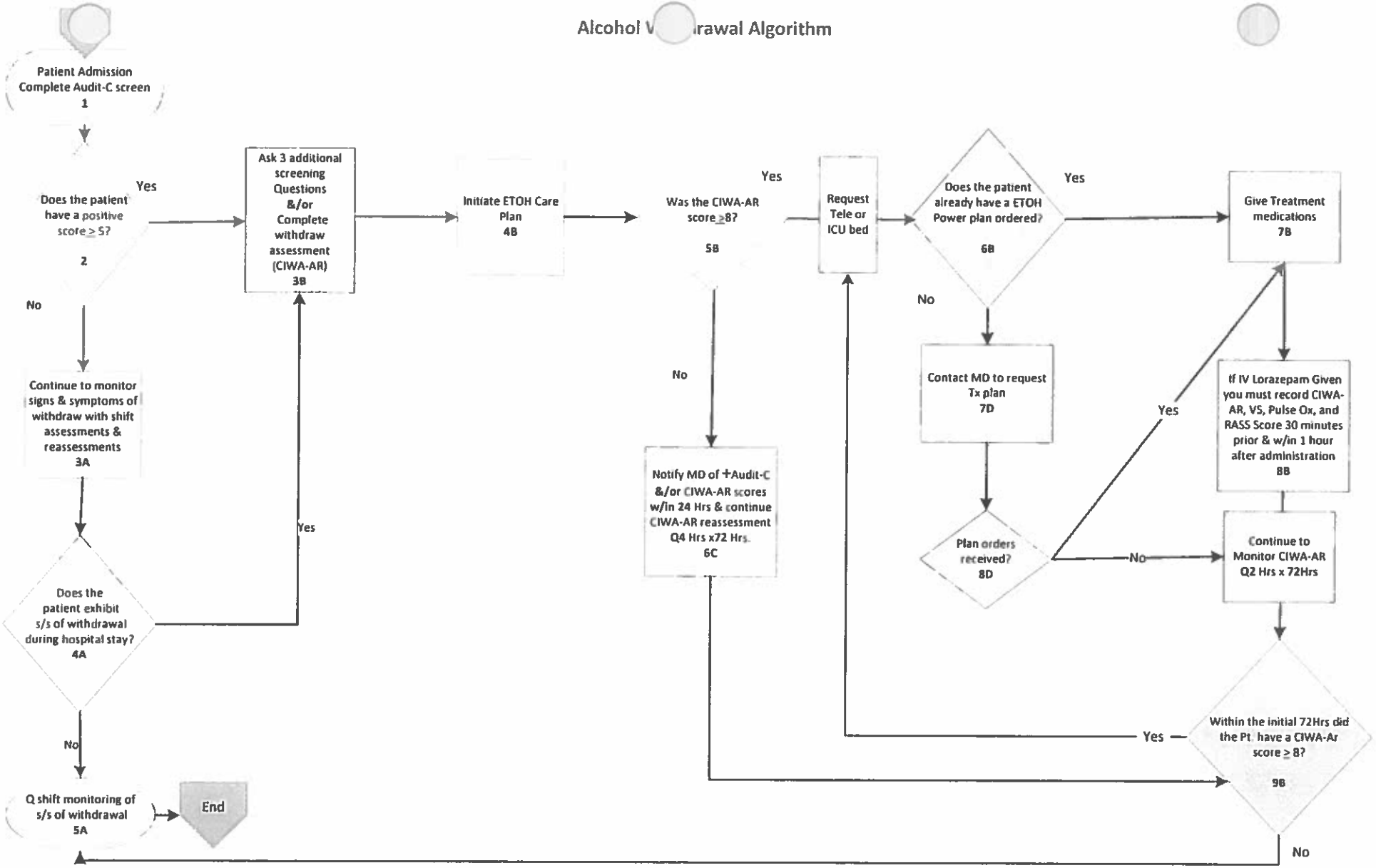
C. **PROCEDURE:**
1. Screen the patient for alcohol use by completing the Audit–C screen in the electronic health record (EHR) upon admission.
   a. If a patient scores less than 5, monitor patient for signs and symptoms of alcohol withdrawal with shift assessments and reassessments.
   b. If a patient scores greater than or equal to 5:
      i. Ask 3 additional screening questions.
      ii. Initiate the Adult Alcohol Withdrawal Interdisciplinary Plan of Care (IPOC).
      iii. Complete the CIWA–Ar in the EHR.
2. CIWA-Ar scores upon admission or during shift assessment,
   a. If the CIWA- Ar is less than 8:

i. Notify the MD of the positive Audit-C and or CIWA-Ar scores within 24 hours.
ii. Continue CIWA-Ar reassessment every 4 hours times 72 hours.
iii. If the patient has 3 consecutive CIWA-Ar scores less than 8, monitor every shift for signs and symptoms of alcohol withdrawal.

b. If the CIWA-Ar score is greater than or equal to 8:
i. Request a higher level of care (i.e. Telemetry or Intensive Care Unit) bed.
ii. Contact MD to request treatment plan if none present.
iii. Monitor CIWA-Ar every 2 hours times 72 hours.
iv. Additional requirements for Intravenous (IV) Lorazepam
1) Assess prior to and 1 hour after administration
a) CIWA-Ar
b) Vital signs
c) Oxygen saturation per Pulse Oximetry
d) Richmond Agitation Scale Score (RASS)

D. **RELATED DOCUMENT(S):**
1. Alcohol Withdrawal Algorithm

Alcohol Withdrawal Algorithm



Notify MD if:

1) Patient exhibits signs/symptoms of delirium tremens (DTs)
2) Vital Signs or RASS score are out of range
3) During the Treatment Plan the patient has "3" consecutive scores >8, for possible increase in PRN dosing

(Rev. 08/2016)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

DELETE - will be replaced by information and website reference in the Newborn Discharge Instructions

ISSUE DATE: 02/2012

SUBJECT: Child Passenger Restraint System Education

REVISION DATE: 04/16

POLICY NUMBER: V.E

Department Approval:	~~08/16~~04/20
Clinical Policies & Procedures Committee Approval:	~~09/16~~04/20
Nurseing Leadership ~~Executive Council~~ Approval:	~~09/16~~05/20
Department of Pediatrics Approval	~~11/16~~07/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~02/17~~ n/a
Board of Directors Approval:	02/17

~~A. PURPOSE:~~

~~1. The purpose is to provide a method for disseminating information to parents/authorized caregivers of infants and young children regarding child passenger safety seats.~~

~~2. Prior to the discharge of any child under age 8, regardless of weight, or less than 4 feet 9 inches (regardless of age), the parents or authorized caregiver to whom the child is being released, will be given information regarding current child passenger restraint system. Included are the risks associated with their non-use or misuse. A list of programs offering rental and no or low cost purchase will be available.~~

~~B. POLICY:~~

~~1. Before an infant or young child is discharged, the parents or authorized caregiver to whom the child is being released, will be verbally informed of the need to have an age appropriate child passenger safety seat, about Car Seat Safety and the importance that all children under 13 years of age ride in the back seat and be properly buckled when being transported.~~

~~a. This information shall be provided to all parents of children receiving care in the Emergency Department and in Women and Newborn Services.~~

~~i. Infants must be properly buckled in a rear facing car seat in the back until they are at least 2 years old (except for those that are 40 inches tall or 40 pounds or more).~~

~~ii. If a child is too large for a safety seat, the AAP recommends children who are 4 feet 9 inches tall or shorter ride in a belt positioning booster seat, regardless of age.~~

~~iii. Children age 8 or older, or who are over 4 feet 9 inches or taller may use a lap-shoulder belt if:~~

~~1) The child can sit all the way back/ hips against the seat.~~

~~2) The child's knees bend comfortably at the edge of the seat.~~

~~3) The shoulder strap should cross the center of the chest.~~

~~4) The belt fits low and flat on the hips.~~

~~5) Child remains seated.~~

~~6) If the answer is no to any of the following, then a booster is still required according to the California Law.~~

~~b. It is illegal for a person to smoke a pipe, cigar or cigarette in a motor vehicle in which there is a minor [Health and Safety Code Section 118948].~~

c. A parent, legal guardian, or other person responsible for a child who is 6 years of age or younger may not leave that child inside a motor vehicle without being subject to the supervision of a person who is 12 years of age or older, under either of the following circumstances.
   i. Where there are conditions that present a significant risk to the child's health or safety.
   ii. When the vehicle's engine is running or the keys are in the ignition, or both.

b. Other regulatory recommendations:
   i. Toddlers should remain rear-facing until they reach 2 years of age, except if they are 40 inches tall or weigh 40 pounds or more. Always follow the manufacturer's instructions for proper use and fit.
   ii. Do not buy a used car seat if you do not know if it has been in a crash.
   iii. Do not buy a car seat that is older than 6 years or has been in a crash.
   iv. Children should ride in the back seat until they are 13 years old.
   v. Never allow your child to place the shoulder belt behind his/her back or under the arm.
   vi. Never seat a child in front of an airbag.
   vii. Never leave your child alone in or around cars.

2. Literature available in both English and Spanish will be provided outlining current state laws regarding proper use of safety seats, and risk of death/injury associated with non-use or misuse, including air-bag issues.
3. Prior to the discharge of the child, parent/conservator or guardian shall provide a signature that this information was reviewed and discussed.
   a. Person receiving information outlining current law requiring child passenger restraint system, will sign the "release of a child under 8 years of age" form. The original will be kept in the medical record and a copy will be given to the person to whom the child is released.
4. Hospitals are required only to provide and discuss information concerning child passenger restraint system laws.
   a. Hospitals are not required to, and should not attempt to prevent a parent (or other authorized person) from transporting a child in a vehicle which does not have a child passenger system.
   b. Hospitals also should not instruct parents regarding how to install a car seat or help parents install a car seat, for liability reasons. A parent with questions about appropriate car seat installation should be referred to a local police or fire station, a local CHP office or loan program. Parents may also call (866) SEAT CHECK or visit www.seatcheck.org to locate free car seat inspection facilities.
5. Facilities that provide the required information to the person to whom the child is released cannot be held legally responsible for the failure of that person to use a child passenger restraint system.

C. **REFERENCES:**

1. California Highway Patrol www.chp.ca.gov, retrieved January 2017
2. Following California Laws Will Keep You Child Safe in the Car, https://www.cdph.ca.gov/HealthInfo/injviosaf/Documents/ParentBrochure-English.pdf, retrieved January 2017
3. www.Kohlscarsafety.org.
4. National Highway Traffic Safety Administration www.safercar.gov/Air+Bags, retrieved January 2017
5. Pacific Safety Council, 9880 Via Pasar, Suite F, San Diego, CA 92126, Phone: 858-621-2313 or http://www.safetycouncilonline.com/full/url/

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/88

SUBJECT: Code Status / Do Not Resuscitate (DNR) / Withholding or Withdrawing Life Sustaining Treatment

REVISION DATE: 09/91; 08/94; 12/96; 11/06; 01/10

POLICY NUMBER: 8610-312

Patient Care Services Content Expert:	11/19
Clinical Policies and Procedures Committee Approval:	~~09/15~~12/19
Nursing Executive Committee Approval:	~~09/15~~02/20
Critical Care Committee Approval:02/17	06/20
Medical Executive Committee Approval:	~~03/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~04/17~~ n/a
Board of Directors Approval:	04/17

A. **PURPOSE:**

1. To outline the policy for withholding and/or withdrawing life sustaining treatment during hospitalization including code status orders.
2. To provide direction to all personnel and medical staff members who may be involved in the care of a patient for whom life-sustaining treatment is withheld or withdrawn during hospitalization.
3. This policy conforms with the decision of the California Court of Appeal, Second Appellate District, in Barber Vs. Superior Court, 147 Cal. APP 3d 1006 (1983), which established guidelines for decisions to withhold or withdraw life-sustaining treatment. These guidelines address all situations in which life-sustaining treatment may be discontinued, including but not limited to cases of irreversible coma and brain death.

B. **DEFINITION(S):**

1. Advanced health care directive or advance directive – Designation of an agent (surrogate) appointed by the patient to make medical decisions for him/her should the patient no longer have the capacity to express his/her wishes.
2. Brain Death: See Patient Care Services Policy, Determination of Brain Death.
3. Capacity: The patient's decision making ability to understand the consequences of his/her decisions. Capacity is commonly secured by determining the patient's ability to understand basic information about his/her condition and prognosis, the nature of a proposed intervention, the alternatives, the risks and benefits, and the consequences of his/her decisions.
4. Code Status:
   a. Full Code: A full code is synonymous with "full resuscitation" which consists of basic and advanced life support. The patient is a "full code" unless withholding of life sustaining treatment is ordered. Resuscitative measures are defined as: electric defibrillation, chest compressions, mechanical ventilations, endotracheal intubations.
   b. No Code: A "no code" is synonymous with "no resuscitation" or "do not resuscitate (DNR)". This means that no basic or advanced life support will be administered.
      i. Resuscitative measures do not refer to ordinary or reasonable methods used to maintain the life, health or comfort of a patient such as the administration of pain or other appropriate medications, IV fluids and nutritional support.
      ii. DNR orders are not intended to govern pre-arrest care.
      iii. A patient may decline basic life support for arrest conditions but may readily agree to mechanical ventilation for a likely reversible respiratory condition (ie., pneumonia, aspiration).

iv. A patient with ventricular tachycardia, bradycardia or heart block is not considered arrested. Emergency medications, external pacemaker and/or rapid fluid infusions may be administered as appropriate.

c. Allow Natural Death (AND): AND orders are intended for terminally ill patients only. An AND order would ensure that only comfort measures are taken. This would include withholding or discontinuing resuscitation, artificial feedings, fluids, and other measures that would prolong a natural death.

5. Incapacitated: A condition of the patient where the capacity to make informed decisions regarding care is temporarily or permanently lost.
6. Individual Health Care Instruction: Designation for a Surrogate – An adult having capacity may give an individual health care instruction orally or in writing. The instruction may be limited to take effect only if a specified condition arises. A patient may also designate an adult as a surrogate to make health care decisions for him/her. The patient must do so by personally informing the supervising health care provider. A~~n oral~~ **verbal** designation of a surrogate must be promptly recorded on the medical record, and is effective only during the course of treatment in the health care institution when the designation is made.
7. Futile Care: Any health care that the primary physician and his or her consultant(s), consistent with prevailing standards of practice, in good faith believe(s) cannot, within a reasonable possibility, be expected to satisfactorily cure, ameliorate, improve, or restore a quality of life to the patient.
8. Permanent Unconscious Condition: An incurable and irreversible condition that, within reasonable medical judgment, renders the patient in an irreversible coma or persistent vegetative state.
9. POLST Form: Physician Order for Life Sustaining Treatment form means a request regarding resuscitative measures that direct a health care provider regarding resuscitative and life-sustaining measures. If a Patient is admitted with completed POLST, POLST order will be honored by staff in accordance with California Assembly Bill 3000, Chapter 266. It is the policy of Tri-City Healthcare District (TCHD) to treat the patient in accordance with a POLST form (Probate Code Sec. 4781.2 (d)). Refer to Patient Care Services Policy POLST.
10. Prehospital DNR: In cases where there is a completed approved "Emergency Medical Services Prehospital Do Not Resuscitate (DNR) Form" (a written request to limit the scope of emergency medical care), an approved DNR medallion or bracelet, or a valid DNR order from the patients medical record from a nursing facility and the patient experiences a respiratory or cardiac arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated unless the patient or surrogate decision maker instructs ~~us to do~~ otherwise. The Emergency and Attending Physicians will be notified of the existence of the advanced directive and a copy will be placed in the patient's medical record. Documentation in the patient's medical record regarding patient's DNR status will be completed.
11. Terminal Illness: ~~means a~~ medical condition resulting in a ~~prognoses~~ **prognosis** of life of one year or less, if the disease follows its natural course (California Health and Safety Code 1746 - p).
12. Withdrawing Life Sustaining Treatment: The discontinuation of specified medical therapies that may be prolonging the patient's death.
13. Withholding Life Sustaining Treatment: The withholding of all or some basic life support (BLS) and advanced life support interventions in the event that a respiratory and/or cardiac arrest is recognized.

C. POLICY:

1. All physician orders regarding code status, withholding or withdrawing life sustaining treatments must be ~~recorded (written) legibly or~~ entered electronically into the patient's health record.
   a. All withdrawing life sustaining treatment orders must specify which treatments and devices are to be discontinued (i.e., ventilator support, endotracheal tube, pacemakers, vasoactive drips, parenteral and enteral fluids, parenteral and enteral nutrition) and how they are to be withdrawn.
   b. A Registered Nurse (RN) may accept verbal/telephone orders; however, another RN

must witness the order by having the physician repeat the order to the second RN and then co-signing the receiving RN's transcription of the order.

2. The treating physician and consulting physicians (if any) shall be responsible for determining the patient's diagnosis, prognosis and providing the patient or the patient's surrogate with the requisite information to enable him/her to evaluate the treatment's benefits and burdens.
3. The decision to withhold or withdraw life-sustaining treatment must be substantiated by physician documentation in the progress notes, which describes the circumstances surrounding the decision to limit or withdraw care.
4. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or decision maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery/procedure and recovery periods. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the health record and an appropriate order ~~written~~ **entered into the patient's health record**.
5. The RN/Respiratory Care Practitioner (RCP) shall follow the physician order for discontinuation of the specified treatment or device.
   a. Every necessary procedure shall be performed to relieve the patient's suffering and to maintain the patient's hygiene and comfort in the setting of DNR and/or withholding/withdrawing treatment orders.
   b. Any health care provider who objects to withholding or withdrawing life-sustaining treatment based on the individual's moral, and/or religious beliefs or affiliations should immediately report their objections to their supervisor or manager. Refer to Administrative Human Resources Policy 480, Staff Requests Not to Participate in Care.
6. The patient shall be the decision – maker whenever possible. If the patient is incapable of making the decision, the health care providers and surrogates shall act in accordance with the patient's desires previously expressed. If a patient is incapable of making the decision because of his/her medical or mental condition, a surrogate decision-maker should be identified.
   a. Parent or Guardian, Attorney-In-Fact, Conservator.
      i. If patient is a minor, his/her parents or guardian must be consulted. If the patient has executed a Durable Power of Attorney for Health Care which remains valid, the designated attorney-in-fact must be consulted. If the patient is an adult for whom a conservator has been appointed with authorization to make health care decisions for the patient, the conservator must be consulted. A copy of the Durable Power of Attorney for Health Care or the certified letters of guardianship or conservatorship must be obtained and placed in the patient's medical record.
   b. Consultations in the event of disagreement.
      i. If the withholding or withdrawal of treatment is appropriate, but a family member or significant other disagrees, the hospital administrator on call shall be contacted and it shall be determined whether court authorization for the issuance of such an order should be sought.
   c. Review if there is no surrogate decision-maker.
      i. If the patient is incompetent, incapacitated and no surrogate decision-maker can be identified, a DNR order may be issued when the treating physician determines it is medically appropriate. It is advisable that the physician seeks a consultation before issuing the order and notifies hospital administration.
7. When a patient's primary physician believes that further or additional health care would constitute futile care, as defined above, the following steps should be taken:
   a. The primary physician shall carefully explain to the patient and/or his or her representative the nature of the ailment, the available treatment options, and the patient's prognosis. The physician shall explain that in no event shall the withholding or withdrawal of health care involve a withdrawal or withholding of comfort, dignity, and psychological care and support.
   b. The primary physician shall provide the names of appropriate medical consultants to provide independent opinions concerning the patient's diagnosis, prognosis and available treatment alternatives, if any.

c. The support of ~~TCMC~~ nurses, chaplain, patient care representative, and social services shall be offered to the patient's representative(s). A joint conference or other collaborative communication between these parties and the primary physician and/or the patient or his or her representative(s) may arrange as needed.
d. Adequate time should be given for the patient or his or her representative(s) to consider the information and situation.
e. If the above steps are taken and the patient or his or her representative disagrees with the primary physician as to whether further or additional health care would be futile:
   i. The primary physician shall cooperate with the patient or his or her representative in transferring the care of the patient to another qualified physician and/or health facility who will consent to implementation of the patient's or his or her representative's health care wishes. The responsibility for finding such an alternate physician and/or health facility shall lay with the patient or his or her representative, though the primary physician and hospital shall make reasonable efforts to assist such efforts.
   ii. If a disagreement persists between the physician and the patient or his or her representative as to the futility of further or additional health care, and the patient cannot be transferred to another physician and/or facility, the physician and/or ~~TCMC~~ **the hospital** shall petition the court to approve or deny the proposed health care. In so doing, the physician shall consult with the Bioethics Committee, who shall in turn consult with legal counsel to ensure compliance with applicable laws and regulations. Life-sustaining treatment shall not be withdrawn when a dispute exists under this Section until the dispute is resolved by an order of the court.

8. Incarcerated patients: When the patient is a prisoner at a state correctional facility and the prisoner is incapable of making decisions on their behalf, the attending physician at the hospital should make an attempt to contact the primary care physician at the state correctional facility before determination can be made on withholding or withdrawing life support.
9. The hospital's administrator and/or risk manager shall be consulted before an order to withhold or withdraw treatment is issued whenever:
   a. The patient's condition has resulted from an injury which appears to have been inflicted by a criminal act.
   b. The patient's injury or condition was created or aggravated by a medical accident
   c. The patient is pregnant.
   d. The patient is a parent with custody or responsibility for the care and support of young children.
   e. A dispute exists regarding the desires or best intentions of an incompetent patient.
   f. No appropriate legal representative exists.

D. RELATED DOCUMENT(S):

1. Administrative Human Resources Policy 480: Staff Requests Not to Participate in Care
2. Patient Care Services Policy 354: Advance Health Care Directive
3. Patient Care Services Policy: End of Life/Comfort Care Policy
4. Patient Care Services Policy 393: Physicians Orders for Life Sustaining Treatment (POLST)

E. FORM(S):

1. Pre-Hospital Do Not Resuscitate (DNR) FORM Sample

F. REFERENCES:

1. California Hospital Association **(CHA).** ~~,~~ 2019~~6~~. **California Hospital** Consent Manual, **(46th ed.).**

EMERGENCY MEDICAL SERVICES
PRE-HOSPITAL DO NOT RESUSCITATE (DNR) FORM SAMPLE

An Advanced Request to Limit the Scope of Emergency Medical Care

1._____requests limited emergency care as herein described.
(Print Name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.
I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital emergency medical care personnel and/or medical care directed by a physician prior to my death.
I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.
I give permission for this information to be given to the pre-hospital emergency care providers, doctors, nurses, or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Surrogate _____ Date _____

Surrogate's Relationship to Patient _____

Witness Signature _____ Print Name _____ Date _____

I affirm this directive is the expressed wish of the patient/surrogate, is medically appropriate, and a copy of this form is in the patient's permanent medical record.
In the event of a cardiac or respiratory arrest, no chest compressions, assisted ventilation, intubation, defibrillation, or cardiotonic medications are to be initiated.

Physician's Signature _____ Date _____

Print Name _____

Address _____ Phone Number _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY.

PRE-HOSPITAL DNR REQUEST FORM
Approved by the San Diego Medical Society
P.O. Box 23581
3702 Ruffin Rd
San Diego, CA 92193-3581
(619) 569-1334

White Copy: To be kept by patient
Canary Copy: To be kept in Patient's permanent medical record
Pink Copy: If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to:
Medic Alert Foundation, Turlock, CA 95381

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CODE TRIAGE ALERT, EMERGENCY DEPARTMENT**
Purpose:	To ensure patients have access to appropriate care when patient care demands exceed resources. To provide care at safe and consistent levels regardless of census overall.

A. **DEFINITIONS:**

1. Code Triage: ~~The code called when t~~The Emergency Department (ED) is experiencing capacity and/or is unable to accommodate incoming patients due to flow of patients through the hospital continuum.
2. Code Triage – Yellow: The status assumed when the availability of inpatient beds and/or staffing is ~~limited~~**limited,** and the ED is experiencing delays in admissions of **greater than** (> 2) hours ~~(~~**and is** boarder~~ing~~ **patients**~~)~~.
3. Code Triage – Red: The status assumed when there is no availability of inpatient beds and/or staffing, and ~~housewide~~**house wide** resources are limited. The ED is experiencing inability to obtain inpatient beds and flow is restricted in the ED~~.~~ **due to multiple boarded patients.**
4. Boarder: delay in admission greater than 2 hours

B. **PROCEDURE:**

1. Bed census information is communicated to the ED **Leadership**~~Assistant Nurse Manager (ANM)~~/Charge RN, by the Administrative Supervisor (AS) when the hospital is experiencing limited availability of staffing and/or beds.
2. Communication will occur 24/7 with updates at least every 2 hours, unless otherwise determined. Communication will be conducted via the daily Administrative Supervisor ~~Daily Census~~ Report **processposted for each shift**, through phone conversations between the ED and the Administrative Supervisor, ~~and~~ during ~~routine~~ **the ~~Daily T~~throughput ~~H~~huddle, ~~and through routine~~** and emergency bed meetings as appropriate.
   a. During **Code T~~the~~ riage** - RED ~~Zone~~, the ED **Charge RN**~~ANM~~ shall communicate with the AS for all diversions, critical patients, and codes.
   ~~b. AS and ED ANM shall communicate with updates at least every 2 hours, unless otherwise determined.~~
   ~~c.~~**i.** ED Leadership shall communicate with the ED ~~ANM~~ **Charge RN** every 2 hours from 0500-2200.
3. The ED ~~ANM, ED Manager/Director~~**Leadership**, and the Senior Administrator/Clinical Operations Manager on call will determine when a hospital response (Code Triage – Yellow or Code Triage – Red) is necessary and notify the AS and PBX.
4. Code Triage Response
   a. Code Triage – Yellow:
      i. AS will ~~initiate~~ **communicate the** emergency **at the morning~~daily~~ throughput huddle** ~~bed m~~**m**eeting ~~at 0830~~ **and afternoon routine bed meeting** ~~at 1530 in the staffing office or French Room~~. Attendees will include:
         1) All inpatient representatives (**Leadership/designee**~~ANM, Managers, or Director~~)
         2) Surgery representative (**Leadership/designee**~~ANM, Managers, or Director~~)
         3) Administrative Supervisor
         4) Case Management **representative** ~~Director~~
         5) Staffing Office representative
      ii. Recommended actions include:
         1) Assess all unit censuses and potential discharges.

Review/Revision Date	Clinical Policies & Procedures	Nursing Executive Committee	Department of Emergency Medicine	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
9/07;5.14; 02/20	11/07, 1/10, 6/10;5/14, 03/20	12/07, 1/10, 7/10; 6/14, 04/20	7/14, 06/20	1/08, 07/10; 8/14, 07/20	08/20	2/08, 08/10;10/14, n/a	2/08, 08/10;11/14

2) Case Management to contact attending physicians to obtain discharges and plan early rounds as appropriate. Initiate active discharge planning to include disposition, education, and transportation.
3) Call in extra staff as needed and/or adjust existing staff to accommodate patients. Consider increasing to 1:5 ratio in Med/Surg unit as appropriate. Utilize premium or incentive pay for staff and agencies.
4) Remove barriers to flow including charge nurse to charge nurse report.
5) Consider sending inpatient staff to ED to "pull" patients and receive face to face report.

b. Code Triage – Red:
   i. AS will initiate emergency bed meeting STAT in the ~~staffing office,~~ French Room, or via conference call. Attendees will includinge **but not limited to**:
      1) All inpatient representatives (**Leadership/designee**~~ANM, Manager, or Director~~)
      2) Surgery representative (**Leadership/designee**~~ANM, Manager, or Director~~)
      3) Administrative Supervisor
      4) Case Management **representative**~~Director~~
      5) Staffing Office representative
      6) Administrator or Clinical Operations Manager on call
      7) Environmental Services (EVS) **Leadership/designee**~~Manager/Director~~
      8) Nutrition Services
      9) Supply Chain Management
      10) Pharmacy as appropriate if opening overflow areas
   ii. Recommended Actions include:
      1) All Code Triage to include Yellow actions.
      2) ED to consider additional staffing for "Provider in Triage" or additional Fast Track/Hallway beds.
      3) ED to aggregate inpatient holds and request nursing support for staffing.
      4) Facilitate Skilled Nursing Facility transfers.
      5) Case Management to contact all physicians of potential discharges to seek early discharge.
      6) Call in additional EVS staff as necessary. Provide STAT clean of all beds within 10 minutes of request.
      7) Evaluate elective procedures for Radiology and Surgery schedule. Consider rescheduling as appropriate.
      8) Evaluate availability of supplies and equipment (IV pumps and channels, monitors, ED gurneys, inpatients beds).
      9) Inpatient units to aggressively seek to "pull" patients from the ED and receive face to face report.
      10) Move patients within 20 minutes of bed ready regardless of shift change or recent admissions to the same unit.
      11) Consider opening an overflow unit.
      12) Consider alternative holding areas for ED "boarders" ~~Special Procedures Recovery Area (SPRA)~~**Phase II Area** or Post Anesthesia Care Unit (PACU).

C. **RELATED DOCUMENTS**
~~1. Code Triage Contact List~~
~~2.~~1. Code Triage Census Zones

DELETE – no longer needed

CODE TRIAGE CONTACT LIST					
Department		Ext.	Cell	Pager	Home Phone
Administrative Supervisor		x7765	644-6968		
Administrator on Call		x7474			
BHU		x7747	908-3388		
Case Management		x5659			
		x3382			
		x3540			
Chief Nurse Executive		X3240	802-7161		760-828-8298
ED Registration					
		x3521		0277	
EVS			644-6973		
Laboratory			802-9944		
			802-9893		
L&D, Mother Baby		X5500			
Supply Chain Mgmt.		x3783			
Medical Staff Office		x3580			
Nursing Directors					
1N, 2P, 3P, Rehab, 3N/S		x5478	908-3925		
ICU, Tele, ED		x5679	277-0990		
Nursing Managers					
1N, 4 Pav, Rehab		X5563			
2P, 3P		x3794	802-3009		
ICU, Tele		x5707	802-8658		
ED		x3824	908-4472		
Pharmacy		x3020	908-3930		
			908-3921		
Radiology		x7835			
			802-7299		
		x7835			
Respiratory			802-1074		
Security/Safety Officer			908-3183		
	On-Duty Supervisor	x3367	908-3191		Via PBX
Surgery		X5400			

Code Triage Census Zones

Census Zone	Situation	Action	Responsible Person
Green	Normal Hospital Operations	• Ensure appropriate assignments of patients to staff and unit. • Facilitate flow at all times.	
Code Triage - Yellow	-Availability of inpatient beds and/or staffing is limited. -ED is experiencing delays in admissions **greater than** (>) 2 hours (boarders)	• Admin Sup/PFC will initate emergency bed meeting at 0830 and 1530. • Assess all unit censuses and potential discharges. • Case management to contact attending physicians to obtain discharges and plan early rounds as appropriate. Initiate active discharge planning to include disposition, education, and transportation. • Call in extra staff as needed and/or adjust existing staff to accommodate patients. Consider increasing to 5:1 ratio in Med/Surg unit as appropriate. Utilize premium or incentive pay for staff and agencies. • Remove barriers to flow including charge nurse to charge nurse report. • Consider sending inpatient staff to ED to "pull" patients and receive face to face report.	• All inpatient representatives (ANM, Manager, or Director) • Surgery representative (ANM, Manager, or Director) • Administrative Supervisor/PFC • Case Management Director • Staffing office representative • AIONEX representative
Code Triage - Red	-No availability of inpatient beds and/or staffing -Housewide resources are limited -ED unable to obtain inpatient beds -ED flow is restricted	• All Code Triage – Yellow activities • ED to consider additional staffing for "Provider in Triage" or additional Fast Track/Hallway beds. • ED to aggregate inpatient holds and request nursing support for staffing. • Facilitate Skilled Nursing Facility transfers. • Case management to contact all physicians of potential discharges to seek early discharge. • Call in additional EVS staff as necessary. Provide STAT clean of all beds within 10 minutes of request. • Evaluate elective procedures for Radiology and surgery schedule. Consider rescheduling as appropriate. • Evaluate availability of supplies and equipment (IV pumps and channels, monitors, ED gurneys, inpatients beds). • Inpatient units to aggressively seek to "pull" patients from the ED and receive face to face report. • Move patients within 20 minutes of bed ready regardless of shift change or recent admissions to the same unit. • Consider opening 3P as overflow unit. • Consider alternative holding areas for ED "boarders" – **Phase II Area~~SPRA~~**, PACU.	• All inpatient representatives (ANM, Manager, or Director) • Surgery representative (ANM, Manager, or Director) • Administrative Supervisor/PFC • Case Management Director • Staffing office representative • Administrator or Clinical Operations Manager on call • EVS Manager/Director • Nutrition Services • Supply Chain Management • Pharmacy as appropriate if opening overflow areas

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**CONTINUOUS PASSIVE MOTION (CPM) MACHINE**
Purpose:	To outline the nursing management of adult/adolescent
Supportive Data:	Continuous passive flexion and extension of the knee n after knee surgery.
Equipment:	CPM Machine

DELETE – follow Online Skills Continuous Passive Motion Machine Skills

A. **PROCEDURE:**

1. Application requires a physician order.
2. Pad pressure areas with sheepskin.
   a. Keep the opening of the sheepskin padding lined up with the joints of the machine.
   b. Use all Velcro straps making padding taut over bars.
   c. Place long end of padding under the patient's hips, assure it is free of wrinkles.
3. Adjust leg length of CPM:
   a. Ensure knee is in bending area of machine and leg is properly aligned.
   b. Ensure foot is in the footplate, leaving enough room in the heel space for the forward motion of the foot during flexion.
      i. The CPM flexion joint should line up with the patient's patella.
   c. Check to make sure footplate has foot at a neutral position to ensure there is no foot drop.
4. Apply and remove CPM machine at full extension and in the off position.
5. Slide machine attached to trolley to and from bed.
   a. When not in use, toggle machine on table and release black knob enabling table to fold up. Do not remove CPM from trolley.
6. Check alignment every two (2) hours.
7. Remove CPM at least once a shift to check for pressure areas.
8. Inspect skin for pressure areas every four (4) hours.
9. Maintain angle and duration of CPM therapy per physicians order.
   a. Advance angle/flexion as ordered.
10. Remove CPM for meals, bath, and therapy treatment.
11. Remove device if patient complains of unusual pain or discomfort and report findings to physician.
12. Elevate the head of the bed no greater than 30 degrees, and ensure the knee mechanism on the bed is locked in the OFF position.
13. Document use, patient tolerance, and angle/flexion in the medical record.

B. **REFERENCE:**

1. National Association of Orthopaedic Nurses (NAON): Core Curriculum for Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.
2. NAON: Scope and Standards of Orthopaedic Nursing Practice 3rd Edition, April 12, 2013.

Revision Dates	Clinical Policies & Procedures	Nurse Executive Council	Division of Orthopedics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/00; 6/02; 3/03; 7/03, 3/04; 6/06, 6/09; 11/15, 10/19	07/11, 12/15, 04/20	08/11, 01/16, 05/20	05/16, 06/20	10/11, 10/16, 07/20	08/20	11/11, 01/17, n/a	11/11, 01/17

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/17 **SUBJECT: Determination of Brain Death**

REVISION DATE:

Patient Care Services Content Expert Approval:	**~~09/15~~11/19**
Clinical Policies & Procedures Committee Approval:	**~~09/15~~12/19**
Nurse Executive Committee Approval:	**~~09/15~~02/20**
Critical Care Committee Approval Date(s):	**~~06/16~~06/20**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval:	**~~10/16~~07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**~~04/17~~ n/a**
Board of Directors Approval:	**04/17**

A. **PURPOSE:**
1. To establish guidelines for brain death determination in adult patients (15 years and older) as a means of standardization of:
   a. Criteria for the diagnosis of brain death
   b. Medical decision making
   c. Health record documentation.

B. **DEFINITIONS:**
1. Brain death: An irreversible cessation of all functions of the entire brain, including the brain stem (Health and Safety Code§ 7180). A physician may determine an individual has suffered brain death (as defined by statute). Law requires that a second physician independently confirm the patient's brain death. (Health & Safety Code§-7181). Patient time of death is recorded at the time the second physician confirms brain death. These physicians:
   a. May not participate in procedures for removing or transplanting part(s)
   b. Must document in the health record procedures used to determine the death and factual basis for determination of death.
   c. Must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.

C. **POLICY:**
1. Determination of Death: Based on current medical standards (California Code, Health and Safety Code §-7180 of The Uniform Determination of Death Act), an individual who has sustained either of the following is dead:
   a. Irreversible cessation of circulatory and respiratory functions or
   b. Irreversible cessation of all functions of the entire brain, including those of the brain stem.
2. A determination of brain death must be made in accordance with accepted medical standards, at this time considered to be those standards outlined in the American Academy of Neurology Guidelines.
3. The declaration of brain death should not be given as a choice for families.
   a. Testing should be performed when clinical signs and symptoms suggest brain death has occurred.
   b. Appropriate efforts should be made to discuss the patient's medical condition and the process of determining death with family or surrogate decision-makers prior to evaluating whether or not the patient is dead.
      i. Family/surrogate must be provided with the policy if requested.

c. Determination of death should be accomplished as early as practical in the patient's clinical course, for the benefit of both family/surrogate decision makers and staff.

4. Declaration of brain death by neurological criteria is outlined in the 2010 American Academy of Neurology (AAN) Guidelines, reaffirmed on April 30, 2014, and is reflected in *Declaration of Brain Death, Physician Progress Note* which should be used for documentation. Brain death by neurologic criteria requires the following evaluations:
   a. Clinical reflexes
   b. Apnea testing
   c. If one of the evaluations cannot be completed, ancillary testing should be considered.
5. Two licensed physicians must independently confirm the diagnosis of brain death, (California Health and Safety code, § 7181).
   a. Each physician must practice within the specialty of Neurology, Neurosurgery, or Critical Care Medicine.
   b. One physician should be an active member of the patient's care team.
   c. One physician must actively participate in the clinical evaluation of any patient where declaration of brain death is determined. This participation must include an appropriate clinical exam performed by the physician to include being present during the apnea test if performed to observe for respiratory movement, and documenting the results of the exam in the patient's health record.
   d. The time of brain death must be recorded as the time the second physician confirms brain death diagnosis.
   e. A physician involved in the declaration of death must NOT participate in the procedure for organ/tissue procurement or transplantation.
6. The Care Team will follow California Health and Safety Code §-1254.4 requiring that a reasonably brief period of accommodation be provided for family or next-of-kin to gather at the bedside after the determination of death has been made through the discontinuation of cardio pulmonary support.
   a. The period of reasonable accommodation is generally not greater than 24 hours after brain death has been declared.
   b. Reasonable accommodation also may include the hospital's consideration of the needs of other patients and prospective patients in urgent need of care.
   c. The care team shall make reasonable efforts to accommodate the religious/cultural practices and concerns of the family.
7. Required Notification to provide for option of Donation of Organ and Tissue.
   a. If imminent death criteria are present and/or brain death is being considered, validate that the Organ Procurement Organization (OPO) has been notified. The OPO will be responsible for the evaluation of potential organ and tissue donation options.
   b. The OPO is responsible for verifying death in any patient where organ donation is being considered or is authorized. The OPO will review the brain death documentation to validate that it meets the requirements set forth in the 2010 AAN Guidelines; this may include a physical assessment of the organ donor patient as well as a review of the brain death declaration documentation.
   c. The OPO will evaluate the declaration of brain death as an element of medical suitability for organ donation. The OPO may ask the hospital for clarification or additional testing if the declaration does not include elements in brain death by neurologic criteria outlined in the AAN Guidelines. The OPO will not participate in the actual brain death declaration process.

D. **FORM(S):**
1. Declaration of Brain Death Physician Progress Note - Sample

E. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Code Status/Do not Resuscitate (DNR)/ Withholding or Withdrawing Life Sustaining Treatment.
2. Patient Care Services Policy: Organ Donation, Including Tissue and Eyes.

F. **REFERENCES:**

1. California Health and Safety Code §-7150.65(c), §-7180-83, §-1254.4
2. Wijdicks, E. F., Varelas, P. N., Gronseth, G. S., and Greer, D. M. Evidence-Based Guideline Update: Determining Brain Death in Adults: Report of the Quality Standards Subcommittee of the American Academy of Neurology (June 8, 2010). *Neurology* (74)23, 1911-1918.
3. Scintigraphic Confirmation of Brain DeathPartha Sinha, MD, and Gary R. Conrad, MD Semin Partha, S., and Conrad, G. R. (2012). Scintigraphic Confirmation of Brain Death. *Seminars in Nuclear Medicine* (42), 27-32.

Declaration of Brain Death Physician Progress Note – Sample

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Prerequisite	**Yes**	**No**
Evidence of acute CNS catastrophe compatible with brain death		
Exclusions:		
1. Presence of CNS-depressant drug effect by history, drug screen*		
2. Recent administration or continued presence of neuromuscular blocking agent		
3. Electrolyte imbalances, acid-base imbalances or endocrine disturbances		
4. Conditions such as severe facial trauma, preexisting pupillary abnormalities, pulmonary disease resulting in CO_2 retention		
5. Core body temperature less than 32°C (90°F)		

**Calculate drug clearance using 5 times the drug half-life*

Clinical Exam ***Do not proceed with Apnea test if any 1-6 in Clinical Exam PRESENT***	**Yes**	**No**
1. Motor response to pain in extremities (nail-bed pressure; supraorbital pressure; temporomandibular joint compression)		
2. Pupillary response to light		
3. Doll's Eyes movement (oculocephalic reflex) present		
4. Eye movement to ice water calorics (oculovestibular reflex)		
5. Eyelid movement to corneal swab/touch (corneal reflex)		
6. Cough or gag to deep endotracheal suctioning		

Apnea Exam Pre Conditions, ~~Guidance for Testing~~ Inclusion Criteria	**Verified**
1. Normotensive (may require vasopressors, MAP greater than or equal to 60-65mmHg)	
2. Normothermic: (core temp greater than or equal to 36°C)	
3. Normal pCO_2 (35 - 45 mmHg) or at patients documented pCO_2 baseline	
4. pO_2 greater than or equal to 200 mm Hg or ability to pre oxygenate to 200mmHg	
If unable to complete Apnea Exam, proceed with Ancillary Testing	
Apnea Exam:	**Completed**
1. Increase FiO_2 to 100% and PEEP of 5mmHg	
2. Draw baseline ABG	
3. Disconnect patient ventilator	
4. Provide O_2 via cannula at level of carina at 6 L/min (or 1-piece with CPAP at 10 cm H_20)	
5. Observe closely for respiratory movements for approximately 8-10 minutes	
6. Repeat ABG in approximately 8-10 min	
7. Reconnect ventilator	

DECLARATION OF BRAIN DEATH, PHYSICIAN PROGRESS NOTE

Apnea Exam Results						
If pCO_2 is greater than or equal to 60mmHg OR pCO_2 increase is greater than or equal to 20 mmHg over baseline normal pCO_2 WITHOUT respiratory movement noted — patient is apneic and apnea testing is consistent with diagnosis of Brain Death. If respiratory movements are observed, the apnea test result does not support the clinical diagnosis of brain death.						
Test 1—Adult	**pH**	**pO_2**	**pCO_2**	**BP**	**SpO_2**	**Apnea Time**
Baseline Blood Gas						
Apneic Blood Gas						

Ancillary Testing		**Verified**
Cerebral Angiography	Flow absent in all major intracranial vessels consistent with death	
CBF Isotopic Scan	Cerebral perfusion is absent in cortex and brain stem, consistent with death.	
Other		

PHYSICIAN COMPLETING ABOVE DOCUMENTATION:

I have examined the patient, together with the health record and laboratory results and was present and observed the apnea test if performed. I declare that the patient is dead on the basis of this evaluation.

Signed: _____ **Date:** / / **Time:** _____

Print: _____

BRAIN DEATH DECLARATION

Attestation: Physician 2

I have examined the patient _____ **together with the health record and laboratory results. This included conducting or reviewing the results of the apnea test and or/any ancillary tests. The patient is declared dead on the basis of this evaluation.**

Signed: _____ **Date:** / / **Time:** _____

Print: _____

This form is a composite drawn from a number of sources, reflecting best practice — and amended in the context of the 2010 AAN Adult and 2011 SPA/SCCM Pediatric guidelines.

Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**EPICARDIAL PACING WIRES**
Purpose:	To outline the nursing responsibilities for: 1. Dressing epicardial pacing ~~wire~~**wires** sites 2. Attaching epicardial pacing wires to A-V sequential pulse generator 3. Assisting with removal of ~~epicardial~~**epicardial** pacing wires 4. Performing an atrial electrogram
Supportive Data:	Epicardial pacing wires are attached to the ~~epicardium~~**epicardium** during cardiac surgery. Two ~~teflon~~**Teflon**-coated, stainless steel wires may be ~~implanted~~**implemented** on the right atrium and brought out through the chest wall at the right subcostal area. Two wires are re-implanted on the right ventricle and brought out on the left ~~subcostal~~**subcostal** area. Only trained staff are allowed to dress epicardial pacing wires and attach epicardial pacing wires to a pulse generator. Only physicians are allowed to remove epicardial wires. Licensed staff may assist with removal.
Equipment:	See sections below.

A. **DRESSING EPICARDIAL PACING WIRES SITES:**

1. Equipment:
   a. **Non-sterile**~~Disposable~~ gloves
   b. Two 2x2 gauze pads
   c. Roll of plastic tape
   d. Roll of silk or paper tape
   e. 70% chlorhexidine gluconate and 30% alcohol or povidone iodine
2. Procedure:
   a. Change epicardial pacing wire dressings every 72 hours, when soiled, or whenever the patient takes a shower.
   b. Perform hand hygiene and don gloves~~.~~
   c. Cleanse each site with chlorhexidine/betadine.
   d. Cover sites with 2x2 gauze pads.
   e. Coil epicardial wires, place on top of dressing and secure to chest with silk or paper tape. Do not put tension on epicardial pacing wires when coiling them~~.~~
   f. Cover **isolated** epicardial wire ends with plastic tape folded with the end tabs.

B. **ATTACHING EPICARDIAL PACING WIRES TO A-V SEQUENTIAL PULSE GENERATOR AND SINGLE CHAMBER GENERATOR:**

1. Supportive Data:
   a. Epicardial pacing wires are attached via a connecting cable to an A-V sequential or single chamber pulse generator. The pulse generator is activated and the ability of the wires to conduct electricity and initiate depolarization of atria and ventricles (capture) is assessed.
2. Equipment:
   a. A-V sequential or single chamber pulse generator with ~~9-volt~~ battery. Allow time for self-test to review if battery is showing "low battery" and replace if necessary.
   b. **One or** Two pacing connector cables
   c. Disposable gloves
   d. Two 2x2 gauze pads
   e. Roll of tape
   ~~f. Gloves~~
3. Procedure:

~~Patient Care Services Content Expert~~~~Department Review~~	Clinical Policies & Procedures	Nursing Executive Committee	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
~~606/93;~~ 12/10, 04/11, 03/20	01/11, 04/20	05/20	06/20	n/a	~~02/~~11/05, 04/08, 07/20	08/20	01/06, 06/08, n/a	~~606/93, 707/03,~~ ~~401/06,~~ 606/08, ~~0305/11~~

~~a. Perform hand hygiene, don gloves, and remove existing dressing covering epicardial wires. Do not put tension on epicardial pacing wires while removing dressings. Wearing gloves minimizes the possibility of stray current passing through the wire to the myocardium.~~
~~b. Identify atrial wires (to the right of the sternum) and ventricular wires (to the left of the sternum).~~
~~c. Attach one pacing connector cable to two atrial wires and one cable to two ventricular wires. Either wire may be inserted into the positive and negative openings. A wire becomes negative when it is inserted into negative opening.~~
~~d. Tighten screw clamps, located on the sides of connector, for each wire. Do not over tighten connections.~~
~~e. Attach connector cable to A-V sequential pulse generator: atrial pins to atrial posts, ventricular pins to ventricular posts.~~
~~f. Set dial settings per physician's order: atrial milliamps (mA), ventricular mA, rate, A-V interval and sensitivity.~~
~~g. Turn pulse generator on.~~
~~h. Observe sense and pace light illumination.~~
~~i. Run rhythm strip and look for appropriate spike with capture.~~
~~j. Perform site care and tape wires securely to chest.~~
~~k. Hang pulse generator on pole above patient or secure to patient gown.~~

a. **Follow procedure in Online Skills for Pacing: Temporary Transvenous and Epicardial.**

C. **ASSISTING WITH REMOVAL OF EPICARDIAL PACING WIRES:**

1. Equipment:
   a. **Non-sterile**~~Disposable~~ gloves
   b. Two 2x2 gauze pads
   c. Scalpel
2. Procedure:
   a. Explain the procedure to the patient.
   b. Ensure patient IV access.
   c. Place patient in supine position.
   d. Have materials available for the physician.
   e. Leave exit sites open to air. If exit site is oozing, redress with sterile 2x2 gauze pad.

~~D.~~A. **PERFORMING AN ATRIAL ELECTROGRAM:**

~~1.~~3. Supportive Data:
   a. An atrial electrogram (AEG) is a method of recording electrical activity originating from the ~~atria~~**atrial myocardium** by using temporary atrial epicardial pacing wires. Evaluate the atrial electrogram for the presence of atrial activity and its relationship to ventricular activity. Compare with surface ECG for interpretation. Atrial electrograms will enhance the atrial activity often masked on the surface ECG, allowing for clarification of the dysrhythmia origin.

~~2.~~4. Equipment:
   a. Nonsterile gloves
   b. Temporary atrial epicardial wires placed during cardiac surgery
   ~~a.~~c. Bedside ECG monitor and recorder
   ~~b.~~d. One or two alligator clips **for continuous monitoring, OR ECG electrodes for quick view**
   ~~c.~~e. Materials to dress epicardial wires

~~3.~~5. Procedure:
   ~~a. Don gloves. Gloves shall be worn whenever handling the epicardial wires to prevent microshock.~~

~~b. Connect one of the atrial wires to the V (precordial) lead of the 5 lead cable of the ECG monitor with an alligator clip **OR**,~~

~~c. Connect one of the atrial wires to the left arm (LA) limb lead and the other to the right arm (RA) limb lead of the 5 lead cable of the ECG monitor with alligator clips. Connection of the epicardial wire to the ECG monitor allows for the detection and recording of atrial electrical activity.~~

~~d. Select the V lead on the lead selector of the ECG monitor and record a tracing **OR** select lead II or lead III with the lead selector on the ECG monitor and record a tracing. Use of the precordial lead will allow detection of the atrial electrical activity between the V lead and an indifferent limb lead in a unipolar configuration.~~

~~e. Redress epicardial wires to prevent infection and microshock.~~

a. Follow procedure in Online Skills for Atrial Electrogram.

~~E.~~**D. DOCUMENTATION:**

1. Document procedure, including patient's tolerance and any difficulties during technique in the medical record.

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

1. ~~Lynn-McHale~~**Weingard**, D.~~J., and Carlson, K.K. (2005).~~ **L. (2017).** AACN procedure manual for **high acuity, progressive, and** critical care (~~*5th*~~7th ed.). St. Louis, MO: Elsevier~~.~~
2. Perry, A.G. & Potter, P.A. **(2013).** ~~(eds).~~ *Clinical nursing skills and techniques, ~~6th edition. St. Louis, MO: Mosby~~*.
3. ***(8th ed.).*** Urden, L.D., Stacy, K.M., and ~~Lough~~**Loguh**, M.E. **(2013).** ~~(2006)~~. ~~*Thelan's*~~***Thelan's*** *critical care nursing: diagnosis and ~~management (5th~~***Management (7th** *ed.)*. St. Louis, MO: Mosby~~.~~

F. EXTERNAL LINK(S):

1. **Online Skills: Pacing: Temporary Transvenous and Epicardial**
2. ~~1.~~**Online Skills: Atrial Electrogram**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 11/11

SUBJECT: Interpretation and Translation Services

REVISION DATE(S): 10/13; 01/14; 01/15, 03/16; 01/17

~~Department~~ Patient Care Services Content Expert Approval:	~~04/1802/1911~~/19
Clinical Policies & Procedures Committee Approval:	~~04/1802/1911/19~~01/20
Nurse Executive ~~Council~~ Committee Approval:	~~04/1803/19~~02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/1803/19~~ 03/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	06/18
Board of Directors Approval:	06/18

A. **PURPOSE:**

1. To outline the policy and procedure for provision of interpretation services within Tri-City Healthcare District (TCHD) for **the** patients with limited English proficiency.

B. **DEFINITIONS:**

1. Communicatively Impaired: A communicatively impaired individual has expressive or receptive language deficits that may be present after an illness or injury. This may include individuals with: voice disorders, laryngectomy, glossectomy, cognitive disorder, or temporary disruption of the vocal cords due to intubation or medical treatment.
   ~~1.~~**a. See Patient Care Services Policy: Communication with the Sensory Impaired (Blind/Deaf)**
2. Limited English Proficiency (LEP): A limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies.
3. Primary or Preferred Language: the language the patient wants to use to communicate with his/her provider(s).
4. Interpretation and Translation:
   a. Interpretation involves the immediate communication of meaning from one language (the source language) into another (the target language). An interpreter conveys meaning orally **(or, in the case of sign language interpreters, both orally and visual-spatially)**, reflecting the style, register, and cultural context of the source message, without omissions, additions or embellishments.
   b. A translation conveys meaning from written text to written text.
   ~~4.~~c. A sight translation is the oral rendition of text written in one language into another language and is usually done in the moment. Interpretation and translation require different skills.
5. Interpreters:
   a. **Qualified interpreter: An interpreter who, via a video remote interpreting (VRI) service, telephone or an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators.**
      ~~5.~~**i. See Tri-City Medical Center Interpretation Resources and How to Access Them for information on contacting Certified In-house Spanish Interpreter.**

~~a. Bilingual Employees: Personnel with validated competency that specifies the parameters within which the employee, in the course of providing services, may communicate directly with patients, family members, surrogate decision makers and visitors in a foreign language. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.~~

~~b. Dual-Role Employees: Personnel with validated competency that specifies the parameters within which the employee may serve as interpreter in the course of providing services within their unit or in emergency situations. Those parameters and requirements are equal to those set for medical/healthcare, service and general information interpreters.~~

~~c. Medical/healthcare Information Interpreter: Personnel with validated competency to interpret critical medical communications including but not limited to medical care, treatment, medical decision making. May include in-house healthcare interpreters and assessed/qualified dual role.~~

~~d. Service Information Interpreters: Personnel with validated competency to interpret limited topics related to critical service information.~~

~~e. General Information Interpreter: Personnel with validated competency to interpret limited topics relating to providing directions, obtaining specific demographic information, and/or assisting patients with registration, basic daily activities, and comfort.~~

~~f.~~**b.** Telephone Interpreters: Contracted provider, designated telephone interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available.

~~g.~~**c.** Video Remote Interpreters: Contracted providers, designated video remote interpreter focused on quality health care communication to be used when a qualified interpreter (facility identified) is not available or in lieu of a telephone interpreter.

6. Critical Medical Communications: Generally includes but not limited to:
   a. Consent and/or acknowledgement of information discussion **(for example, obtaining consent for medical treatment, surgical treatment, administration of medication, or any other treatment or procedures)**
   b. Advance directive discussion
   c. "Do Not Resuscitate" (DNR) and discussion
   d. Explaining any diagnosis and plan for medical treatment
   e. Explaining any medical procedures, tests or surgeries
   f. Discussing a patient's medical history
   ~~f.~~**g.** Initial medication education
   ~~g.~~**h.** Patient complaints
   ~~h.~~**i.** Final discharge **and follow-up** instructions
7. Critical Service Information: Generally includes but not limited to:
   a. Agreement for Services
   b. Notices pertaining to the denial, reduction, modification or termination of services and benefits, and their right to file a grievance or appeal
   c. Applications to participate in a program or activity or to receive hospital benefits or services.

C. POLICY

1. TCHD provides qualified interpreters at no cost to the patients whenever a language or communication barrier exists **and must provide interpreter services for all Critical Medical Communications and Critical Service Communications.**
   a. Individuals with disabilities may need auxiliary aids and services in addition to translation or interpretation

~~1.~~**2.** Interpretation services **will be provided as soon as possible**~~are available on the premises or accessible~~ by telephone ~~or video remote interpreting (~~VRI~~)~~ **or in person/on-site (as appropriate or necessary)** 24 hours a day, seven (7) days a week. **If interpretation services are not obtained on first attempt within 60 minutes an alternate source of interpretation will be utilized.**

~~2. TCHD qualified interpreters will be utilized for interpretation appropriate to their level of competency.~~

~~a.~~3. The telephone interpretation service or VRI shall be used in the absence of **an on-site Certified In-house Spanish Interpreter** ~~a TCHD qualified interpreter~~ whenever necessary for any language.

~~3.~~4. After being informed of the availability of interpreters who are qualified to interpret medical information at no charge, patients may refuse the TCHD's interpretation service and select an individual of their choice to assist with their communication needs. **Any costs incurred in this situation will be the responsibility of the patient.**

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

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

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

5. Documents and forms shall be either provided in the preferred language of patient/family when available or explained verbally.

~~4.~~a. **For deaf or hard of hearing patients who are also LEP and communicate primarily in sign language, documents and forms should be interpreted by sign language by a qualified interpreter.**

~~5.~~6. Notices advising patients and families of availability of interpretation services, procedures for obtaining assistance and lodging complaints are displayed in public areas on the Patient Rights posters and patient handbooks.

7. Education on interpretation services shall be provided in New Employee Orientation and as needed in department/committee meetings.

8. **Video Remote Interpreting:**

a. **TCHD will contract with a VRI provider to provide Video Remote Interpreting on a 24-hour basis.**

b. **TCHD staff who utilize VRI must recognize that an on-site interpreter may be the only effective means of interpretation in certain circumstances, particularly when the deaf or hard of hearing person's ability to use the VRI device is compromised.**

~~6.~~c. **TCHD will specify where the VRI devices are stored and how hospital staff can access the devices.**

D. PROCEDURE

1. Registration

a. Upon first encounter (registration, check-in), Access personnel shall identify the patients preferred language for discussing health care. The designation shall be documented in the electronic health record as appropriate.

i. An ~~service information~~ interpreter shall be utilized as needed **to ensure effective communication throughout the this process**

~~i.~~ii. **For patients who are deaf or hard of hearing or who have vision impairments, see the Patient Care Services Policy: Communication with Sensory Disabilities.**

2. Inpatient or Outpatient Areas

a. Assess and document patient needs and preferred methods(s) for interpretation services in the **electronic health**~~medical~~ record and incorporate into the plan of care/**treatment plan**.

b. Contact a~~TCHD~~ qualified interpreter ~~**as needed**~~**for critical medical communications or critical service information**~~based on the level of interpretation services (general information or critical medical communication) needed (see definitions and reference Tri-City Healthcare District qualified interpreters information on the Intranet).~~

c. If an **on-site Certified In-house Spanish Interpreter** ~~TCHD qualified interpreter~~ is not available, contact either the facility designated telephone interpreting service (see **telephone interpreting resources** ~~Language Services Associates instructions on the Intranet~~), or ~~facility designated~~ video remote interpreting services (see **VRI resources** ~~Language Services Associates , NexTalk and Status instructions on the intranet~~).

E. DOCUMENTATION

1. Document the use of all interpretation/translation services, including patient selected individual for medical interpretation in the patient's **electronic health** ~~medical~~ record and include: date, interpreter's name or ID number, language, and reason for interpretation / call (i.e., "John Smith, patient's wife or "Mary Jones, Official Interpreter, or "telephone Interpreter ID # 123, Language: Korean, Reason: to discuss surgical procedure).

F. FORM(S):

1. **Waiver of Interpretation Services 8610-NEW - Sample**

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

1. **Patient Care Services Policy: Communication with Sensory Impaired Disabilities (Blind/Deaf)**
2. ~~TCHD Interpretation and Translation Resources Quick Reference & User Guides~~ **(Deleting packet and separating into individual documents.)**
2. **Interpretation Resources and How to Access Them**
3. **Servicing the Deaf and Hard of Hearing Helpful Hints**
4. **Telephonic Interpretation Corded and Cordless Phones**
5. **Translation Services**
~~3.~~6. **Video Remote Interpretation (VRI) Resources**
   a. **VRI Device Deployment**
   b. **VRI Language List**
   c. **VRI Schedule PST**
   d. **VRI Super User Guide**
   e. **VRI User Guide**

~~G.~~H. REFERENCES

1. National American with Disabilities Act (ADA) www.usdoj.gov/crt/ada/adahom1.htm
2. 42 CRF 124.602(c)
3. 45 CFR 84.52 (c) and (d)
4. Section 504 of Rehabilitation Act of 1973
5. Title VI of Civil Rights Act of 1964
6. Section 1259, California Health & Safety Code
7. National Standards for Culturally and Linguistic Appropriate Services (CLAS)
8. National Association for the Deaf: www.nad.org
9. Federal Interagency Working Group on Limited English Proficiency: www.justice.gov/crt/lep/
10. The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals
11. Limited English Proficiency (LEP) A Federal Interagency Website (www.lep.gov).

SAMPLE

Patient Name: _____

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

Please check an option below:

_____ I decline interpretations services.

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

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

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

Please list special requests here:

_____
_____
_____
_____

_____ _____ ___/___/___ _____AM/PM
Name Patient/Representative | Signature Patient/Representative | Date | Time

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

If patient is unable to sign, state reason _____

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

INTERPRETATION (Complete if Interpretation provided)

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

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

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

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

XXXX-XXXX

Waiver of Interpretation Services
Page 1 of 1

Affix Patient Label

(Rev. xx/xx)

Tri-City Medical Center
Oceanside, California

Interpretation Resources and How to Access Them

Certified In-House Spanish~~Healthcare~~ Interpreter 760.802.2656	Spanish/English interpretation and translation. Interpreters **hired into the role who** are available per schedule. Call the number to request service. **Current schedule: 6:00 AM – 6:30 PM, 7-days a week.**
~~Dual-Role Bilingual Employees~~	• ~~Dual-role employees are assessed and qualified individuals that can communicate in a language other than English and can serve as interpreters within their department and hospital-wide only during emergency situations. The level of service that they can provide depends on their assessment score (more information on pages 14- 15).~~
Telephone Interpreters **760.769.1889** **~~855.273.6410~~**	Interpretation via telephone is available in over 200 languages. The current contracted service provider is **InDemand Interpreting**~~Language Services Associates (LSA) and the service is called *InterpreTalk*~~. Telephones are available throughout the hospital and should ONLY be used to provide interpretation services. You may also reach this service by dialing this number (unique to TCMC) from any telephone.
Video Remote Interpreters (VRI) **IMPORTANT:** Please return equipment to its station after each use and plug it into an electrical outlet so the computer remains charged and ready to use.	~~Stratus~~ **InDemand Inpreting** VRI **devices**~~contracted service (iPads) • Mobile unit(s)~~ are available at every nurses' station. American Sign Language and Spanish are offered 24/7, 365 days. ~~As of the date on this document, fifteen o~~**O**ther languages are available during hours that are specified on the language selection screen. ~~Note that CDI/LSA is a team two interpreters, a Certified Deaf Interpreter and an American Sign Language interpreter. For ASL use the ASL only button.~~
	~~LSA also offers VRI services (on PCs). Mobile units can be found in PBX (this shared unit. PBX is located in the basement across from surgery scheduling) and the ER. American Sign Language and Spanish are offered 24/7, 365 days.~~
Face-to-face interpreters for American Sign Language (ASL)	Signs of Silence Interpreting Services: **760.580.3562** Deaf Community Services of San Diego: **619.398.2488** ~~(fillable form is also available on the Intranet for scheduling).~~ In emergency situations. Interpreters can generally be available within 30-45 minutes.

Tri-City Medical Center
Oceanside, California

Servicing the Deaf and Hard of Hearing

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

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

For Medical Interpretation:

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

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

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

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

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

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

For General Interpretation - Relay Services:

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

- TTD/Video relay in English: **1-800-735-2929** (Patient with machine) ~~**or 711** from any phone or video phone~~.
- **TTD/Video relay in English: 1-800-735-2922 (Patient without machine)**
- TDD/Video relay in Spanish: **1-800-855-3000** from any phone ~~or video phone~~.

~~Video Phone:~~

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

~~designated number.~~

- ~~TCMC staff can use VRI service included in this unit.~~

~~This shared video phone will soon be located in the PBX office and can be used with Ethernet (best) or Wi-Fi connections. Details on page~~

Tri-City Medical Center
Oceanside, California

Telephonic Interpretation – Corded Phones

InDemand Interpreting~~Language Services Associates (LSA)~~ is the current contracted provider for Telephonic interpretation services:

1) Press the **Interpreter** ~~**INTERPRETALK**~~ button or dial **1.760.7696.1889**
~~**1.855.273.6410**~~

2) The automated system will give these choices to connect directly to an interpreter:
Press 1 for Spanish, **2** ~~**for**~~**Farsi** ~~**Mandarin**~~,
3 ~~**for**~~ **Punjabi**~~**Cantonese**~~, **4** ~~**for**~~ **Mandarian**~~**Arabic**~~, ~~**5 for Vietnamese,**~~
~~**6 for Haitian creole, 7 for Russian, 8**~~ for **all other languages**~~**French**~~

*Or press **9** to speak with a coordinator if you need another language or if you do not know the language of the patient/person with whom you will be speaking.*

3) **If a third party call is needed, communicate to operator before being transferred to an interpreter. The operator needs to make the third party call and conference in all parties, including the interpreter.**

~~**3)**~~**4)** An automated voice will introduce you to the interpreter with their **6-digit ID number** Remember to write down this information to include in the Interpreter Service Form in the EMR/EHR.

~~**4)**~~**5)** When asked, please provide:

- Name of patient care unit in which the interpretation is taking place
- The Cost Center of that unit
- Your first and last name
- Patient's Medical Record Number

Note: This information is needed for documentation and accounting purposes.

~~**5)**~~**6)** You may explain the objective of the call to the Interpreter. Then proceed by speaking directly to the Limited English Proficient speaker in the first person. **For example: "What is your name?" NOT "Ask her what her name is."**

~~**6)**~~**7)** Once the call is completed, say thank you and hang up. The time of the interpretation service will be automatically recorded.

Remember:

- **Chart** the interpretation call in the electronic medical/health record
- Sanitize the phones
- These telephones and the line they are connected to are for **interpretation ONLY**

Tri-City Medical Center
Oceanside, California

Telephonic Interpretation – Cordless Phones

Make sure to place handset 1 on the main, larger base.
Give handset 1 to the Limited English proficient person.

~~The numbers on the base and handsets should match. In this case, all should be labeled 12.~~

1. Press the **BLACK SOFT key** at top left labeled: "Phone Book" or dial **1.760.769.18891-855-273-6410**
2. Press **# 5** (the display will show **InDemand Interpreting**~~LSA~~).
3. Press **"Talk"** - The automated system will give these choices to connect directly to an interpreter: Press **1** for Spanish, **2** ~~for~~ **Farsi**~~Mandarin~~, **3** ~~for~~ **Punjabi**~~Cantonese~~, **4** ~~for~~ **Mandarian**~~Arabic~~, **5** ~~for Vietnamese, 6 for Haitian creole, 7 for Russian,~~ **8** for **all other languages**~~French~~

   Or press 9 to speak with a coordinator if you need another language or if you do not know the language of the patient/person with whom you will be speaking.
4. **If a third party call is needed, communicate to operator before being transferred to an interpreter. The operator needs to make the third party call and conference in all parties, including the interpreter.**

~~4.~~5. An automated voice will introduce you to the interpreter with their 6-digit ID number Remember to write down this information to include in the Interpreter Service Form in the EMR/EHR.

~~5.~~6. When asked, please provide:

- Name of patient care unit in which the interpretation is taking place
- The Cost Center of that unit
- Your first and last name
- Patient's Medical Record Number

Note: This information is needed for documentation and accounting purposes.

~~6.~~7. You may explain the objective of the call to the Interpreter. Then proceed by speaking directly to the Limited English Proficient speaker in the first person. For example: "What is your name?" NOT "Ask her what her name is.

Remember:

- **Chart** the interpretation call in the electronic medical/health record
- Sanitize the phones

AFTER USE

- Sanitize the handsets.
- Return them to their appropriate base as shown above.

The phones must be charged in order to work. Repeated discharges will damage the battery.

- These telephones and the line they are connected to are for **interpretation ONLY**

Tri-City Medical Center
Oceanside, California

Telephonic Interpretation – 3-Way Calling

Three-way calling (also referred to as 3rd party calling) connects provider, interpreter and patient or 3rd party. LSA is a contracted provider of interpretation services via telephone for Limited English Proficiency (LEP) individuals.

- Dial **855-273-6410** to connect with an LSA interpreter and follow the same instructions described on pages 5 and 6. Make sure to provide the necessary information.

  Once the interpreter is on the line, tell him/her that you wish to call a third party, state the reason of your call and provide the interpreter with the telephone number of the person you wish to call. The interpreter will then place the 3-way call.

  OR

  - Once the interpreter is on the line, let him/her know that you will be placing the call to a 3rd party and explain the objective of the call.
  - Connect the parties: If your phone is the same as the ones on the main hospital campus, press the "**Conf**" button, located on the bottom left corner of the screen. Then dial the number of the person you wish to call.
  - Press the "**Connect**" button on the TCMC telephone, which will set up a conference call between you, the person you wish to call, and the interpreter.

When all three parties are connected, proceed by speaking directly to the LEP speaker in the first person. For example: "My name is Jane Doe and I am calling from Tri-City Medical Center to schedule your next appointment. Would you be available to come in on …"

- Once the call is completed, say thank you, the call has ended and hang up.
- The time of the interpretation service will be automatically recorded.
- **Chart the interpretation call in the patient's EMR**

Tri-City Medical Center
Oceanside, California

Translation Services

- There are two types of translation services: **document** translations and **sight** translations.

  A **document translation:** Written information in one language is written in another language.
  A **sight translation:** An interpreter reads a document on the spot in the foreign language.

- Please note that translations require very different and unique skills. A good interpreter may or may not be a good translator.

Document translations

- In-house -- Spanish ONLY: Send documents to be translated to **Patricia Guerra**~~Isabel Escalle~~ via email: guerrapi@tcmc.com ~~escallei@tcmc.com or hand them to the in-house Spanish interpreter~~.
  Editable (MS Word) documents preferred, sent via email. This is both appreciated and expedites translations.

- ~~Contracted Service: Send the document to translations@lsaweb.com. Please cc George Doukas, Account Manager gdoukas@lsaweb.com and Isabel escallei@tcmc.com.~~

  Estimates will be provided within 24 hours (fees are per contract). Project delivery depends on language, size and complexity, 2 business day minimum unless rush option is applied. The Translation Department is staffed Monday – Friday, 9AM – 5PM, EST

Sight translations

- In-house -- Spanish ONLY: Call the in-house interpreter for services: 760.802.2656.

- ~~Contracted Service: Sight Translations are managed through the Language Services Associates (LSA)'s Call Center (staffed 24/7). The process is as follows:~~

  ~~Dial TCMC's dedicated telephonic interpretation line 855.273.6410.~~
  ~~Press 9 and ask the Coordinator to connect you to the Call Center Supervisor on staff.~~
  ~~The supervisor will direct you to provide the document via email and will schedule an appointment for the sight reading once the appropriate interpreter has been identified.~~

  ~~The turnaround time for the sight reading appointment is dependent on requested language and availability. Common languages can be scheduled as quickly as within 30 minutes, less common languages can take longer.~~

Video Remote Interpretation (VRI) Device Deployment

	Department	CartUsername	FriendlyName
1	Admissions	tricir0030	Admitting_Essential
2	Catheterization Laboratory	tricir0029	Cath Lab_Essential
3	Emergency Department	tricir0003	ED_Essential
4	Emergency Department	tricir0024	ER_ABC_Essential
5	Emergency Department	tricir0025	ER Station D_F_Essential
6	Emergency Department	tricir0026	ED Triage_Essential
7	Intensive Care Unit	tricir0013	ICU_Essential
8	Medical Surgery	tricir0006	4Pavillion_Essential
9	Medical Surgery	tricir0011	Med Surg 2P_Essential
10	Orthopedics	tricir0005	1NOrtho_Essential
11	Post Anesthesia Care Unit	tricir0028	PACU_Essential
12	Preoperative	tricir0016	Preop Hold_Essential
13	Preoperative	tricir0027	Pre-Op Tech_Essential
14	Progressive Care Unit	tricir0017	PCU_3NS_Essential
15	Radiology	tricir0019	Interventional Radiology_Essential
16	Radiology	tricir0022	Radiology_Essential
17	Roam	tricir0031	PBX_Essential
18	Surgery	tricir0023	Surgery_Essential
19	Telemetry	tricir0014	Tele 4Eand4W_Essential
20	Telemetry	tricir0015	Tele 2Eand2W_Essential
21	WNS Labor and Delivery	tricir0002	LD_Essential
22	WNS Mother Baby	tricir0012	Mother and Baby_essential
23	WNS NICU	tricir0004	NICU_Essential
24	Outpatient Specialty Clinic (off site)	tricir0018	Outpatient Progressive Care_Essential
25	Rehabilitation (off site)	tricir0021	El Camino Rehab_Essential
26	Rehabilitation (off site)	tricir0032	Wellness Center_Rehab_Essential
27	Wound Care (off site)	tricir0020	WoundCare_Essential

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 5/78

SUBJECT: **Meals, Patients – Times, Menus, Substitutions and Nourishments**

REVISION DATE: 04/00, 06/03, 08/05; 05/08; 02/11 06/15

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

Patient Care Services Content Expert~~Department Approval~~:	**~~02/17~~05/20**
Clinical Policies and Procedures Approval:	**~~03/17~~06/20**
Nursing Leadership~~Executive Council~~ Approval:	**~~03/17~~07/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy ~~and~~ & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**~~04/17~~ n/a**
Board of Directors Approval:	**04/17**

A. **PATIENT MEALS~~POLICY~~:**

1. The Food and Nutrition Services Department provides three (3) patient meals daily and offers between-meal nourishments three (3) times daily. No more than 14 hours shall elapse between the serving of the dinner meal and the breakfast meal of the following day.
   a. Patient tray line shall operate according to the following schedule:
      i. Breakfast: 7:00 AM – 8:30~~15~~ AM
      ii. Lunch: 11:00 AM – 12:30~~15~~ PM
      iii. Dinner: 4:45 PM – 6:~~15~~30 PM
      iv. (All finish times are approximate)
   b. Patient trays shall be loaded on food carts and delivered to the nursing units in a predetermined sequence.
2. Meal service shall be provided for patients who are not served meals during normal meal service time.
   a. Delayed trays are ordered via the computer system.
      i. **Nursing or designee must call the diet office for all late tray meal requests**
      ~~i.~~ii. All delayed tray requests shall be filled with a minimum of delay.
      ~~ii.~~iii. Food and Nutrition personnel ~~trained on special diets~~ **will**~~shall~~ prepare the tray as listed on the diet slip. ~~Supervisory personnel shall monitor performance.~~
      ~~iii.~~iv. All food items shall be covered.
      ~~iv.~~v. Normal tray line delivery systems shall be used to ensure maximum temperature retention.
   b. Early breakfast trays are available upon request.
   c. Standard late breakfast trays are served from 8:30 AM until ~~10~~9:00 AM. Late trays shall be delivered on the half-hour.
      ~~d.~~i. From 10 AM to 10:30 AM, Continental-type breakfast may be served.
   ~~e.~~d. Standard late lunch trays are served from 12:30 PM until 2:30 PM.
      i. From 2:30 PM until 4:00 PM, soup, sandwich, dessert, and beverage lunch shall be served.
   ~~f.~~e. Standard late dinner trays are served from 6:00 PM until 7:00 PM.
      i. From 7:00 PM until 1:30 AM, grilled items and cold sandwiches, appropriate to the patient's diet, can be obtained in the cafeteria.
   ~~g.~~f. Late trays served shall comply with the patient's diet order.
   ~~h.~~g. Floor stocks are used for **non-emergency** after-hours.

B. MENUS:

1. Menu Pre-Adjustment:

a. The proper menu, based on the most restrictive diet order, is selected.

i. Exceptions include: newly admitted patients, patients who are NPO, patients on liquid diets, severely restricted diets, and those patients opting to not select a menu.

b. Additional diets, restrictions, name and room number are documented on the most restrictive menu

c. The diet manual and/or menu correction guide is referenced to assure accuracy.

d. Fluid restrictions are noted on the menu. Food and Nutrition provide half of the total fluid restriction per 24 hours.

2. Menu Distribution:

~~3.~~**a.** Most patients receive selective menus from which to make their meal choices.~~ Exceptions are: New admissions, patients who are NPO, patients on liquid diets, severely restricted diets, and those electing not to select.~~

b. The next day's menu is **delivered**~~distributed~~ **to the patient** by a **Food Service Partner or designee**~~representative from Food & Nutrition. The menu is reviewed with the patient and appropriate selections are made~~.

~~a.~~**c.** ~~-~~Newly admitted~~s~~ **patients** receive a selective menu **within two (2) meals of receipt of the diet order**~~by their second meal~~. **House menus are provided for patients not selecting a menu.**

~~b.~~**d.** Patients willing but unable to fill out the menu by themselves shall receive assistance from family members, Nursing or Food & Nutrition personnel.

~~c. Upon receipt of a new diet order, the patient shall be visited by a dietitian or food service partner within two (2) meals of receipt of the diet order.~~

~~i. The patient shall receive the house menu prior to visitation.~~

~~ii. Patients with new diet orders received by 8:00 AM shall be allowed to choose a lunch and dinner for that day in addition to the next day's menu.~~

~~iii. Patients with new diet orders received between 8:00 AM and 12:30 PM shall be allowed to choose dinner for that day as well as the next day's menu.~~

~~iv. Patients with new diet orders received between 12:30 PM and 8:00 AM the next day receive a house diet for dinner and breakfast and then are allowed to choose subsequent meals.~~

3. Menu Substitutions:

~~4.~~**a.** Menu substitutions are offered to patients who cannot make adequate choices from the printed menu.

b. A minimum of a two-hour notice is required for staff to request a substitution item. **If nursing is unable to provide this notice, every effort within reason will be made to accommodate the patient's nutritional needs.**

~~a.~~**c.** Substitutions are offered from the substitution list when the patient asks for other foods due to reasons as stated above.

~~b. Suggestions are made based on the reason for patient's request from substitution list.~~

~~c.~~**d.** Production area is alerted by diet clerk if "write-ins" are done on the day food substitutions are to be served.

~~d. Patients are familiarized with available menu substitutions.~~

e. The hospital cafeteria menu~~, appropriate to the patient's diet,~~ is made available to patients who request additional selections. **If these selected items are contraindicated on prescribed diet, a verbal approval is required by a Dietitian or Nurse.**

f. **Patients may refuse foods served; alternate choices that will meet nutritional needs are provided. Nursing may substitute foods from available floor stock items or contact Food & Nutrition for an alternate tray.**

4. Menu Collection:

a. The Food Service Partner creates a list of patient menus that need to be collected

b. **Upon entering a patient's room, the Food Service Partner conducts proper hand hygiene, identifies self, and uses two patient identifiers before obtaining menu selections.**
c. **Assistance is offered to patients who are unable to fill out their menus.**
d. **If the menu is not ready at the time of collection, help may be offered in filling** out the menu. **Otherwise, these menus are collected at the next appropriate time.**
   i. **If the patient is unavailable, the Food Service Partner will return at a later time to complete the menu**
e. **The patient is notified when food choices are contraindicated with the diet order.**
f. **Each menu is screened and corrected by a Food Service Partner or designee to ensure that the contents of the menu is in accordance with the diet prescription and is marked in a legible manner.**
g. **The menu is in three parts: Breakfast, Lunch, and Dinner. Each part should have the patient's name, room number, and diet order.**
~~g.~~h. **The evening Food Service Partner creates production and tally sheets based off menu selections received.**

5. Nourishments or "between meal feedings" shall be recommended and provided to meet the patients' nutritional requirements **per Food and Nutrition Procedure: Supplemental Feedings and Nourishments, Ordering, and Review**.

~~a. Criteria for recommending/providing supplements or nourishments:~~
~~i. Multiple feeding plans, i.e. IDDM, dumping syndrome, and hypoglycemia.~~
~~ii. Patients' inability to consume daily caloric requirements within a three (3) meal per day plan.~~
~~iii. Calorie or protein needs are greater than the prescribed diet.~~
~~b. All nourishment orders shall be received and planned by the food service partner or dietitian. The food service partner or the dietitian shall initiate specific nourishment orders. The dietitian or food service partner shall review patient acceptance and tolerance and revise the nourishment/meal plan as appropriate.~~

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

~~c.~~1. **Food and Nutrition Procedure: Supplemental Feedings and Nourishments, Ordering, and Review**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**10/97**	**SUBJECT:**	**Nursing Students in Patient Care Areas**
REVISION DATE:	**3/05, 4/05; 5/08; 07/09, 07/12, 02/13 01/17**	~~**POLICY NUMBER: VIII.M**~~	

Patient Care Services Content Expert~~Department~~ Approval:	~~**10/16**~~**06/20**
Clinical Policies & Procedures Committee Approval:	~~**10/16**~~**06/20**
Nursinge Leadership~~Executive Council~~ Approval::	~~**10/16**~~**07/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**11/16**~~**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	~~**01/17**~~ **n/a**
Board of Directors Approval:	**01/17**

A. **POLICY:**

1. Students from several ~~professional~~ registered nursing (RN) schools are affiliated with Tri-City Healthcare District (TCHD)~~TCHD Nursing Services~~. All RN students must be affiliated with a school that has an agreement/contract with TCHD.
   a. Student affiliation agreements are maintained in the Education Department and are signed by the Chief Nurse Executive.
2. Annually, the schools make clinical requests through the San Diego Nursing Service-Education Consortium. Requested schedules for nursing students are submitted to the Education Department for coordination and approval. Finalized schedules are distributed to the clinical areas prior to the students' arrival There are two types of clinical rotations:
   a. Clinical Rotation with Instructor On Site: a group of RN nursing students in one of the ~~four~~ primary clinical areas: Acute Care Services, Telemetry, ~~Behavioral Health Unit~~ or Women~~'s~~ and **Newborn**~~Children's~~ Services ~~Mother Baby,~~ where the clinical instructor is on site.
   b. Clinical Rotation with Instructor Off Site: a RN nursing student in a clinical rotation where the nursing student follows an assigned staff nurse for a designated number of hours determined by the school, where the clinical instructor is off site.
   c. Any change in approved clinical rotations (department, day, time) must be authorized by the TCHD Academic Liaison through the Education Department.
3. The Student Orientation Record **and rotation share** from the **designated** San Diego Nursing Service-Education Consortium **(SDNEC) website** with the list of students and instructors must be submitted 2 weeks before the start of the semester for background**/drug screen** checks.
   a. Any flagged background checks will be reviewed and any action will be decided by the Director of Human Resources and the Director of Education ~~and Clinical Informatics~~. The background checks must be cleared or resolved before the start of the clinical rotation.
4. Responsibility for nursing care and related duties is retained by nursing unit when students are providing care within a patient care unit.
   a. The nursing staff has the right and responsibility to intervene or prevent a student from performing any nursing activity that appears inappropriate or potentially injurious to patients.
5. The faculty and students of affiliated schools are responsible for knowing and complying with TCHD Policies and Procedures.

6. The Director or designee and the TCHD Academic Liaison have the option to discuss behavioral or practice issues with students and/or instructors.
7. Staff issues identified by the nursing student instructor are to be directed to the **Nursing Leader (NL)**~~Assistant Nurse Manager (ANM)~~ or designee of the unit.
8. All medications shall be administered under the direct supervision of the Instructor/following Patient Care Services (PCS)~~)~~ **Policy:** Medication Administration~~ Policy (IV.I)~~.
   a. The staff RN may provide the direct supervision as available.
   b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the medication administration process.
   c. When removing medications from the Pyxis machine, the Instructor or staff RN will enter their access code and student may remove medications under the direct supervision of the Instructor/staff RN.
      i. Nursing Students will not be issued their own Pyxis code.
9. A skill will be performed by the student under the direct supervision of the nursing instructor until competency is validated. Certain skills may be performed by the RN nursing student without supervision once competency has been validated by the school (**see** RN Nursing Student Skills List~~ attachment 1~~).
   a. The staff RN assigned to the patient in may provide direct supervision as available once the student has demonstrated competency with the skill. The school is responsible for validating competency.
   b. If neither the Instructor or staff RN is able to provide direct supervision, the RN nursing student may only observe the skill.

B. **CLINICAL ROTATIONS WITH INSTRUCTORS ON SITE (REQUIREMENTS):**

1. The nursing school is responsible for planning the education program and providing Nursing Services with outlined goals and objectives relating to the clinical experience. Instructors are also responsible for updating and reviewing clinical goals for each student for every unit rotation.
2. Instructor Responsibilities:
   a. Establish orientation dates for themselves and the student groups.
      i. Orientation shall include time spent on the unit to learn standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, patient assignment mechanism, call light system, daily schedules and roles of the staff and students.
   b. The instructor shall turn in all completed forms/tests for faculty and students to Academic Liaison in the Education Department. Once the required documentation is completed and turned in, TCHD badges and access codes will be issued.
      i. The orientation forms/tests are available on the **designated SDNEC**~~consortium~~ website.
      ii. The completed forms should be returned **during orientation to**~~within the first week of the~~ TCHD rotation.
      iii. Instructors/students must complete the TCHD orientation annually.
      iv. Access codes shall be issued for each semester.
   c. Select students' patient assignment and post by start of shift.
      i. The **NL**~~ANM~~ or designee may change assignment according to unit needs including the number of students and TCHD orientees assigned to a staff RN.
      ii. Instructor is to assess needs of the unit as well as educational objectives of students prior to making patient assignments
   d. Monitor the activities of the students at all times and is present on the units to monitor students or is available to students via pager and/or cell phone.
   e. Ensure students comply with all policies related to protected health information (PHI).
   f. Assessments may only be documented by RN nursing student when performed under the direct supervision of the instructor. The instructor supervising the assessment will authenticate the documentation.

i. Assessments performed without direct supervision may not be documented in the medical record.
ii. The staff RN assigned to that patient may provide direct supervision as available once the student has demonstrated competency with the skill. If the staff RN provides supervision, they will authenticate the documentation.

g. The instructor shall review student documentation including but not limited to:
i. Medication administration
ii. Vital Signs
iii. Plan of care
iv. Clinical notes
v. The staff RN assigned to the patient may review the student documentation as available.

h. Teach and supervise student education and actions while on the unit.
i. Communicate expectations of student's performance.
j. Evaluate the student's clinical competency prior to arrival on the floor and also during performance of patient care skills.
k. Assume final responsibility for management and evaluation of students.

3. Student Responsibilities:
a. Report to work at a specified time to receive report on their assigned patients from the primary nurse.
i. Perform nursing care according to TCHD policies and procedures. Care delivery must be under the direct supervision of the Instructor or staff RN according to **the RN Nursing Student Skills List**~~attachment 1~~.
ii. Students are not to leave floor/unit without reporting to primary nurse.
iii. Ensure documentation is reviewed and authenticated by instructor/staff RN.
iv. Students shall not be excused until Intake and Output and charting is reviewed by the Instructor and verbal report is given to the primary nurse.
v. All unfinished work is to be reported to the primary nurse.

b. Communicate all pertinent information including changes in patient status, problems, concerns, and questions or learning needs to patient's primary RN.
c. Work with all health care team members in an effective/professional manner.
d. Review paper and electronic chart prior to the start of patient care and throughout the shift.

4. Staff RN Responsibilities:
a. Function as role models and are responsible for the nursing care given to the patients/families.
b. Facilitate the student learning experience as available.

C. **CLINICAL ROTATIONS WITH INSTRUCTORS OFF SITE (ADDITIONAL REQUIREMENTS):**

1. Clinical Instructor
~~Submit the request for preceptors to the TCHD Academic Liaison prior to the start of the rotation.~~
a. Ensure students are oriented to TCHD and forms/tests for faculty and students are completed and turned in **prior to the start**~~within the first week~~ of the rotation.
b. Provide to the department goals of the rotation and hours required.
c. Ensure students have access to clinical application including but not limited to Cerner, capillary blood glucose meter and Supply Pyxis.
d. Manage any concerns/problems with students including conflicts with schedule

2. TCHD Academic Liaison Responsibilities
a. Collaborate with the Clinical Educator/**NL**~~Manager~~ to assign students to a specific department.
b. Provide to the department dates of the rotation and minimum hours required.

3. Clinical Educator/**NL**~~Manager~~ Responsibilities
a. Identify staff RN and provide the name of staff RN to facilitate scheduling the RN nursing student with the staff RN

i. The instructor is responsible for managing any concerns/problems including conflicts with schedules.

4. RN Nursing Students Responsibilities:
   a. Follow designated staff RN's schedule.
      i. If staff RN is not available (Hospital Requested Time Off or illness) the nursing unit is responsible for assigning an alternative staff RN for that shift.
      ii. If the student unable to report for an assigned shift, they must notify the nursing unit. The student will make arrangements with the nursing unit to make up the shift.
   b. Report to nursing unit with academic skills checklist and clinical goals/objectives for each shift. The student may only perform skills for which they have demonstrated competency as validated by the school.
   c. Discuss any schedule conflicts with Clinical Instructor.
5. Staff RN Responsibilities:
   a. Ensure the student functions appropriately within their scope of practice and in accordance TCHD policies and procedures.
   b. Review the skills the RN nursing student has demonstrated competency which have been validated by the school. The staff RN is not responsible for teaching new skills.
   c. Observe assessments performed by the RN nursing student. The staff RN will authenticate the assessment documentation.
   d. Review student documentation including but not limited to:
      i. Medication administration
      ii. Vital Signs
      iii. Plan of care
      iv. Clinical notes
   e. Provide feedback to the Instructor on the student's performance during the rotation.

D. <u>RELATED DOCUMENT(S)</u>:

~~a.~~1. RN Nursing Student Skills List

RN Nursing Student Skills List

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
ADLs	Yes		Yes
Ambulation/Transfer (Fall Risk Procedure)	Yes		Yes
Assessments	Yes	Yes	
Bath	Yes		Yes
Blood Product Administration	NO		
CAPD, Peritoneal Dialysis Administration	NO		
Capillary Blood Glucose Testing	Yes		Yes
ECG Monitoring Electrode Application	Yes		Yes
Endotracheal Suctioning Deep	Yes	Yes	
Enema Administer Non-Medicated Solution	Yes	Yes	
Feeding Tube (weighted/non-weighted) Discontinuation	Yes	Yes	
Feeding Tube (weighted/non-weighted) Insertion	Yes	Yes	
Feeding Tube (weighted/non-weighted) Irrigation	Yes	Yes	
Gastrostomy Tube Care	Yes	Yes	
Hand Off Communication	Yes		Yes
Hygiene (personal) Administration	Yes		Yes
Intake/Output	Yes		Yes
Isolation Precautions	Yes		Yes
IV Central Venous Access Dressing Change	Yes	Yes	
IV Peripheral Access/Venipuncture Insertion	Yes	Yes	
IV Peripheral Access Discontinuation	Yes	Yes	
Pulse Oximetry Monitoring	Yes		Yes
Epidural Infusions Maintain/Discontinue	NO		
Meal - Assist with Feeding (Aspiration Precautions)	Yes		Yes
Medication Administration - Chemotherapy	NO		
Medication Administration Investigational/Experimental Drugs	NO		
Medication Administration – Gastrostomy Tube	Yes	Yes	
Medications Administration - Eye	Yes	Yes	
Medications Administration - Intramuscular (IM)	Yes	Yes	
Medications Administration - Oral	Yes	Yes	
Medications Administration - Subcutaneous	Yes	Yes	

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Medications Administration IV Peripheral Push*	Yes	Yes	
Medications Administration IV Central Venous Access	Yes	Yes	
Medications Administration IV Peripheral - Infusion pump	Yes	Yes	
Nasogastric Tube Discontinuation	Yes	Yes	
Nasogastric Tube Insertion	Yes	Yes	
Nasogastric Tube Irrigation/Care	Yes	Yes	
Neonatal – Bath	Yes		Yes
Neonatal – Developmental Care	Yes	Yes	
Neonatal – Diaper Change	Yes	Yes	
Neonatal – Heel Sticks	Yes	Yes	
Neonatal - Medication Administration Eyes	Yes	Yes	
Neonatal - Medication Administration IM	Yes	Yes	
Neonatal – Feeding Breast & Bottle	Yes	Yes	
Neonatal – Skin Care	Yes	Yes	
Neonatal – Transcutaneous Bilirubin (TCB) screening	Yes	Yes	
Neonatal – Universal Saturation Screening	Yes	Yes	
Oral gastric tubes insertion/irrigation/discontinuation	**NO**		
Ostomy maintenance	Yes	Yes	
Ostomy irrigation	**NO**		
Rectal Tube Insertion/irrigation/discontinuation	**NO**		
Skin Care Pressure Ulcer Precautions	Yes		Yes
Skin Care Simple Dressing Change	Yes	Yes	
Specimen Collect urine / stool / expectorated sputum	Yes	Yes	
Standardized Procedure Initiation	**NO**		
Staple Removal	Yes	Yes	
Sterile Procedures / Surgical Skin Preparation (excluding Surgical Area)	Yes	Yes	
Suprapubic catheter Irrigation	**NO**		
Surgical drains (penrose, constavac, JP) removal	Yes	Yes	
Telephone/Verbal Orders	**NO**		
Tracheotomy care	Yes	Yes	
Urinary drainage catheters (Foley) Care	Yes		Yes

Skill	RN Nursing Student Able to Perform	Direct Observation by Instructor or RN Staff Required	Able to Perform after Competency Validated by Instructor
	Yes/No		
Urinary drainage catheters (Foley) Discontinuation	Yes	Yes	
Urinary drainage catheters (Foley) Insertion	Yes	Yes	
Vital signs (Temp, BP, HR, RR SpO_2, Pain)	Yes		Yes

* Medications Administration IV Peripheral Push: antidysrthmics, intropes and medications for cardiac rhythm control may not be administered by RN nursing students.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services

PROCEDURE:	PERCUTANEOUS TRACHEOSTOMY ASSIST
Purpose:	Percutaneous Dilational Tracheostomy (PDT), also referred to as bedside tracheostomy, is the placement of a tracheostomy tube without direct surgical visualization of the trachea. It is a procedure that can be performed in the intensive care unit at the patient's bedside with continuous monitoring of patient's vital signs. The procedure may be performed under local anesthesia.
Supportive Data:	A. Advantages of Percutaneous Dilational Tracheostomy: 1. Time required for performing bedside PDT is considerably shorter than that for an open tracheostomy. 2. Eliminates complications that can occur during transport to or from the OR such as accidental extubation or intravascular catheter decannulation. 3. Elimination of the need to use an operating room and anesthesiology team 4. A smaller operative scar 5. Less bleeding and tracheal erosion 6. Reduced likelihood of infection. B. Indications: 1. The need for prolonged artificial airway. 2. The patient that is unable to cough effectively requiring assistance in the removal of bronchial secretions. 3. The need for positive pressure ventilation when using a cuffed tracheostomy\tube. 4. To prevent aspiration of gastric secretions or contents in the unconscious (or paralyzed) patient by the use of a cuffed tracheostomy tube that will not allow those fluids to communicate with the trachea.

A. **POLICY:**

1. The procedure should be scheduled in advance to ensure the availability of the Video bronchoscope. The Pulmonary lead should be called to schedule: 760-802-1974.
2. The bedside nurse and respiratory therapists will be responsible for monitoring the patient and providing the Physician with the necessary equipment for the bedside tracheostomy procedure.
3. One respiratory therapist is responsible for ventilator adjustments and tube manipulations. The physician is responsible for manipulating the bronchoscope.

B. **PROCEDURE (NURSING):**

1. Ensure that all the necessary supplies are available – obtain Percutaneous Tracheostomy Cart
2. Provide education to the patient about the procedure.
3. Ensure that the procedural consent is signed.
4. Place patient in a supine position with the head midline and the neck extended with chin pointing toward the ceiling.
5. Assist physician with sterile draping and site preparation
6. Ensure Time Out is performed per Patient Care Services (PCS) Universal Protocol Procedure
7. Document Time Out in the medical record.
8. Support and reassure the patient during the procedure.
9. Administer sedation as ordered by physician per PCS Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures.

Department Review	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Council~~	Critical Care Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
3/13, 12/16,3/20	3/13, 1/17, 05/20	3/13, 02/17, 06/20	03/17, 06/20	n/a	8/13, 04/17, 07/20	08/20	10/13, 05/17, n/a	10/13, 05/17

10. Assist the physician with the procedure and equipment as needed. Open sterile supplies as directed by physician.
11. Monitor and document patient's vital signs every 5 minutes during procedure. Vital Signs include but are not limited to:
    a. Heart rate,
    b. Respiratory rate,
    c. Blood pressure,
    d. Pulse oximetry,
    e. End-tidal CO_2 and Color.
12. Assist with post procedural tube securement and dressing.

C. **PROCEDURE (RESPIRATORY):**

1. Make sure protective equipment is being worn, such as gown, gloves, mask and eye protection.
2. Assist with monitoring vital signs as noted above.
3. Monitor end-tidal CO_2 measurements (if applicable)
4. Place patient on 100% FiO_2 in preparation for the procedure and increase peak pressure limit to allow adequate V_T delivery during procedure.
5. Suction patient (both orally and down endotracheal ~~([ET])~~ tube) if necessary.
6. Attach syringe to pilot balloon for cuff inflation and deflation.
7. Have videoscope/bronchoscope ready to insert down ET tube and follow physician instructions.
8. Deflate the cuff upon physician request and slowly withdraw the ET tube to a level just above the vocal cords—physician will guide the RCP during the process.
9. The RCP may need to adjust the V_T and rate on the ventilator to compensate for the air leak created when the ET tube cuff is deflated. Another option is the RCP may gently re-inflate cuff only until V_T is achieved.
10. Observe insertion of needle, dilators and tracheostomy tube by the physician.
11. Inflate cuff on tracheostomy tube and attach ventilator tubing.
12. Check end-tidal CO_2.
13. Assess breath sounds.
14. Remove the scope.
15. Remove ET tube after proper placement is confirmed.
16. Secure tracheostomy tube.
17. Return ventilator to the ordered settings.
18. Tape obturator at the head of bed to assist in emergent replacement in case of decannulation.
19. Keep appropriate sized back up tracheostomy at bedside.
20. Clean scope appropriately per Patient Care Services: High Level Disinfection Procedure.

D. **RELATIVE CONTRAINDICATIONS TO PERCUTANEOUS TRACHEOSTOMY:**

1. Children younger than 12 years of age
2. Emergency Airway Access
3. Hemodynamic instability
4. Anatomic abnormality of the trachea
5. Palpable blood vessel over the tracheostomy site
    a. For example malposition of the brachiocephalic or innominate artery
6. FiO_2 > 60%
7. PEEP >15 cmH_2O
8. Coagulopathies
9. Limited ability to extend the cervical spine

E. **COMPLICATIONS THAT CAN OCCUR WITH PERCUTANEOUS TRACHEOSTOMY:**

1. Bleeding
2. Infection
3. Accidental ~~E~~extubation
4. Para-tracheal ~~I~~insertion

5. Esophageal perforation
6. Subcutaneous emphysema
7. Pneumothorax
8. Tracheal stenosis.
9. Airway obstruction as evidenced by:
   a. Restlessness
   b. Tachycardia
   c. Tachypnea, wheezing, stridor
   d. Decreased SpO_2 levels, cyanosis, pallor
10. Injury to thyroid or laryngeal nerve.

F. **DOCUMENTATION:**
1. Document in the **electronic health**~~medical~~ record.
2. Respiratory to chart new tracheostomy insertion under Artificial Airway

G. **RELATED DOCUMENT(S):**
1. Patient Care Services: High Level Disinfection
2. Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures
3. Patient Care Services: Universal Protocol Procedure

H. **REFRENCES:**
1. Cianchi G, Bonizzoli M, Batacchi S, Cammelli R, Biondi S, Spina R, Peris A. A Comparison between single step and balloon dilatational tracheostomy in intensive care unit; a single centre, randomized controlled study. Br J Anaesth. 2010 Jun: 104 (6): 728-732. Epub 2010 April 2010.
2. Marchese S,Corrado A, Scala R, Corrao S, Ambrosino N; Intensive Care Study Group, Italian Association of Hospital Pulmonologists (AIPO) Tracheostomy in patients with long-term mechanical ventilation: a survey.Respir Med. 2010 May; 104 (5) 749-753. Epu2010 Feb 1.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/06

SUBJECT: Rapid Response Team Activation and Condition Help (H)

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

POLICY NUMBER: IV.L

Patient Care Services Content Expert~~Department~~ Approval:	**~~07/16~~11/19**
Clinical Policies & Procedures Committee Approval:	**~~09/16~~12/19**
Nursing Executive Council Approval:	**~~09/16~~02/20**
Critical Care Committee Approval:	**~~10/16~~06/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/17~~07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**~~03/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **DEFINITIONS:**

1. Bipap (NIPPV): A type of mechanical ventilation which provides inspiratory and/or expiratory positive pressure ventilation via nasal, full face or total face mask in order to improve hypoxemia, reduce ventilatory muscle fatigue, and to support ventilation.
2. Condition Help (H): A program that enables patients and family members to call for immediate help if they feel the patient is not receiving adequate medical attention.
3. Multidisciplinary Medical Team: A team consisting of multiple members with varying medical education backgrounds such as an **Intensive Care Unit** (ICU) Nurse, a~~n~~ **Respiratory Care Practitioner** (RCP), Patient's Primary Nurse and the Administrative Supervisor if duties/time permits. -For Condition H, a social worker and a chaplain also will respond.
4. Rapid Response Team (RRT): A multidisciplinary team that responds to urgent patient situations throughout the hospital.

B. **PURPOSE:**

1. To provide, within minutes a multidisciplinary medical team approach using a formalized process, to assess and treat a patient, whose condition is deteriorating or when nursing staff on the floors has concerns related to patient's condition.
2. To provide support when a patient/family recognizes a noticeable medical change in condition and feels they are not receiving the appropriate response from the healthcare team.
3. Tri-City Medical Center (TCMC) will plan for, support, and coordinate a systematic approach to complex patients such as the implementation of the ~~Rapid Response Team (~~RRT~~)~~ to respond to deterioration in patient status outside the critical care setting.
4. The role of the **RRT**~~Rapid Response Team~~ is to:
   a. Assess
   b. Stabilize
   c. Assist with communication
   d. Educate and support
   e. Assist with transfer to a higher level of care if necessary

C. **POLICY:**

1. The goal of the team is to provide early and rapid intervention in order to promote better outcomes such as:
   a. Reduced cardiac and/or respiratory arrests in the hospital;
   b. Reduced or more timely transfers to the ~~Intensive Care Unit (~~ICU~~)~~ or a higher level of care;

c. Reduced patient intubations; and
d. Reduced number of hospital deaths.

2. The RRT Nurse provides clinical expertise, advanced assessment skills and support for the patient's primary nurse, patient and patient's family, as well as facilitates a more timely transfer to a higher level of care when needed.
3. The Primary Nurse is a critical member of the team who shall provide report, remain in room to collaborate with the RRT Nurse, and assist in the care of the patient.
4. The Respiratory Care Practitioner (RCP) provides advanced respiratory assessment, immediate oxygen therapy, delivery of aerosolized medications, and assistance in delivering mechanical ventilation, through Non-Invasive Positive Pressure Ventilation (NIPPV) if required.

D. **PROCEDURE:**

1. When a nurse is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will:
   a. Contact the operator by dialing "66." The operator will announce "Rapid Response Team to Room -----", three times overhead.
      i. Once notified, the RRT members will simultaneously respond to that room/location within 5 minutes.
   b. Call RRT cell phone.
2. When a caregiver/family member is concerned about the condition of a patient or feels that a patient needs immediate intervention, they will contact the operator by dialing "66." The operator will announce "Condition H" and the RRT members will respond.
3. Criteria to call the Rapid Response Team:
   a. Staff member is concerned/worried about the patient
   b. Acute change in:
      i. Heart rate (less than 50 or greater than 130 beats per minute)
      ii. Systolic blood pressure (less than 90 mm/Hg or greater than 180 mm/Hg)
      iii. Respiratory rate (less than 8 or greater than 28 breaths per minute) or threatened airway
      iv. Oxygen saturation, which reflects the percentage of red blood cells, saturated with oxygen (level is less than 92% despite oxygen therapy)
      v. Level of consciousness, sudden unexplained agitation and confusion.
      vi. Urine output (less than 50 mL in 4 hours)
   c. New onset unilateral motor weakness, sensory loss, and/or aphasia or other neurological changes suggestive of stroke.
   d. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS)
   e. Acute significant bleed
   f. New, repeated, or prolonged seizures
   g. Failure to respond to treatment for an acute problem/symptom
   h. Change in skin tone (pale, dusky, gray or blue)
   i. The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.
4. Criteria to Call a Condition H Rapid Response:
   a. A caregiver or family member is worried about the patient's condition and feels it is not receiving appropriate response from the healthcare team.
   b. Noticeable medical changes:
      i. Shortness of breath or barely breathing
      ii. Severe pain not resolved after treatment
      iii. Feels as though heart is beating too fast
      iv. Difficulty speaking or moving arms or legs
      v. Confusion, agitation, or other mental changes
      vi. Difficulty waking up when aroused
      vii. Using the bathroom less or more frequently
5. RRT Nurse Responsibilities:

a. Takes emergency cart to room.
b. Speak with the primary nurse to get the situation, background, assessment and recommend (SBAR) of the patient.
c. Assist with further assessment of the patient.
d. Speak with the physician/family/patient about the situation.
e. Assist with/facilitate transfer to higher level of care if indicated.
f. Provides necessary treatment and obtains pertinent diagnostic tests per Rapid Response Standardized Procedure.
g. In emergency situations implements current standards of care by following **Advanced Cardiac Life Support** (ACLS) protocols.
h. Functions as role model.
i. Provides education pertinent to event and general clinical education as time allows.
j. Follows up on patients maintained on the floor ~~within 4 hours of the call.~~
k. Completes a RRT Cart check at least daily and documents the following on the RRT Cart Checklist located inside the RRT Cart:
    i. **Verifies p**~~P~~resence of:
        1) RRT cellular telephone and charging cable.
        2) Cart keys
        3) Manual blood pressure cuff
        4) Emergency supplies, including
            a) Three sets of gel defibrillation pads
            b) Three sets of multifunction defibrillator pads
            c) Resuscitation bag (Ambu).
            d) Restock any missing supplies
    ii. Verifies contents of Respiratory bag and tool box
        1) Restock any missing supplies
    iii. **Checks e**~~E~~xpiration dates of all supplies completed on the first day of each month
        1) Replace any expired supplies
    iv. **Checks for p**~~P~~roper functioning of defibrillator**, per Patient Care Services Procedure: Defibrillator Checks, every shift that an RN is assigned to the RRT role:**
        ~~1) Verify adult paddles are installed and are pushed all the away into their holders on the side of the M series unit~~
        ~~2) Ensure the Multi-Function Cable is plugged into the unit~~
            ~~a) The Multi-Cable Function should not be plugged into the test connector~~
        ~~3) Switch unit to *DEFIB* and set energy to 30 joules~~
            ~~a) The messages *CHECK PADS* and *POOR PAD CONTACTS* will alternately display~~
        ~~4) Plug the Multi-Function Cable into its test connector~~
            ~~a) The message *DEFIB PAD SHORT* will display~~
        ~~5) Press the *CHARGE* button on the front panel or on the apex paddle handle~~
        ~~6) Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules~~
            ~~a) The message will read *DEFIB 30J READY*~~
            ~~b) The strip chart recorder will print a short strip indicating *TEST OK* energy delivered if the unit delivered energy within specifications~~
                ~~i) During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules~~
            ~~c) If *TEST FAILED* appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately~~
        ~~7) Defibrillator battery change performed~~
    v. Signs ~~your~~ name in the signature box of the Cart Checklist

6. Respiratory Care Practitioner Responsibilities:
    a. Assesses and provides treatment.

b. Assists in managing airway and providing ventilatory support.
c. Assists with and provides treatment as necessary to facilitate transfer to higher level of care.
d. Functions as role model.

7. Primary Care Nurse Responsibilities:
   a. Briefs the team on patient history, current assessment, and identified concerns.
   b. Ensures patient's chart, all labs and diagnostic test results are available for the team.
   c. Remains with patient as a vital member of the team, repeats vital signs and other assessments as needed.
   d. Contacts physician if asked by RRT Nurse and give information as needed, using SBAR communication.
   e. Follows through with determined plan of action and ongoing patient assessment.
8. Administrative Supervisor Responsibilities:
   a. Responds and assists as needed if duties/time permits.
   b. Provides necessary resources.
   c. Facilitates efficiency of the team.
   d. Recognizes and utilizes the chain of command to obtain appropriate medical care when necessary to ensure patient's well-being.
   e. Facilitates transfer and bed assignment if a higher level of care is indicated.
   f. Responds to Condition H on nights, weekends, and holidays in place of social worker to address patient/family non-medical concerns.
9. Social Worker Responsibilities:
   a. Responds to Condition H to address patient/family non-medical concerns.
10. Chaplain:
    a. Responds to Condition H to provide spiritual and emotional support to patient/family.
11. In the event the ICU is unable to provide a RRT RN (such as in times of unanticipated low staffing), the following steps will occur:
    a. The ICU Charge Nurse will notify the **Administrative Supervisor (AS)** when there is no RRT; the ICU Charge Nurse will notify the AS when the RRT becomes available.
    b. The AS will notify each unit's ~~Assistant Nurse Managers (ANMs)~~**Management Team/designee**~~Charge Nurses~~ that the RRT has been pulled to patient care.
       i. Each unit's ANM/Charge Nurse will ensure their immediate staff is aware of the lack of RRT coverage.
       ii. Each unit's ANM/Charge Nurse will be available to all immediate staff to address patient concerns prior to calling a Rapid Response event.
    c. The ICU Charge Nurse (or other designated ICU RN) will be available for telephone consults.
       i. Call forwarding from the RRT phone to the Charge Nurse phone *may* be done to avoid carrying more than one cell phone (optional).
          1) Dial *72 760 802 1939 and press *CALL* from the RRT phone to forward calls to the charge nurse phone (you will hear 3 beeps when the task is complete).
          2) Dial *720 and press *CALL* from the RRT phone to cancel call forwarding (you will hear 3 beeps when the task is complete).
    d. The ICU Charge Nurse (or other designated ICU RN) will respond to overhead RRT pages and/or provide bedside support to floor nurses when necessary.
       i. If a designated ICU RN other than the Charge Nurse will respond to a Rapid Response call, the Charge Nurse will ensure adequate coverage of that RN's patient assignment.

E. **DOCUMENTATION:**
1. The Emergency Event Record will be used to document the RRT and Condition H activation and interventions performed.
2. ~~An evaluation tool (Form# 6010-1006) may be completed by the primary nurse on the floor.~~

F. **RELATED DOCUMENTS:**

1. **Patient Care Services Procedure: Defibrillator Checks**
2. **Patient Care Services Standardized Procedure:** Rapid Response

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW

SUBJECT: Safe Patient Handling, Bariatric

REVISION DATE:

POLICY NUMBER: NEW

Department Approval:	05/20
Clinical Policies & Procedures Committee Approval:	06/20
Nurse Executive Council Approval:	07/20
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. **To outline the management of the bariatric ~~surgery~~ patient and ~~T~~to ensure that caregivers assisting patients, including bariatric patients, are protected from patient handling injuries while patients are cared for safely. This policy describes ways to ensure that employees use safe patient handling and movement techniques and use equipment specific for the safe handling of bariatric patients. This policy is set forth to provide the patient an environment of dignity and respect in a supportive caring culture

B. **POLICY:**

1. **This policy is specifically designed to maintain the safety, dignity, skin integrity, and outcomes of the bariatric ~~surgery~~ patient. The policy is designed to insure employee's safety when caring for the bariatric ~~surgery~~ patient.** Tri City **Healthcare District (TCHD)** ~~Medical Center~~ wants to ensure that its patients are cared for safely while maintaining a safe work environment for employees. To accomplish this, a comprehensive safe patient handling program will be implemented to ~~ensure~~ **identify** appropriate and adequate provisions, ~~are identified and made for~~ **and** safe patient handling equipment. ~~,~~ ~~t~~**T**raining resources in keeping with an effective "Culture of Safety" in the work environment **are identified and available to staff**. ~~Identified s~~**S**afe patient handling techniques and guidelines will be followed at all times. Additionally, mechanical lifting equipment and/or other approved patient handling aids will be used to prevent injury from the manual lifting and handling of bariatric patients.

C. **DEFINITIONS:**

1. ~~A~~ Bariatric Patient~~: Can be defined as a~~**A**nyone who has limitations in health due to physical size, health, mobility, and environmental access. For the purpose of using our assessment form and bariatric algorithms, we defined bariatric as individuals exceeding standard capacity equipment (300 lbs) with a BMI of 50.
2. Patient Handling: ~~Refers to t~~**T**he repositioning, lifting, turning, transferring, transporting and assisting in ambulation provided by health care workers to patients that need assistance
3. High Risk Patient Handling Tasks: Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include, but are not limited to, transferring tasks, lifting tasks, repositioning tasks, bathing patients in bed, tasks with long duration and those involving bariatric patients.
4. High Risk Patient Care Areas: Inpatient hospital units with a high proportion of dependent patients, requiring full assistance with patient handling tasks and activities of daily living and who are frequently moved in and out of bed.

5. Manual Lifting: Lifting, transferring, repositioning, and moving patients using a caregiver's body strength without the use of lifting equipment/aids that reduce forces on the worker's musculoskeletal structure.
6. Mechanical Patient Lifting Equipment: Equipment used to mechanically lift, transfer, reposition, and move patients. Examples include mechanical lateral transfer aids.
7. Patient Handling Aids: Equipment used to assist in the lift or transfer process. Examples include gait belts, sliding boards, friction reducing devices and glide mats.
8. Culture of Safety: Describes the collective attitude of employees taking shared responsibility for safety in a work environment and by doing so, providing a safe environment of care for themselves, co-workers and patients.

D. **PROCEDURES:**

~~1. **Compliance: It is the duty of employees to take reasonable care of their own health and safety, as well as that of their co-workers and their patients during patient handling activities. Non-compliance will indicate a need for retraining.**~~

1. **Level of Care: Patient will be triaged appropriately according to the level of nursing care required for their specific needs.** ~~Assessment Prior to Program Implementation:~~ Prior to performing procedures set forth in this policy, it is mandatory that ~~two assessments be completed:~~ a Needs Assessment and Risk Assessment **are completed**. These facilitate development of individualized processes and facility plans and help guide management to allocate resources appropriately to prepare for patient care and admissions.
   a. Needs Assessment: To identify and prevent potential barriers encountered in the admission and care processes ~~and complete a needs assessment~~. This includes **obtaining a medical history to identify** ~~collection of data, identifying~~ medical conditions, patient characteristics, weight, height, equipment use and location trends (units).
   b. Risk Assessment: This assessment identifies patient and staff safety issues and risk factors for safe patient care. These include risks from patient **transport and** transfers, ~~patient transport~~, compatibility with ~~transport~~ equipment, room size, elevator size, etc.
2. **Nursing Care: The specialized nursing care of the bariatric ~~surgery~~ patient include thorough assessments, pain management, wound/skin care, venous thromboembolism prophylaxis, pulmonary care, early and frequent ambulation, line and drain maintenance, nutrition therapy, and Psychosocial support.**
   a. **Pain Management: ~~Ongoing Aassessment and manageing of post-op~~ Ongoing Assessment and Management of a patient's pain level. Increases in BMI can be directly linked to a greater incidence of pain-related conditions. ~~due to the difficulty in the pharmacokinetics of certain medications in bariatric patients~~.**
   b. **Skin Integrity~~Wound Care~~: Assess skin integrity. Bariatric patients are at risk for a myriad of skin integrity issues. Inspect all skin folds and provide intervention to maintain ~~skin~~ clean and dry skin. If present, monitor wounds ~~The bariatric surgery patient is prone to skin breakdown due to pressure from surgical drain and foley catheter tubing. These devices should be repositioned every two hours as the patient is turned. Skin should be kept clean and dry. Monitor the surgical site(s)~~ for bleeding or hematoma development, ~~observing~~ observe for signs of infection, ~~and keeping~~ and keep ~~the~~ dressings clean and dry.**
   c. **Venous thromboembolism prophylaxis. The bariatric patient is at great risk for embolic event due to immobility. Initiates and maintains properly fitted sequential compression device and/or administers ~~The bariatric surgery patient is at great risk for an embolic event. Initiate and maintain sequential compression device and administration of either~~ unfractionated or low-molecular weight heparin preparations for prevention of DVTs. ~~, early postoperative mobilization and frequent ambulation.~~**
   d. **Pulmonary Care: Due to the changes in pulmonary function associated with obesity, ~~bariatric surgery patients~~ bariatric patients are at risk for ~~are at increased risk anesthetic agents and narcotic medications contribute to~~ respiratory depression/complications. Assess and monitor respiratory function by assessing**

lung sounds, rate and depth of respirations; initiate a continuous pulse oximetry and/or cardiac monitoring, encourage ~~ging~~ cough and deep breathing exercises, and the use of an incentive spirometer. ~~Place on continuous pulse oximetry, supplemental oxygen, cardiac monitoring and encourage cough and deep breathing and the use of an incentive spirometer.~~

e. Mobility: Obesity restricts mobility due to musculoskeletal problems. Encourage ~~Early~~ ambulation/mobility ~~after surgery is a major goal, encouraged~~ and participation in ~~to provide~~ providing their own care as much as ~~when~~ possible ~~and to help with their mobility as much as possible.~~ Consult/implement physical therapy ~~in designing~~ to design a treatment plan to increase activity. ~~Use of specialized equipment to promote the safety of patients and caregivers is encouraged.~~

f. Line and Drain Maintenance: Assess and monitor drains, foleys and IVs for patency.~~,~~ ~~m~~Monitor intake and output, reposition ~~of devices~~ every two hours to prevent pressure/skin breakdown. ~~Patients may have a nasogastric tube (NG), an IV and a Foley catheter in their bladder. These devices should be repositioned every two hours to prevent pressure/skin break. Monitoring of output and discontinuing of drains as per MD orders.~~

g. Nutrition Therapy: Bariatric patients are at risk for malnutrition; fat stores for energy cannot be mobilized efficiently and rapidly thereby leaving protein as the primary energy source. Assess, monitor and maintain patient's nutritional status and implement diet as ordered. Focus on maintaining adequate fluid and protein intake. Consult a dietician to assist patient in determining nutritional needs. ~~When patient begins to eat the focus is on maintaining adequate fluid and protein intake. Educate eating and drinking slowly, chewing food thoroughly, drinking fluids between meals and before eating but not with meals, and sitting in a reclining position for 30 minutes after meals. Consult a dietician to assist patient in determining nutritional needs.~~

h. Psychosocial Needs: Bariatric patients may have low self-esteem, decreased socialization, and feelings of shame, embarrassment, and fear. Assess patient's psychosocial needs.~~,~~ ~~a~~Assess and report feelings of shame, embarrassment, and fear. Maintain a professional attitude and build a therapeutic relationship with these patients. Initiate a multidisciplinary educational approach that includes psychological supportive care, education, behavioral therapy, counseling, and supporting groups. ~~Caregivers will initiate a multidisciplinary educational approach that includes psychological supportive care, education, behavioral therapy, counseling, and supporting groups.~~

~~2. Training:~~

~~a. Staff will complete and document Safe Patient Handling and Movement training annually, and as required to correct improper use/understanding of safe patient handling and movement.~~

~~b. Staff will complete and document Safe Patient Handling and Movement training as required to correct improper use/understanding of for safe patient handling and movement.~~

~~c. Annual competencies will assess ability to provide appropriate safe patient care.~~

~~3.~~2. Equipment:

a. Equipment provisions should be varied and sufficient to care for multiple patients of various sizes and medical conditions. Choose equipment carefully based on patient's shape, size and medical conditions.

b. The nursing unit will arrange for patient's own equipment to be inspected and a safety check will be performed by the engineering department prior to patient use.

~~4.~~3. Bariatric Patient Supplies:

a. Appropriately-sized patient care items such as gowns and blood pressure cuffs, linens etc. shall be readily available and stored for easy accessibility.

~~E. DELEGATION OF AUTHORITY AND RESPONSIBILITY:~~

~~1. Clinical Nurse Managers shall:~~
~~a. Ensure employees complete annual Safe Patient Handling and Movement training and additional training as required. if employees show non-compliance with safe patient handling and movement or equipment use.~~
~~2. Employees shall:~~
~~a. Comply with all parameters of this policy.~~
~~b. Use proper techniques, lifting devices, and other approved equipment/aids during performance of patient handling tasks.~~
~~c. Notify supervisor of any injury sustained while performing patient handling tasks.~~
~~d. Notify supervisor of need for re-training in use of lifting devices, other equipment/aids and lifting/moving techniques.~~
~~e. Provide care in a manner that acknowledges the patient as a unique individual, treating them with compassion and respect. They shall ensuring that dignity and self-worth are maintained. by appropriate and professional treatment.~~
~~3. Union shall:~~
~~a. Support the Safe Patient Handling policy in partnership with administration.~~

~~F.~~E. **REFERENCES:**

1. **Barth, M.M. & Jenson, C.E., (2006). Postoperative Nursing Care of Gastric Bypass Patients. American Journal of Critical Care, v15(4). Retrieved June 30, 2016 from http://ajcc.aacnjournals.org.**
2. **CME Policies. American Society for Metabolic and Bariatric Surgery Retrieved Line 29th, 2016 from** https://asmbs.org/
~~2.~~3. **Bariatric equipment training video http://mediasrvr/EZWay/Default.html**

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**SPIRITUAL CARE FOR FAMILY OF CRITICALLY ILL OR DECEASED INFANT**
	To outline the steps in performing a Blessing or critically ill infant.
Supportive Data:	Infant blessing or baptism may be desired by pa
Equipment:	Sterile water

DELETE – incorporated into Patient Care Services Policy: Spiritual Care of the Patient

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

~~1. Ask the parents if they have any faith- based practice they wish for the infant- such as being blessed or baptized.~~

~~2. Attempt to reach appropriate clergy if the family has not already done so.~~

~~3. If clergy is unavailable, **or per parent(s) request** a bereavement support staff or any member of the medical or nursing staff may perform an emergency blessing or baptism.~~

~~a. It is preferable, but not necessary, for the person performing the blessing or baptism to be of the same denomination as the family.~~

~~i. If the parents are Christian pPour a small amount of sterile water three times, saying: "I bless or baptize you in the name of the Father, and of the Son, and of the Holy Spirit."~~

~~b. If infant has been named, use the full given name in place of "you".~~

~~c. If possible, another staff member should witness the blessing or baptism.~~

~~B. **DOCUMENTATION:**~~

~~Document in the medical record and on the Checklist for Assisting Parent(s) Experiencing Neonatal Death/Stillborn that blessing or baptism was performed with date, time, and name of person who performed the blessing or baptism.~~

~~**REFERENCES:**~~

~~1. **Walter, M.A., Limbo, R., Wilke, J. (2015). *Resolve Through Sharing: Bereavement Training: Perinatal Death*. La Cross, Wisconsin. Gundersen Lutheran.**~~

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
5/03, 6/09, 5/12, 4/16, 04/20	5/12, 5/16, 04/20, 06/20, 07/20	5/12, 5/16, 08/20	n/a	n/a	08/20	7/12, 6/16, n/a	7/12, 6/16

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01	**SUBJECT: Spiritual Care of the Patient**
REVISION DATE: 6/03, 1/04, 4/06, 8/08, 4/11	**POLICY NUMBER: IV.N**

Patient Care Services Content Expert:	**06/20**
Clinical Policies & Procedures Committee Approval:	**~~03/15~~07/20**
Nursing Leadership~~Executive Council~~ Approval:	**~~03/15~~08/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**~~04/15~~ n/a**
Board of Directors Approval:	**04/15**

A. **POLICY:**

1. Healthcare providers may not impose their own values on patients, nor may they represent themselves as spiritual advisers, but may interact in a non-judgmental and supportive way as patients express their spiritual concerns.
2. When appropriate, healthcare providers advise the patient or family of spiritual services available (i.e., the hospital chaplain, other members of the religious community).
   a. If the patient or family wishes, healthcare providers may call a member of the clergy to visit the patient or family.
3. The social worker and hospital chaplain may work together when responding to the emotional and spiritual needs of patients and families.
4. The primary service and activity of the chaplains is to meet with the patients, their families, and healthcare providers.
5. The Pastoral Care Department may be utilized at any time by patients, families, or staff. The chaplains are present in the hospital from 8:00am – 4:00 pm, Monday through Friday and may be reached through the operator. At all other times a chaplain is on-call for emergencies and may be contacted through the Administrative Supervisor.
6. The chaplaincy staff shall assist in arranging sacraments and religious rites for patients in accordance with the patient's denominational and religious traditions.
7. The professional staff shall facilitate support by the patient's/family's personal clergy if requested. All local clergy are welcomed and assisted in the Pastoral Care office.
8. Requests for Pastoral Care visitation and reception of the sacraments shall be documented in the medical record.
9. Pastoral counseling is available for patients, faculty, and staff by making a referral or appointment with one of the chaplains.
10. Trained Pastoral Care volunteers shall visit patients on a regular basis.
11. The chapel is available to all faiths for prayer and quiet time.
12. **If the parents of critically ill infants or deceased infant have any faith-based practice they wish for the infant such as being blessed or baptism, healthcare providers should attempt to honor this request.**
    a. **Attempt to reach appropriate clergy if the family has not already done so.**
    b. **If clergy is unavailable, or per parent(s) request a bereavement support staff or any member of the medical or nursing staff may perform an emergency blessing or baptism.**
       i. **It is preferable, but not necessary, for the person performing the blessing or baptism to be of the same denomination as the family.**

1. Pour a small amount of sterile water three times, saying: "I bless or baptize you in the name of the Father, and of the Son, and of the Holy Spirit."

ii. If infant has been named, use the full given name in place of "you".

iii. If possible, another staff member should witness the blessing or baptism.

c. Document in the medical record and on the Checklist for Assisting Parent(s) Experiencing Neonatal Death/Stillborn that blessing or baptism was performed with date, time, and name of person who performed the blessing or baptism.

B. REFERENCE(S):

~~11.~~1. Walter, M.A., Limbo, R., Wilke, J. (2015). *Resolve Through Sharing: Bereavement Training: Perinatal Death*. La Cross, Wisconsin. Gunderson Lutheran.

Tri-City Medical Center
Oceanside, California

DELETE – no longer needed with electronic medical record

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 12/01	**SUBJECT:** Thinning of Patient Record
REVISION DATE: 6/03, 8/05, 1/06; 7/08; 6/10; 10/13	**POLICY NUMBER:** IX.F

Patient Care Services Content Expert:	06/20
Clinical Policies & Procedures Committee Approval:	~~10/13~~07/20
Nursing Executive Committee Approval:	~~10/13~~08/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~01/14~~ n/a
Board of Directors Approval:	01/14

~~A. POLICY:~~

~~1. Charts must contain all documents from the preceding two weeks.~~

~~2. Documents with physician documentation shall remain in the chart.~~

~~3. Thinned portions of the patient's record are maintained in a designated area on the unit for reference for 2 weeks. After this time, these documents shall be forwarded to Medical Records Department for filing.~~

~~4. Update thinned part document that is filed with the chart. Reflect the date(s) thinned parts were removed.~~

~~5. Forward the cover sheet and discharge record to Medical Records/HIM where all parts will be interfiled prior to the scanning of the chart.~~

Medical formation

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s:

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Date Thi _____ Initials

Date Thi _____ Initials

Date Thi _____ Initials

Dischar

Keep thi patient's
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Discharg **l Records**

Thinned Record

Affix Patient Label

DELETE

(NOT part of the Permanent Record)

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 10/02

SUBJECT: Disclosure of Unanticipated Adverse Outcomes to Patients, Families, Surrogates, and Agents

REVISION DATE: 04/06; 07/09; 06/11; 09/14; 06/11

POLICY NUMBER: 8610-275

Administrative Content Expert Approval:	06/20
Administrative Policies & Procedures Committee Approval:	~~01/15~~06/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/15~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~03/15~~ n/a
Board of Directors Approval:	03/15

A. **DEFINITIONS:**

1. Disclosure – Communication to patients, their families, surrogates, or agents, of information regarding an unanticipated adverse outcome.
2. Surrogate - an adult, other than a patient's agent or conservator, authorized under the Health Care Decisions Law to make a health care decision for the patient. This designation is made verbally by the patient to the Attending Physician and expires upon the earlier of discharge from the hospital or after 60 calendar days.
3. Agent - an adult, other than a patient's surrogate or conservator, authorized under the Health Care Decisions Law to make a health care decision for the patient. This designation is made in writing, by the patient.
4. **Adverse Event – Any occurrence that is not consistent with the routine operation of TCHD and that potentially may, or actually did, result in injury, harm, or loss to a patient.**
- ~~4.~~**5.** Unanticipated Adverse Outcome – An adverse result that differs significantly from the anticipated result of a treatment or procedure.
- ~~5.~~**6.** Treating physician - physician responsible for ongoing patient care.
- ~~6.~~**7.** Physician-Related - An adverse event, unanticipated outcome, or error which is attributed primarily of the treating physician.
- ~~7.~~**8.** Hospital-related - An adverse event, unanticipated outcome, or error which is attributed primarily to other hospital staff, enon-physician, **or** non-**allied health professional**~~AHP~~.
- ~~8.~~**9.** **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

B. **PURPOSE:**

1. **To foster a culture of open communication with patients**, families, surrogates **and** agents and **recognize their right to information about the** patient's **medical care.**
2. ~~This policy and procedure~~ **To** provide~~s~~ **Tri-City Healthcare District (TCHD)** ~~staff~~**Workforce Members with** guidance and direction regarding communication of **unanticipated or adverse** outcomes of treatment, ~~including unanticipated outcomes,~~ **to patients**, families, surrogates, and agents.
- ~~1.~~**3.** To **maintain high-quality health care and the integrity of the patient–physician relationship.**

~~2.~~4. **Commitment on the part of all health care practitioners** to establish and utilize **the tools needed to help patients, families,** surrogates, agents, and **health care practitioners through adversity** associated with unanticipated adverse outcomes.

C. **POLICY:**

1. It is TCHD's policy to support the right of patients, their families, surrogates and agents to be notified when an unanticipated, adverse outcome occurs. Parties notified will be provided with sufficient information to fully understand the scope and gravity of the event. TCHD will assure that any unanticipated adverse outcome is promptly communicated to the patient, their family, surrogate, or agent **and provide assurances that steps have been taken to** mitigate harm to the patient as well as **prevent** similar occurrences in the future, for all patients.

D. **PROCESS:**

1. Reporting
   a. It is the responsibility of all **Workforce Member**~~employees and contracted staff~~ to report any unanticipated adverse outcome immediately to their **Department Leadership**~~supervisor~~. An investigation of the event will be conducted in a non-punitive and non-accusatory manner. Failure to report such events may result in progressive discipline as outlined in Human Resources policies.
      i. An incident report must be completed in accordance with **Administrative** ~~hospital~~ **p**Policy: Event Reporting #8610-396.
         1. The incident report shall NEVER be discussed with the patient, family, surrogate, or agent due to its protected nature under state and federal law.
   b. **The** ~~reporting~~ **Workforce Members**~~healthcare provider~~ **involved may need support due to the feelings of guilt, shame,** and or responsibility. **Disclosures** to patients, family, surrogates and agents should be encouraged while avoiding an environment of blame and or shame.
   c. It is the responsibility of the Manager of Regulatory Compliance **and Accreditation** to draft and submit the initial report to the California Department of Public Health (~~the California Department of Public Health (~~CDPH~~)~~) as well as serve as a liaison with that agency during the subsequent investigation process. The Chief **of Patient Care Service**~~Nursing Executive~~ shall remain apprised of all regulatory matters by the Manager of Regulatory Compliance and Accreditation.
   d. Reporting to regulatory agencies (i.e., CDPH, Centers for Medicare/Medicare Services (CMS), The Joint Commission (~~The Joint Commission (~~TJC~~)~~), Occupational Safety and Health Administration (OSHA), etc.) shall be done in compliance with regulations and applicable law. All reporting to any regulatory agency must first have the approval of a member of the C-Suite.
2. Immediate Actions of ~~Staff~~**Workforce Member**
   a. The individual or individuals identifying the event will take the following steps:
      i. Assure that all necessary action is taken to mitigate the extent of the harm to the patient that may be caused by the adverse event.
      ii. Immediately notify the patient's treating Physician, **Department Leadership**~~the Clinical Nurse Manager, Department Director~~ and the Risk Manager.
      iii. Complete an incident report per hospital policy.
      iv. Participate in any investigation initiated to determine the cause of the event and actions that may prevent recurrence of similar events
   b. Risk Management, with the cooperation of the Department **Leadership**~~Director~~ will conduct such investigations as indicated. All reports of unanticipated adverse outcomes will be reviewed by Risk Management and evaluated for further action, including disclosure to the patient, family, surrogate, or agent, as appropriate.
      i. Risk Management will discuss the disclosure with the interdisciplinary team to assure consistency and support. **The** composition of the **team will** vary in each

case. ~~Staff~~**Workforce Members** with **whom the patient and/or family have developed a** positive **relationship and trust** should be strongly considered for inclusion on the interdisciplinary team.

3. Disclosure
   a. Once it has been determined that an unanticipated adverse outcome has occurred, disclosure is necessary **as soon as possible**. ~~The~~ Department **Leadership**~~Director or Clinical Nurse Manager~~, in consultation with the treating Physician, will determine the most appropriate time and manner for disclosure. Risk Management and or Legal Counsel may be involved with the initial decision to disclose, as well the manner, time, and location of disclosure. Preliminary disclosure may need to occur prior to all of the facts being determined. **Before disclosure**, ~~staff~~**Workforce Member** that will be present during the disclosure should meet to agree upon the content of the discussion and limitations of that content i.e. no acknowledgement of liability or promises regarding billing adjustment(s). The provider bears primary responsibility for the disclosure as well as documentation of same in the medical record. In cases where the unanticipated adverse outcome is associated with non-physician staff, the duty to disclose will rest with responsible hospital leadership with the most thorough knowledge of the event. The treating physician will be made aware of the disclosure prior to the disclosure occurring.
   b. If there is disagreement or uncertainty as to the need to disclose or the means by which disclosure will be conveyed, the Chief of Staff, in conjunction with the Chief Medical Officer, will make the final determination.
   c. Disclosure will include the following elements:
      i. **Interpreter services shall be arranged as needed and the patient's level of understanding of medical terminology shall be taken into consideration.**
      ~~i.~~**ii.** A clear explanation of the unanticipated adverse outcome to the patient and, when appropriate the family, surrogate, or agent. Disclosure will be limited to a factual explanation of the circumstances and speculative comments will be avoided.
      iii. A clear explanation of the investigation that will take place and plans to discuss the matter further with the patient or family as more facts become known. A tentative time frame and point of contact should be provided.
      ~~ii.~~**iv.** **The focus should be on the patient's condition, concerns, and treatment plan.** It should be clear **that their treatment and care are the** primary **concern.**
      ~~iii.~~**v.** Adequate explanation to ensure understanding of unanticipated adverse outcome and prognosis.
      ~~iv.~~**vi.** Information regarding resources available to support and comfort the patient and/or family.
      vii. Expressions of empathy to include, as appropriate, an expression of sympathy for the patient's inconvenience, distress or discomfort. **Communicate what will be done to prevent the error from occurring again.** Discuss the **treatment plan to remedy** or **mitigate the effects of any injury.**
      ~~v.~~**viii.** **Healthcare providers shall not make promises they cannot guarantee, for example,** billing adjustments or specific clinical outcomes.
   d. If the patient's clinical condition or care may be negatively impacted by the notification after the event, then the discussion should be held with the patient's family, surrogate, or agent, if appropriate. If this is not practical, notification will be deferred until a later time however, the notification should take place prior to discharge.
      i. If the unanticipated significant event is reported or discovered after discharge, the patient, family, or agent should be notified as soon as information about the event and its impact on the patient's health has been determined. **Convey to the family and/or family member(s) what will be done to prevent the error from occurring again, and work with the patient to develop a treatment plan** to **mitigate** and or remedy **the effects of any injury resulting from the error.**
4. The disclosure process will not include the following elements:

a. Acceptance of liability.
b. Assignment of fault.
c. Statements of proposed or actual causation.
d. Acknowledgement of an existing incident report or intent to file one
e. Confidential information under State or Federal law. Patient **confidentiality must be preserved.**
~~e.~~**f.** **Legal** Counsel may be consulted at any time. Occasions when such counsel is indicated include, but are not limited to, apologies, permanent injuries, parties have already threatened legal action, or any time **a ~~staff~~Workforce Member** involved wish to have the support and guidance of legal counsel. **California allows a party in an accident to apologize or express sympathy to an injured party without fear that the statements will be used against the party as evidence of an admission of liability.** The apology ***must not*** include statements of fault, responsibility, or offer of financial compensation.

5. Documentation
   a. The Risk Manager or other appropriate individual participating in the disclosure shall document the disclosure of unanticipated adverse outcomes **in the incident report**. This documentation should contain a brief statement that the disclosure has occurred and include the following elements:
      i. A full description of the facts of the event.
      ii. A note outlining the substance of the disclosure discussions with the patient, family member, surrogate, or agent, about the event, including dates, times, and a list of who was present.
      iii. Treatment and follow up plans as indicated.
      iv. Hospital ~~staff~~**Workforce Member** to serve as a point of contact for the patient or their representative.
      v. The identity of any interpreter whose services were used.
      vi. In cases where a decision is made to withhold some or all of the information about the event, the reason(s) for this decision.
      vii. Any follow-up discussions with the patient, family member or surrogate should be similarly noted.
   b. Documentation **within the medical record** should be limited to the medical facts of the case and a brief note stating simply that disclosure occurred and to whom.
6. Waiving of Cost and Charges
   a. The purpose of this procedure is to establish guidelines for billing and account resolution when the Business Office is notified to hold or not bill a portion of the account.
   b. The process for this will be a coordinated effort between Administration, Risk Management, **Legal Counsel,** and the Chief Financial Officer; who are the only individuals authorized to waive charges.
   c. When an unanticipated adverse ~~event~~ **outcome** occurs, the Business Office will, at the request of the Risk Manager, Legal Counsel, or appropriate C-Suite member, ensure that no bills are submitted for reimbursement from the patient or third party payer for charges related to the event. Bills will be placed on hold until an investigation reveals or does not reveal, a need to adjust any aspect of the patient's bill.
   d. The billing adjustment decision will be based on confirmation of the event, investigation, and administrative review.
   e. The Director of Patient Accounting will be the contact person for billing inquiries.

E. RELATED DOCUMENT(S):

1. **Administrative Policy: Event Reporting #8610-396**

~~E.~~F. REFERENCES:

1. The Joint Commission Manual, 2019, RI.01.02.01, EP 20, 21, 22
2. California Hospital Association Consent Manual 2019 Pgs. 517-5184

3. California **Health & Safety Code §§ 1279.1**
~~2.~~4. **California Evidence Code § 1160**
~~Hospital Policy #8610-396: Event Reporting.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 08/80 **SUBJECT: Equal Employment Opportunity**

REVISION DATE(S): 01/09; 04/12; 03/13, 12/13, 02/16 **POLICY NUMBER: 8610-418**

Human Resources Department Approval:	**~~11/16~~03/20**
Administrative Policies & Procedures Committee Approval:	**04/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
~~Human Resources Committee Approval:~~	**~~11/16~~**
Board of Directors Approval:	**12/16**

A. **PURPOSE:**
1. To comply with EEOC and DFEH guidelines and mandates.

B. **POLICY:**
1. Tri-City Healthcare District (TCHD) is an equal opportunity employer. It is TCHD's policy to provide equal employment opportunity for all applicants and employees, in all areas of employment including recruitment, hiring, training, promotion, compensation, benefits, transfer, and general treatment during employment.
2. TCHD does not unlawfully discriminate on the basis of race, **spiritual and religious belief,** religious creed (including religious dress and grooming practices), color, national origin, ancestry, **ethnicity, socio-economic status, education, social customs,** physical disability, mental disability, medical condition (including AIDS and/or HIV status), genetic information, marital status, military and veteran status, sex, gender, gender identity, gender expression, age, sexual orientation, pregnancy, childbirth, breastfeeding and/or related medical conditions **or any other status protected by State or Federal Law** ; these characteristics are defined as "protected classes." TCHD will accommodate nursing employees' lactation needs in accordance with state and federal law. TCHD will make reasonable accommodations for religious belief or observance (including religious dress and grooming practices), for pregnant employees, and for the known physical or mental disabilities of an otherwise qualified applicant/employee, unless undue hardship would result. Requests for accommodation should be made to ~~Employee Health Services~~ **Human Resources**, who will determine whether a reasonable accommodation can be made for a qualified individual. Requests for accommodation of religious belief or observance should **also** be directed to Human Resources.
3. It is the responsibility of every manager and employee to conscientiously follow this policy. Any employee with questions or concerns about any type of discrimination or harassment on any of these bases in the workplace is encouraged to bring these issues to the attention of their immediate supervisor or to a Human Resources representative. Employees can raise concerns and make reports without fear of retaliation (refer to Administrative Policy: **Discrimination, Harassment and Retaliation Prevention Policy** -#403). Anyone found to be engaging in any type of unlawful discrimination will be subject to disciplinary action up to and including termination of employment with TCHD.
4. In carrying out this responsibility TCHD will:
   a. Conduct recruitment practices and base hiring decisions for all job classifications upon the position requirements and an individual's qualifications for the position.

b. Make transfer and promotional decisions based on the individual's qualifications as related to the position for which ~~he/she~~ **they are** ~~is~~ being considered unless otherwise required by law.

5. Any person who believes they have experienced discrimination may file a complaint with a Human Resources representative.
6. Employees may also file a complaint with the Department of Fair Employment and Housing or the Equal Employment Opportunity Commission. Telephone numbers for each agency are available online ~~and in the telephone book~~.
7. The ~~lead~~ **Head of** Human Resources ~~official~~ has overall responsibility for implementation of this policy.
~~7.~~**8. To the extent that any applicable that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 09/82

SUBJECT: Coaching and Counseling for Work Performance

REVISION DATE(S): 09/90, 11/94, 12/00, 10/01, 03/03, 07/05, 02/09, 02/11; 09/13, 09/16

POLICY NUMBER: 8610-424

Human Resources Department Approval:	**~~09/16~~03/20**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval:**~~	~~**09/16**~~
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/16**

A. **PURPOSE:**

1. To provide supervisors with guidelines for implementing ~~disciplinary~~ **coaching** and ~~non-disciplinary~~ **counseling** procedures and to facilitate discussions with employees regarding work performance and/or work-related behavior and conduct. The objectives are:
   a. To exchange information
   b. To give and receive feedback
   c. To identify and resolve problems
   d. To explore topics related to successful work performance
   e. To provide opportunities for the employee to modify ~~his/her~~ **their** behavior in order to perform **job duties** effectively
   f. To ensure that corrective action is taken when and as appropriate

B. **DEFINITIONS:**

1. Coaching:
   a. Informal discussions with employees to identify areas of employees' work performance that do not meet performance expectations and to provide guidance in developing skills, modifying behaviors and addressing undesirable conduct.
2. Counseling:
   a. Formal discussions implemented by supervisors when coaching is not successful at motivating an employee to change ~~his/her~~ **their** work performance or when employee conduct or behavior violates TCHD policy or service standards, presents an immediate danger or threat of danger to other employees or to patients.
   b. Counseling will result in written documentation to the employee's file, and may result in termination of employment. Counseling sessions will be documented on a Work Performance Improvement Form (WPIF).
3. Administrative Leave:
   a. When an employee appears to have been involved in misconduct or performance deficiency, ~~he/she~~ **they** may be placed on Administrative Leave in order to allow TCHD to conduct a comprehensive investigation. Human Resources must be notified when placing an employee on Administrative Leave.
   b. Human Resources will notify Information Technology and Security.
4. Supervisor:
   a. Supervisor refers to any level of leadership from supervisor to Chief level.

C. **POLICY:**

1. Employee ~~discipline~~ **Coaching and Counseling** is intended to be corrective in nature with the objective of obtaining compliance with rules, orders, procedures, standards of conduct and competent job performance. ~~Disciplinary~~ **Corrective** action will be commensurate with the facts surrounding the alleged violation(s) and the past record of the employee. When coaching is not effective, then supervisors must engage in more formal counseling which may be ~~disciplinary~~ **corrective** in nature. Examples of ~~discipline~~ **corrective actions** are verbal counseling, written counseling, final written, or termination. Tri- City Healthcare District (TCHD) reserves the right to impose any of these forms of ~~discipline~~ **coaching and counseling** at any time it deems appropriate at its discretion.
2. Employees represented by a ~~CBA~~ **Collective Bargaining Agreement** must follow the terms and conditions of that agreement.
3. The following are examples of behavior that may warrant ~~disciplinary~~ **corrective** action, including counseling, up to and including termination.
   a. Criminal conduct, a violation of federal, state or local law that is related to the employee's job duties, employee and patient safety, or impinges on TCHD's reputation, including but not limited to, fraud, theft, misrepresentation, and/or dishonesty including falsification of time records and misrepresenting reasons for any absence from work. Where violations of law are suspected, TCHD reserves the right to report such suspected violations to the appropriate law enforcement agency and the licensing board.
   b. Employees must report any criminal convictions under state or federal law, in writing to the ~~Human~~ Resources Department within five (5) working days of such conviction.
   c. Performing duties in an unsatisfactory or unacceptable manner.
   d. Insubordination, including but not limited to improper conduct toward a supervisor or refusal to perform a task assignment in an appropriate manner.
   e. Failure to treat other TCHD employees, officials, patients, or the public with respect and courtesy in accordance with the TCHD ~~Service Standards,~~ Mission and Values.
   f. Violation of TCHD policies, including but not limited to, TCHD **Administrative Policies:** Alcohol and Drug Testing for Employees ~~(AP 429)~~, **Discrimination,** Harassment **and Retaliation Prevention** ~~policy~~ ~~(AP 403)~~, Workplace Violence ~~(AP 463)~~, or any other TCHD policy.
   g. Failure to comply with all TCHD rules, standards, guidelines, and regulations including all safety regulations.
   h. Disruption of District Business.
   i. Misuse and/or unauthorized use of property, including but not limited to, equipment or material owned by TCHD, employees, staff, physicians, patient or guests (**Administrative Policies:** ~~609~~ Disciplinary Action for Breaches of Confidentiality **of Restricted Electronic Information~~,~~ 609,**~~257~~ Cellular Phone & **Other Wireless Electronic Digital Devises** ~~Radio Transmission~~ **257**, and ~~p~~Pay ~~p~~Practice: ~~475.12~~ Meal and Rest Breaks **475.13**).
   j. Any unauthorized disclosure or use of **all** TCHD's records, including but not limited to administrative files, documents, or data bases, patient information files or records, or employee information files, or records. (**Administrative Policies:** ~~455~~ Confidentiality **455,** and ~~AP 479~~ Social Media **479**).
   k. Possession of weapons while on TCHD property or while conducting TCHD, related business or TCHD sponsored events, including off-site (**Administrative Policy:** ~~463~~ Workplace Violence **Prevention Plan 463**).
   l. Failure to adhere to TCHD's procedure for safeguarding and preventing the waste of controlled drugs or an inappropriate or unauthorized use of TCHD's Pyxis Pharmacy override system (**Administrative Policy:** ~~429~~ Alcohol and Drug Testing ~~of~~ **for** Employees **429**).

m. Disclosure of any information deemed as confidential included but not limited to information received during an investigation, passwords and other secure codes and employee information (**Administrative Policy:** ~~455,~~ Confidentiality **455**).

4. TCHD's policy is not a progressive ~~discipline~~ **corrective** policy. Certain types of unsatisfactory employee performance or misconduct may result in ~~disciplinary~~ **corrective** action up to and including termination without other informal or formal ~~disciplinary~~ **corrective** action.

D. **COACHING AND COUNSELING PROCESS – WORK PERFORMANCE IMPROVEMENT FORM:**

1. Coaching consists of a documented verbal discussion between the manager or supervisor and the employee. Coaching is informal in nature and should be used when matters do not require formal counseling of an employee's performance. If coaching is unsuccessful in resolving an employee's identified deficiencies or if the nature of the deficiency warrants more than informal action, then supervisors should engage in the counseling process.
2. Counseling consists of a meeting involving the supervisor and employee to discuss deficiencies in the employee's conduct and/or performance expectations. Counseling should be documented on the WPIF and should include the following:
   a. A written description of the incident/event/deficiency including observable behaviors and comments as well as the date, time, place and the policy/policies violated or conduct to be improved.
   b. A copy of the policy, standard, practice, rule, or regulation that has been violated, if any.
   c. An action plan for improvement.
   d. A concise description of the consequence if the action plan is not followed and/or expectation is not met.
3. The employee will be given the opportunity to write a response to the work performance ~~4.~~ improvement action during or after the meeting.

~~5.~~**4.** The supervisor will sign and date the WPIF.

~~6.~~**5.** The employee will sign and date the WPIF indicating that the supervisor has reviewed the incident with the employee.
   a. An employee's signature or initial does not signify admission or agreement with the work performance improvement action, but only that ~~he/she~~ **they** ~~have~~**s** received a copy of the WPIF and has been counseled on the subject matter referenced therein. If an employee refuses to sign or initial the WPIF, the supervisor will state the same on the form to verify that the counseling occurred and that the employee refused to sign the form A completed copy of the WPIF is to be given to the employee at the time of the counseling and the original sent to **Human Resources**.

~~7.~~**6.** Administrative Leave:
   a. When an employee appears to have engaged in misconduct or performance deficiency, ~~he or she~~ **they** may be placed on Administrative Leave in order to allow a full and comprehensive investigation.
   b. TCHD employees may be placed on Administrative Leave.
   c. Administrative Leave requires the approval of a Human Resources Representative. Before an employee is placed on administrative leave, the supervisor will review ~~his/her~~ **their** intended course of action with the Human Resources Representative, unless emergency conditions warrant otherwise.
   d. If an employee is on Administrative Leave, ~~his/her~~ **their** badge, hospital keys, and any equipment (computer, pager), as deemed necessary, will be held by the supervisor.
   ~~d.~~**e.** **Employee may be placed on Administrative Leave via written communication (Administrative Leave Form), or via verbal communication (Telephone).**
   ~~e.~~**f.** When ~~an employee is placed on Administrative Leave,~~ **using** the Administrative Leave Form, **it** ~~-~~shall be completed including the beginning date of the leave, **and be provided to employee** .
   ~~f.~~**g.** The supervisor updates the employees' Kronos record with the administrative leave ~~paycode~~**pay code** for the scheduled days.

~~g.~~**h.** The employee is not allowed on TCHD property, unless for medical treatment, until the conclusion of the investigation.

~~8.~~**7.** Notice of Intent to Terminate Employment (Involuntary):

a. Before an employee is terminated, the supervisor will review ~~his/her~~ **their** intended course of action with the Human Resources Representative. In some circumstances the employee may be placed on administrative leave in order to investigate. The supervisor updates the employees' Kronos record with the administrative leave pay code for the scheduled days.

b. The letter of intent to terminate defines the reason for the termination. This includes a statement of any policy, standard, practice, rule, or regulation that the employee has been found to have violated and a description of the evidence upon which the proposed action is based. The letter will state the ~~effective~~ **intended** date of termination. The letter will include information regarding the Fair Treatment/SKELLY Process policies **Administrative Policies: ~~427~~Fair Treatment for Supervisory and Management Employees 427**, ~~or~~ ~~428~~**Fair Treatment for Non-Management 428**, including any of TCHD's policies on which the termination is based. The intent to terminate letter must be reviewed by the Human Resources Representative before sending or giving the letter to the employee.

~~b.~~**8.** ~~**To the extent that any applicable that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**~~

E. **~~FORM(S) REFERENCED WHICH CAN BE LOCATED ON THE INTRANET:~~**

1. Administrative Leave Form

~~1.~~**2.** **Work Performance Improvement Form**

F.

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

1. Administrative Policy: Alcohol and Drug Testing for Employees - 429,
2. Administrative Policy: Cellular Phone & Other Wireless Electronic Digital Devises - 257
3. Administrative Policy: Disciplinary Action for Breaches of Confidentiality of Restricted Electronic Information - 609
4. Administrative Policy: Discrimination, Harassment and Retaliation Prevention - 403,
5. Administrative Policy: Pay Practice: Meal and Rest Breaks - 475.13.
6. Administrative Policy: Workplace Violence – 463
7. Administrative Policy: Confidentiality - 455
~~1.~~**8. Administrative Policy: Social Media - 479**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
HUMAN RESOURCES

ISSUE DATE: 7/87 **SUBJECT:** Leave of Absence

REVISION DATE: 08/12, 12/13, 12/16 **POLICY NUMBER:** 8610– 435

Human Resources Department Approval:	**~~11/16~~03/20**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval:**~~	~~**11/16**~~
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/16**

A. **PURPOSE:**

1. To establish guidelines for authorized time away from work for Tri-City Healthcare District (TCHD) employees.

B. **POLICY:**

1. It is the policy of TCHD to grant time away from work to eligible employees. ~~Types of leave time authorized by TCHD are: Pregnancy Disability Leave (PDL), Family and Medical Leave (FMLA), California Family Rights Act Leave (CFRA), Kin Care, Reasonable Accommodation Leave, Military Family Leave, Military Leave, Workers' Compensation, and Personal Leave. In addition, in accordance with federal and California state law and established TCHD guidelines, TCHD accommodates and authorizes short term absences for parental school leave, jury duty, bereavement leave, voting, volunteer firefighters, victims of stalking and other specified crimes, and other legal matters.~~ Eligibility **and leave entitlement vary under legislated leave provisions.**~~, duration, and conditions vary based upon the type of leave and are outlined in the sections that follow.~~
2. The following conditions apply to all types of leave time:
   - a. **Requesting a Leave of Absence**
     - i. **Requests for a leave of absence must be submitted through the appropriate third party administrator as far in advance as possible.**
     - ii. **Other than planned PTO, if there are more than three (3) consecutive scheduled missed work days, employees need to contact the third party administrator to request a leave.**
     - iii. **Employees are responsible for notifying their manager or direct supervisor and the third party administrator as far in advance as possible for the time away from work.**
       1) **For foreseeable events, the employee should notify their manager or direct supervisor and third party administrator at least thirty (30) days in advance of the anticipated leave start date.**
       2) **If the event is unforeseeable, notice must be given by the employee as soon as possible.**
       3) **In some instances, failure to give advance notice may result in postponement or denial of the leave.**
       4) **Intermittent uses need to be reported to the third party administrator within forty-eight (48) hours of the absence for the absence to be protected. Employees must also follow normal call out procedures**

for their given department when using approved intermittent.

iv. Documentation to authorize or renew the leave may be required based on the nature and anticipated duration of the leave.

1) Any leave of absence requiring certification from a health care provider will be denied if the appropriate certification is not received by the due date **or is incomplete**. This may result in the leave being designated as unapproved and will be subject to the **Administrative Policy:** Absence and Tardiness Policy # 408.

2) **TCHD may require recertification of the condition for an employee who is on leave due to their own or a qualified family member's medical condition, including intermittent leave requests. TCHD may also request periodic reports during an employee leave regarding the leave status and intent to return to work.**

b. **Compensation and Benefits**

i. Any accrued Paid Time Off (PTO) must be used during a leave (except for Work **Related Injury/Illness**~~ers Compensation~~, Pregnancy Disability, and Military Leave).

1) **Work Related Injury/Illness: An employee is placed on temporary or total disability leave for more than three (3) days for a work place injury/illness will be compensated by the Workers Compensation insurance carrier at the appropriate compensation rate established by the state of California.**

ii. Employees who have Annual Leave Bank (ALB) and/or Extended Leave Bank (ELB) hours must use the **accrued hours**~~m~~ during any leave attributable to the employee's own medical condition.

iii. **It is the responsibility of the employee to apply for compensation and benefits through California Workers' Compensation Insurance (WCI), State Disability Insurance (SDI) or Paid Family Leave (PFL).**

iv. Benefits will be continued during a leave as required by the statutes and regulations that apply to the particular type of leave. ~~Medical b~~**B**enefits through TCHD will continue for 12 cumulative weeks in a rolling year that an employee is on leave of absence. **Premiums will continue to be deducted from your pay while using approved PTO, ALB and/or ELB.** ~~After~~ **After benefits are terminated**~~which, their benefits will terminate~~, ~~and they~~ **employees** will be given the opportunity to enroll with COBRA.

c. **Returning from a Leave of Absence**

i. An employee who is on an approved leave is expected to return to work at the time designated in the leave documentation or in accordance with applicable federal and California state statutory provisions. If the employee does not return as indicated, the absence will be subject to the provisions of **Administrative** Policy: ~~# 408,~~ Absences and Tardiness **408.**

ii. **An employee who is returning from a leave due to their own medical condition must provide a medical release to the Human Resources department (HR) or third party administrator at least twenty-four (24) hours prior to the employee returning to work.**

1) **An employee returning from leave with work restrictions is responsible for requesting any accommodations through HR. HR may coordinate an interactive process with the employee and the employee's manager to review the request. A determination is made based on the essential functions of the employee's position, medical certification, and needs of the department without creating an undue hardship on the organization.**

2) **Disability related information, including medical documentation, is treated as confidential and access is limited to protect the**

requesting party's privacy. Requests for accommodations and accompanying documentation are kept separate from the employee's personnel file.

iii. An employee returning from an approved, protected leave will be returned to the same or an equivalent position, unless the position has ceased to exist for reasons of business necessity or unless otherwise exempted by law.

iv. An employee's benefits will be reinstated upon return from a leave.

d. TCHD will not interfere with, restrain, or deny employees their rights to **protected** leave time.

e. TCHD may delay or continue with any counseling, performance review, or disciplinary action, including discharge, that was contemplated or started prior to an employee's request for or receipt of a leave of absence or that has come to TCHD's attention during the leave. If any such action is delayed during the leave of absence, TCHD may proceed with the action upon the employee's return to work.

f. Employees on an authorized leave of absence may not work for another health care facility during the leave that is the same or substantially the same in nature to the work performed by TCHD. Such outside employment may be grounds for dismissal.

~~2.~~**g. An employee misrepresenting the reason for requesting time off or applying for a leave of absence may be subject to disciplinary actions, up to and including termination.**

3. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

~~4. TCHD may grant a leave of absence to employees under the circumstances described in the "Fact Sheets" of each specific leave. These fact sheets are designed to comply with the leave of absence requirements prescribed by state and federal law. TCHD may modify, add to, or delete any of these fact sheets at any time.~~

~~5. Requests for time away from work must be submitted on the appropriate request form as far in advance as possible and approved as required by the department manager/director and Employee Health Services (if indicated by the nature of the leave).~~

~~6. Documentation to authorize or renew the leave may be required based on the nature and anticipated duration of the leave. Any leave of absence requiring certification from a health care provider will be denied if the appropriate certification is not received by the due date. This may result in the leave being designated as unapproved and will be subject to the Absence and Tardiness Policy # 408.~~

~~7. Specific leave approval and documentation requirements are available from Employee Health Services.~~

~~8. An employee who is on an approved leave is expected to return to work at the time designated in the leave documentation or in accordance with applicable federal and California state statutory provisions. If the employee does not return as indicated, the absence will be subject to the provisions of Policy # 408, Absences and Tardiness. A medical release must be provided to Employee Health Services prior to the employee returning to work.~~

~~9. Any accrued Paid Time Off (PTO) must be used during a leave (except for Workers Compensation, Pregnancy Disability, and Military Leave). If an employee chooses to decline the use of PTO time, the employee must make the request in writing by signing the declination on the *Leave of Absence* form, which is generated in Employee Health Services. Employees who have Annual Leave Bank (ALB) and/or Extended Leave Bank (ELB) hours must use them during any leave attributable to the employee's own medical condition.~~

~~10. If an employee on leave is eligible for payments under California Workers' Compensation Insurance (WCI), State Disability Insurance (SDI) or Family Temporary Disability Insurance (FTDI), he/she must apply.~~

~~11. Benefits will be continued during a leave as required by the statutes and regulations that apply to the particular type of leave. Medical benefits through TCHD will continue for 12 cumulative~~

~~weeks in a rolling year that an employee is on leave of absence. After which, their benefits will terminate, and they will be given the opportunity to enroll with COBRA.~~

~~12. An employee returning from an approved, protected leave will be returned to the same or an equivalent position, unless the position has ceased to exist for reasons of business necessity or unless otherwise exempted by law.~~

~~13. TCHD will not interfere with, restrain, or deny employees their rights to leave time.~~

~~14. TCHD may delay or continue with any counseling, performance review, or disciplinary action, including discharge, that was contemplated or started prior to an employee's request for or receipt of a leave of absence or that has come to TCHD's attention during the leave. If any such action is delayed during the leave of absence, TCHD may proceed with the action upon the employee's return to work.~~

~~C. PREGNANCY DISABILITY LEAVE (PDL):~~

~~1. In accordance with California state law, TCHD provides pregnancy disability leave for up to four months (17 weeks + 3 days) to any female employee who becomes disabled and is unable to perform the essential functions of her position as a result of pregnancy. This leave can be taken continuously, intermittently, or on a reduced work schedule based upon medical certification.~~

~~D.~~C. **FAMILY AND MEDICAL LEAVE (FMLA) AND CALIFORNIA FAMILY RIGHTS ACT (CFRA):**

1. In accordance with federal and California state law, TCHD provides an eligible employee up to 12 work weeks of leave during a rolling 12-month period for a qualifying reason with accompanying certification. This leave can be taken continuously, intermittently, or on a reduced work schedule **based upon medical certification**.
2. Intermittent leaves require semi-annual certification. According to Section 825.308 of the U.S. Department of Labor, an employer may request recertification more frequently if circumstances described by the previous certification have changed significantly, or the employer receives information that casts doubt upon the employee's stated reason for the absence.
3. An employee is eligible for FMLA/CFRA if ~~he/she~~**the employee** has:
   a. Completed 12 months of ~~service (does not need to be consecutive)~~**employment and**
   b. Worked at least 1250 hours in the 12 consecutive months immediately preceding the leave **start date.**
4. ~~If eligible,~~ FMLA/CFRA ~~will~~**may** be granted for the following reasons:
   a. Birth of an employee's child (within one year of birth). ~~Six weeks~~**A portion of the 12 weeks is** paid under CPFL (California Paid Family Leave).
   b. Placement of a child (age 18 or less) with an employee through adoption or foster care (within one year of placement).
   c. To care for an employee's ~~spouse, child or parent~~**qualifying family member** with a serious health condition.
   d. An employee's own serious health condition makes them unable to perform one or more of the essential functions of ~~his or her~~ **their** job.
   e. To bond with the child of a domestic partner (CFRA only).
   f. To care for an employee's domestic partner with a serious health condition (CFRA only).

~~f.~~**5. Any FMLA/CFRA leave taken by an eligible employee will be designated as such and will be counted against the employee's leave entitlement whether the leave is paid or unpaid.**

~~g.~~**a.** ~~Employees returning from continuous leave are required to submit a medical release from their healthcare provider in order to return to work.~~

D. **PREGNANCY DISABILITY LEAVE (PDL):**

1. In accordance with California state law, TCHD provides pregnancy disability leave for up to four months (17 weeks **and**~~+~~ 3 days) to any ~~female~~ employee who becomes disabled and is unable to perform the essential functions of ~~her~~**their** position as a result of pregnancy, **childbirth, or related medical condition**. This leave can be taken continuously, intermittently, or on a reduced work schedule based upon medical certification.

E. **KIN CARE LEAVE:**

1. In accordance with California state law, TCHD provides ~~an~~ eligible employees with Kin Care Leave ~~to care~~ for **care, diagnosis, or treatment of an existing health condition of, or preventative care for an employee's** qualifying family ~~member (child, parent, spouse or domestic partner) who is ill~~. **A qualifying family member is defined as:**
   a. **Child, which for purposes of this article means a biological, adopted, or foster child, stepchild, legal ward, or a child to whom the employee stands in loco parentis. This definition of a child is applicable regardless of age or dependency status.**
   b. **Biological, adoptive, or foster parent, stepparent, or legal guardian of an employee or the employee's spouse or registered domestic partner, or a person who stood in loco parentis when the employee was a minor child.**
   c. **Spouse.**
   d. **Registered domestic partner.**
   e. **Grandparent.**
   f. **Grandchild.**
   g. **Sibling.**

~~1.~~2. An employee is eligible for Kin Care immediately upon becoming eligible to use accrued PTO as outlined in **Administrative** Policy: ~~# 433,~~ Paid Time Off Program **433**. ~~An e~~Eligible employees may use **up to a maximum of one-half of their** ~~actual accrued~~ **annual** PTO **accrual** ~~up to a maximum of one half the amount of PTO that the employee accrues in the current year as long as they continue to have~~ **if the** PTO ~~hours in their bank~~**is available**.

F. **AMERICAN~~merican~~ DISABILITY ~~isability~~ ACT (ADA) REASONABLE~~easonable~~ ACCOMMODATION ~~ccommodation~~ LEAVE~~eave~~**

1. **In Accordance with ADA, TCHD may provide time off work as an accommodation if the employee is not eligible for FMLA and/or any other applicable leave entitlement.**
2. **HR may coordinate an Interactive Process with the employee and the employee's manager to review the leave request.**
   a. **In certain situations, an accommodation may not be possible or required. Examples include when the medical condition is not a qualifying disability under the ADA; the requested accommodation would relieve an employee if performing an essential job function or the requested accommodation would cause an undue hardship or would pose a direct threat to the safety of the employee or others.**
   b. **Should the employee be granted a leave of absence as a reasonable accommodation and later become eligible for FMLA and/or any other applicable leave entitlement, the remaining requested time off may be counted against the employee's leave time entitlement under those leave laws.**

~~2.~~3. **Disability related information, including medical documentation, is treated as confidential and access is limited to protect the requesting party's privacy. Request for accommodation and accompanying documentation are kept separate from the employee's personnel file.**

~~F.~~G. **MILITARY AND MILITARY FAMILY LEAVE:**

1. **Uniformed Services Employment and Reemployment Rights Act (USERRA):**
   ~~1.~~a. Leave without pay is provided when an employee enters military service of the Armed Forces of the United States or the Armed Forces Reserves. The employee is afforded reemployment rights and retains full seniority benefits for all prior service upon reemployment in accordance with the ~~Uniformed Services Employment and Reemployment Rights Act~~**USERRA** and the California Military and Veterans Code. The employee needs to ~~bring military orders to Employee Health Services for review prior to commencement of the leave.~~**file for leave through the third party vendor.**
2. **Unpaid Spousal Leave:**

~~2.~~a. In accordance with ~~Assembly Bill No. 392~~**CA MVC §395.10**, a qualified spouse of a qualified member of the Armed Forces, National Guard or Reserves may take up to 10 days of unpaid leave ~~during a qualified leave period, (meaning~~ **when** the qualified member is on leave from deployment during a period of military conflict). PTO may be declined for this leave.

3. **Qualifying Exigency Leave:**

~~3.~~a. ~~FMLA entitles e~~Eligible employees ~~with a~~**who are a** spouse, registered domestic partner, son, daughter, or parent **of a**~~on active duty or recall to active duty status in the National Guard or Reserves in support of a contingency operation,~~ **military member, including active duty and reserves, may** ~~may use their~~ **take up to** 12-week**s of FMLA during any 12 month period** ~~leave entitlement~~ to address ~~certain~~ qualifying exigencies. Qualifying exigencies may include attending **military sponsored** ~~certain~~ events, arranging ~~for~~ alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

4. **Military Caregiver Leave:**

~~4.~~a. ~~FMLA includes a special leave entitlement that permits e~~Eligible employees **who are a spouse, son, daughter, parent or next of kin of a covered service member, including active duty and reserves, may take up to 26 weeks iof FMLA** ~~to take up to 26 weeks of leave to care for a covered service member~~ during a single 12-month period **to care for**~~.~~ **a**~~A covered~~ service member ~~is a current member of the Armed Forces, including a member of the National Guard or Reserves,~~ who has a serious injury or illness incurred **or aggravated** in the line of duty **on active duty** ~~that may render the service member medically unfit to perform his or her duties, for which the service member~~ **who** is undergoing medical treatment, recuperation, or therapy; or is in outpatient status, or is **otherwise** on the temporary disability retired list.

~~G.~~H. WORK RELATED INJURY OR ILLNESS ~~ERS' COMPENSATION~~:

1. In accordance with California state law, TCHD provides any employee who sustains a work-related injury or illness with workers' compensation leave and benefits. Workers' compensation leave will simultaneously count toward any available FMLA/CFRA leave time.

~~H.~~I. PERSONAL LEAVE:

1. Personal leaves are **requested and** granted for a **minimum of seven (7) calendar days and a** maximum of 31 **calendar** days, at the sole discretion of TCHD, and can only be authorized by a department manager or director. Among the concerns taken into consideration will be TCHD's legitimate business needs and the ability to find a temporary replacement, or to leave the position vacant for the expected duration of the leave. **An employee must have worked a minimum of ninety (90) days before they can request a personal leave.** An additional 30 days may be approved with administrative approval by **C-Suite and Head of HR**~~a Vice President or above~~.

J. SHORT TERM ABSENCES

1. **Parental School Leave:**

a. **An employee who is a parent, guardian, stepparent, foster parent, or grandparent of, or a person who stands in loco parentis to one or more children of the age to attend Kindergarten or grades 1 to 12, inclusive or a licensed child care provider may take off up to forty (40) hours per calendar year but not exceeding eight (8) hours in any calendar month of the year to:**

i. ~~To f~~**Find, enroll, or reenroll the child in a school or with a licensed child care provider.**

ii. **Participate in activities if the school or licensed child care provider ~~i~~of the child.**

iii. ~~To a~~**Address a school or child care provider emergency**

b. The employee, of requested by TCHD, shall provide documentation from the school or licensed child care provider as proof that the employee engaged in child-related activities permitted in subdivision (a) on a specific date and at a particular time.

2. Bereavement Leave:
   a. Refer to Administrative Policy:~~Pay Practice~~ Bereavement Leave for Benefited Employees 435.01
3. Subpoena/Jury Duty:
   ~~2.~~a. Refer to Administrative Policy:~~pay Practice~~ Jury Duty 435.02

K. RELATED DOCUMENTS:
1. Administrative Policy: Annual and Extended Leave Bank 489
2. Administrative Policy: Paid Time Off Program 433
3. Administrative Policy: Absences and Tardiness 408
4. Administrative Policy: ~~Pay Practice:~~ Bereavement Leave for Benefited Employees 435.01
~~3.~~5. Administrative Policy: ~~Pay Practice:~~ Subpoena/Jury Duty 435.02

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
HUMAN RESOURCES
~~**TRI-CITY HEALTHCARE DISTRICT PAY PRACTICE MANUAL**~~

ISSUE DATE:	**10/~~3~~/04**	**SUBJECT:**	**Subpoena/Jury Duty**
REVISION DATE:	**10/05**	**POLICY NUMBER:**	**435.02**

Human Resources Department Approval:	**02/20**
Administrative Policies & Procedures Committee Approval	**03/20**
Medical Executive Committee:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	**10/05**

~~**TITLE: Subpoena/Jury Duty EFFECTIVE DATE: 10/3/04 NUMBER: 435.02 REVISION DATE: POLICY REFERENCE: Leave of Absence--AP&P#435 RESPONSIBLE PARTY: VP, Human Resources APPROVAL:**~~

A. **PURPOSE:**

1. To provide guidelines for time off to TCHD employees who are summoned **to testify or** ~~-~~to jury duty.

B. **PROCEDURE:**

1. ~~1)~~ TCHD shall grant benefited employees time off with or without pay for actual time spent on mandatory jury duty **or is summoned to testify** if the jury ~~**jury**~~ duty **or summons** results in the employees missing scheduled workdays. ~~**or is summoned to testify.**~~
2. ~~2)~~ Employees shall receive up to eight (8) hours of regular base pay for each day **summoned to testify or** served on jury duty for up to five (5) scheduled workdays if the **testimony or** jury duty results in the employee missing scheduled work.
3. ~~3)~~ If the **subpoena or** ~~-~~jury duty exceeds five (5) scheduled workdays, employees ~~shall be~~ **may be** placed on leave of absence without pay for the balance of their **subpoena or** jury duty.
4. ~~4)~~ Benefited employees may use their available PTO to receive pay for their regularly scheduled hours.
5. ~~5)~~ Exempt employees whose **subpoena or** jury duty exceeds five (5) scheduled workdays shall be paid consistent with their salary as required under federal law.
6. ~~6)~~ Benefited employees who regularly work ten (10) or twelve (12) hour shifts shall be paid **up to** eight (8) hours of **subpoena or** jury duty pay and may use their available PTO to supplement their additional normally scheduled hours of work missed while serving.
7. ~~7)~~ Benefited employees serving a minimum of six (6) hours per day shall be paid for eight (8) hours.
8. ~~8)~~ Benefited employees serving less ~~that~~**than** six (6) hours per day shall be paid for the actual hours served and may use their available PTO to supplement their additional scheduled hours of work missed while serving.
9. ~~9)~~ Employees who normally work evening or night shifts may elect to work their regularly scheduled shift in addition to **testifying or** serving jury duty or may elect to take time off.
10. ~~10)~~ Time off for **subpoena or** ~~-~~jury duty shall not be included in the calculation of overtime.
11. ~~11)~~ Non-benefited and per diem employees ~~shall~~ **may** receive unpaid leaves of absence to ~~-~~ perform mandatory jury duty **or who are subpoenaed**.
12. ~~12)~~ Employee presents a copy of the **subpoena or** jury summons to his/her supervisor or manager immediately upon receipt of it.
13. ~~13)~~ Employee completes Request for Time Off form **or designated process per manager**.

~~Jury Duty – 10/3/04 – 1 of 2~~

14. ~~14)~~ Manager arranges for time off for employee.
15. ~~15)~~ Employee ~~attaches~~ **submits** official **subpoena or** jury duty time ~~slip~~ **sheet** to ~~the back of his/her timecard~~ **payroll**.
16. ~~16)~~ Time taken off for **subpoena or** jury duty shall be coded on the employee's timecard as ~~**Subpoeona**~~**Subpoena** /JD- Jury Duty.
17. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

C. **FORMS/TASBLES/SCHEDULES:**

1. Request for Time Off form

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

1. **Administrative Policy: Leave of Absence 435**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 12/87 **SUBJECT:** Flex/Float To Activity

REVISION DATE(S): 10/12; 02/13; 09/13, 09/16 **POLICY NUMBER:** 8610-437

Human Resources Department Approval:	**~~09/16~~03/20**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~Human Resources Committee Approval:~~	**~~09/16~~**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/16**

A. **INTRODUCTION:**

1. ~~The District~~ **Tri-City Healthcare District (TCHD)** reserves the unrestricted right to engage in Flex/Float to Activity. No ~~District~~ **TCHD** employee, representative or agent has the authority to limit this right, and any attempt to do so shall be void.

B. **PURPOSE:**

1. Management is responsible for the daily monitoring activities to ensure adequate staffing. Once it has been determined scheduled staffing levels exceed anticipated activity, this procedure is to be implemented. In interpreting this procedure it should be reinforced that the principal criteria for any flex/float activity will be to retain those personnel necessary to meet the requirements of patient care. All other criteria for a flex/float activity are subject to, and limited by, that overriding consideration.

C. **DEFINITIONS:**

1. Job Classification - The position an employee holds, i.e., secretary, food service worker, registered nurse, etc.
2. Unit Seniority - Employee with the longest length of ~~District~~ **TCHD** service in the specific department/unit.
3. Period of Service - The amount of time an employee spends in a particular job classification department. This date is specific to Reassignment flex-to-activity situation only.
4. Activity - Unique to each department, activity may be defined in areas as census, units, procedures, employees, etc., by which levels of staffing are determined.
5. Alternative Work Assignment - Work available in a department other than an employee's primary work area in which an employee holds credentials and experience.
6. PTO Payment Eligibility Requirement - As defined in the "Paid Time Off Program" (PTO).
7. Flex-to-Activity - The daily review of activities versus scheduled staffing, which may result in **being flexed off.** ~~Hospital Requested Time Off (HRTO).~~
8. PTO-Flex Time — **Code used in lieu of "working hours" to record** ~~T~~time an employee is normally scheduled to work, which a manager determines, is not necessary due to a decrease in activities.
9. ~~8.~~ **Float-to-Activity – The daily review of activities versus scheduled staffing which may result in being temporarily assigned to another department or assignment in which they are competent to provide care or service**

D. **FLEX/FLOAT-TO-ACTIVITY:**

1. Management is responsible to ensure the adequate provision of staffing. Once it is determined

that planned levels are in excess of anticipated activity, this procedure is to be implemented.

2. Appropriate staffing needs are determined by job classification.
3. Once a job classification has been identified as being over staffed relative to activity, the management must investigate the staffing needs of other areas of the facility for alternative work options appropriate for the employee's skills and knowledge. In determining the priority of offering alternative work, the process below will prevail:
   a. There will be no seniority recognition in alternative work assignments.
   b. An employee accepting appropriate work assignment will be paid at their regular rate of pay.
4. If there is not appropriate alternative work available the following may occur:
   a. The hours the employee voluntarily takes off will be designated as PTO Flex Time. ~~(formerly) "Hospital Requested Time Off" on an employee's time record.~~
   b. Non-Exempt Employees on PTO Flex Time may choose to use PTO, **or** ~~PTO~~ Flex zero pay~~, or go into the negative (up to 40 hours max). Non-exempt employees who choose to go into the negative must pay back the negative hours balance through future accruals before utilizing any further negative hours~~.
   c. If exempt employees are required to take a flex day they must use PTO ~~or go into negative PTO.~~. Exempt employees may not use **Flex** zero pay unless it is for a full week increment in which they did not do any work during that week.
5. If attempts to reduce extra staff by placing staff in alternate available positions or voluntary PTO Flex Time are not completely successful, then extra staff will be placed on non-voluntary PTO Flex Time based on the following criteria:
   a. The principal criteria for any ~~reduction in force~~ **flex to activity** will be to retain those personnel necessary to meet the requirements of patient care. All other criteria for flex to activity is subject to, and limited by, that overriding consideration. The following priority of criteria, therefore, may be altered or modified consistent with that need and requirement or approved department specific criteria.
      i. The following is an example of status priority:
         1) 1st - Temporary , from least senior to most senior
         2) 2nd - Per Diem, from least senior to most senior
         3) 3rd - Benefited, from least senior to most senior
         4) 4th - Employee training period
6. Management **or designee** -will attempt to call employees at least two hours prior to the beginning of their shift to notify them of PTO Flex Time.
7. It is each employee's responsibility to provide ~~his or her~~ **their** supervisor with a telephone number where ~~he/she~~ **they** can be reached. This telephone number will be used to contact the employee when being placed on PTO Flex Time.
8. Employees who report to work after being called not to report within the appropriate time frame are not eligible for report-in pay but may use PTO.
9. **If the employee is not contacted and reports to work, the employee will be paid two hours of "report in pay" at their base pay rate.**
   a. **The department director or designee may require the employee to stay and work through the two-hour "report in pay" period before being released from their shift.**
   b. **"Report in pay" will be recorded as such on the employee's timecard.**
   ~~8.~~c. **Employees who are sent home early due to being flexed are not eligible for "report in pay"**
10. ~~All employees that are a member of a union must follow the terms of the collective bargaining agreement.~~ **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

Tri-City Medical Center
Oceanside, California

Administrative Policy
Human Resources

ISSUE DATE:	**05/83**	**SUBJECT: Reduction in Work Force**	
REVISION DATE:	**08/96, 01/97, 02/98, 08/00, 06/03 10/05, 12/08. 08/09, 05/11, 11/14**	**POLICY NUMBER: 8610-448**	

Human Resources Department Approval:	**~~08/17~~02/20**
Administrative Policies and Procedures Committee Approval:	**~~08/17~~03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval:**~~	~~**08/14**~~
~~**Governance Council Committee Approval:**~~	~~**11/14**~~
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/14**

A. **INTRODUCTION:**

1. Tri-City Healthcare District (TCHD) reserves the unrestricted right to engage in a Reduction in Force (RIF). No TCHD employee, representative or agent has the authority to limit this right, and any attempt to do so shall be null and void.
2. The Chief Executive Officer (CEO) has the ability to implement a RIF at ~~his/her~~ **their** sole discretion, at any time, and in any manner, that ~~he/she~~ **they** deems in the best interests of TCHD. This policy may be amended, revised or completely restated at any time before, after or during any particular RIF. The adoption and/or implementation of this policy does not create and shall not be deemed to confer upon any employee any right to continued employment, or to transfer or rehire following ~~an~~ RIF.
3. This policy shall not supersede any agreement between TCHD and the exclusive representative of any bargaining unit of TCHD employees and shall not abrogate the rights of any such employees under the Meyers-Milias-Brown Act and the Worker Adjustment and Retraining Notification Act (WARN Act), if applicable.

B. **PURPOSE:**

1. It is the purpose of this policy to allow ~~an~~ RIF to proceed while limiting disruption to TCHD operations and adverse effects upon TCHD employees. A principal goal of any RIF will be to retain those personnel necessary to meet the operating needs of ~~the District~~**TCHD** and its patients. All other considerations are subject to, and limited by, this overriding goal.

C. **PROCESS:**

1. A RIF may be implemented district-wide, by department, by work group, by job classification or by some other criterion identified by the CEO or designee. Once the scope of the RIF has been determined, the ~~Vice President (VP)~~ **Head** of Human Resources (HR) **or ~~his/her~~ designee** will work with each affected department to identify positions that may be eliminated as part of the RIF. In identifying these positions, the ~~VP~~ **Head** of HR and department supervisors may consider the specific experience, training, and competencies of the incumbents in those positions. By way of example, they may consider whether an incumbent has the ability to perform duties that would allow the position ~~he/she~~ **they** occupy~~ies~~ to be restructured and to avoid elimination under the RIF.
2. Subject to the second sentence of C.1., above, after identifying the positions to be eliminated, the ~~VP~~ **Head** of HR and the affected supervisors will identify the individuals to be laid off as part

of the RIF. Selection of such individuals shall be at TCHD's sole and absolute discretion, based upon the operating needs of TCHD and the needs of its patients, provided, however, ~~that~~ individuals may not be identified by lay off based on their race, national origin, gender, disability, or other characteristic protected under state or federal law, or in retaliation for any protected activity.

3. Notification of the individuals selected to be laid off as part of the RIF shall be provided in compliance with applicable state and federal laws.

D. **TRANSFER/REHIRE:**

1. Employees who are selected for layoff may apply to transfer to any open position **at TCHD**~~in the District~~ for which they are qualified.
2. Employees who have been laid off may be considered for re-hire as long as they are otherwise in good standing and possess the qualifications of the position for which they are applying. It is an employee's responsibility to inquire and apply for any job openings.
3. Employees who are rehired in the first six months following ~~an~~ RIF shall maintain their prior seniority date. Reinstatement of benefits will begin the 1st of the month following the date of re-hire.
4. TCHD will cease payments of any outstanding severance amounts payable under **Administrative** Policy: ~~# 454~~ **Severance Plan 454** for any employee rehired following ~~an~~ RIF **and subsequent to first day of return to work**.
5. The ~~VP~~ **Head** of HR, in consultation with the department head, shall have discretion and authority to approve if any employee is eligible for a transfer or for re-hire into a position not previously held by the employee.

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

1. **Administrative Policy: 432 Employee Transfers**
2. **Administrative Policy: 454 Severance Plan**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

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

REVISION DATE(S): 06/12, 04/15 **POLICY NUMBER: 8610-471**

Human Resources Department Approval ~~Date(s)~~:	**04/15**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval Date(s):**~~	~~**04/15**~~
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**04/15**

A. **DEFINITION:**

1. Multicultural Diversity: refers to the unique characteristics that distinguish people as individuals and identify them as belonging to a ~~recognizable~~ group or groups. Diversity transcends concepts of **race, spiritual and religious belief, religious creed (including religious dress and grooming practices), color, national origin, ancestry, ethnicity, socio-economic status, education, social customs, physical disability, mental disability, medical condition (including AIDS and/or HIV status), genetic information, marital status, military and veteran status, sex, gender, gender identity, gender expression, age, sexual orientation, pregnancy, childbirth, breastfeeding and/or related medical conditions or any other status protected by State or Federal Law** ~~race, ethnicity, socio-economic status, gender, transgender, spiritual and religious beliefs, education, sexual orientation, disability, beliefs language, body language, social customs and age.~~
2. **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

B. **PURPOSE:**

1. To create an environment where differences among people are valued and appreciated and are ~~treated~~ **treated** with dignity and respect; thus comprising a workforce consisting of individuals with diverse competencies, values, backgrounds, ethnicity and experiences who realize their maximum potential within a multicultural organization.
2. To further facilitate **Tri-City Health District (TCHD) Workforce Members** ~~(e.g. employees, and volunteers)~~ **in** working together respectfully, to foster appreciation for their unique and diverse talents, and perspectives, and how together **TCHD's Workforce Members** ~~employees and volunteers~~ contributes to the mission, vision and effective achievement of the business goals of **TCHD** ~~Tri-City Healthcare District (the "District").~~

C. **POLICY:**

1. Diversity at all levels among **TCHD's Workforce Members** ~~employees and among volunteers~~ requires to display sensitivity and respect for the needs of others including visitors, customers, employees, volunteers, and patients and their families, friends, support persons, and surrogate decision makers.
2. ~~The District~~**TCHD** values diversity among staff and will recruit, retain, and promote at all levels of the organization in order to meet the needs of our unique population. ~~The~~

~~District's~~**TCHD's** culture and practices contribute to a workplace which values diversity and encourages **Workforce Members** ~~employees and volunteers~~ to provide service excellence in carrying out their responsibilities. .

3. ~~TCMC~~ **TCHD** expects **Workforce Members** ~~employees and volunteers~~ to treat each other with dignity, fairness, and respect regardless of their differences. This includes how they treat physicians, visitors, patients and their families, friends, support persons, and surrogate decision makers and those who provide on-site vendor services.
   a. ~~Employees and volunteers~~ **TCHD's Workforce Members** will support diversity through ~~the District's~~**TCHD's** ~~-~~mission statement, values, ethics statement~~, and it will be supported by the Service Excellence initiative.~~
   b. Commitment to workplace values is measured and documented in employee performance evaluations.

~~c.~~**4.** Administrative policies and procedures support respect and diversity including Administrative Policies: **Coaching and Counseling for work Performance** ~~#~~ 424, ~~, Code of Conduct and Work Performance Improvement,~~ and **Discrimination, Harassment and Retaliation Prevention Policy #** 403. ~~, Harassment Reporting~~.

~~4.~~**5.** ~~The District~~ **TCHD** will offer diversity education and training to support and facilitate diversity awareness and positive recognition of the unique talents among ~~the District's~~**TCHD** diverse **Workforce Members**~~staff~~.

~~5.~~**6.** ~~The District~~**TCHD** ~~-~~places a high value on diversity and inclusion. We believe that diversity and inclusion are essential to organizational effectiveness and excellence, and that services are enhanced when organizations are a reflection of the communities they serve. The objectives are:
   a. To create a diverse and inclusive workplace environment that promotes mutual respect, acceptance and cooperation among **TCHD's Workforce Members** ~~employees and volunteers~~.
   b. To support an environment where all **TCHD's Workforce Members** ~~employees and volunteers~~ are valued, supported and empowered.
   c. To plan and coordinate activities which deepen the appreciation and celebration of differences, including but not limited to race, ethnicity, age, gender, sexual orientation, ~~disability, and~~ geographic diversity **color, national origin, ancestry, marital status, socio-economic status, sex, gender identity, gender expression, spiritual and religious beliefs, education, physical disability, mental disability, medical condition, genetic information, military and veteran status, social customs, or any other status protected by State or federal law.**
   d. To facilitate high quality, high-standard initiatives providing opportunities for capacity building through diversity and inclusion.
   e. To provide a communication link to **TCHD's Workforce Members** ~~employees and volunteers~~ at all levels of the organization.
   f. To promote excellence in healthcare, and patient safety and satisfaction by recognizing the diversity of the ~~District's~~ **TCHD** patient population, and the diversity of patients' families, friends, support persons, and surrogate decision makers, and by promoting cultural diversity, awareness, and sensitivity among **TCHD's Workforce Members** ~~employees and volunteers~~.

~~6.~~**7.** ~~"All employees that are a member of a union must follow the terms of the collective bargaining agreement."~~ **To the extent that any applicable that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

D. <u>RELATED DOCUMENT(S)</u>:

1. **Administrative Policy: Coaching and Counseling 424**
2. **Administrative Policy: Discrimination, Harassment and Retaliation Prevention 403**

Tri-City Medical Center
Oceanside, California

DELETE – no longer needed

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE:

SUBJECT: Compensation and Benefits Eligibility

REVISION DATE(S): 08/04

POLICY NUMBER: 472.01

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval	10/19
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~COMPENSATION AND BENEFITS ELIGIBILITY - #472.01~~

Compensation and Benefits Eligibility							
~~Employment Status~~	~~NSRP~~	~~Lincoln Deferred Compensation~~	~~MAPP~~	~~Health &Welfare~~	~~PTO~~	~~EAP~~	~~Merit Awards~~
~~Regular Full-time and Part-time Benefited~~	~~Y with LTD and SIB~~	~~Y~~	~~Y~~	~~Y~~	~~Y~~	~~Y~~	~~Y, if non-union~~
~~Regular Full-time and Part-time Non-benefited~~	~~Y~~	~~Y~~	~~N~~	~~N~~	~~N~~	~~Y~~	~~Y~~
~~Per Diem~~	~~Y~~	~~Y~~	~~N~~	~~N~~	~~N~~	~~Y N~~	~~N~~
~~Week-end Professional~~	~~Y~~	~~Y~~	~~N~~	~~N~~	~~Y~~	~~Y, unless PD~~	~~Y, if non-union and not PDN~~
~~Temporary~~	~~N~~	~~N~~	~~N~~	~~N~~	~~N~~	~~Y N~~	~~N~~
~~Leave of Absence~~	~~Y~~	~~Y~~	~~Y, based on status if prior prior status benefited~~	~~Y, based on status prior, duration varies~~	~~Y, if pay received~~	~~Y, unless PD~~	~~Y, upon return, if non-union.~~
~~Terminated~~	~~Y, if pay received~~	~~Y, if pay received~~	~~Y, if pay received and prior status benefited~~	~~N, except through COBRA~~	~~N~~	~~N~~	~~N~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

DELETE – covered in Collective Bargaining Agreements

ISSUE DATE: 02/20/05 **SUBJECT:** Charge Pay

REVISION DATE(S): **POLICY NUMBER:** 473.01

Human Resources Content Expert Approval:	~~10~~12/19
Administrative Policies & Procedures Committee Approval	03/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TITLE: Charge Pay~~
~~EFFECTIVE DATE: 2/20/05~~
~~NUMBER: 473.01~~
~~REVISION DATE:~~
~~POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473~~
~~RESPONSIBLE PARTY: VP/Human Resources APPROVAL:~~

~~A. PURPOSE:~~
~~1. To establish guidelines for the payment of additional compensation for~~ed work, in a charge or lead position, for a designated shift.

~~B. PROCEDURES:~~
~~1 Charge duties are assigned for a limited time interval by the department Manager~~
~~2 The date, shift, and duration of the Charge assignment are documented on the schedule.~~
~~3 These individuals who have been assigned a permanent job classification as Charge Nurse are exempt from shift specific Charge pay.~~
~~4 Charge differential will be compensated at a rate of 5% above the employee's base salary pay rate for the designated time the employee functions in the charge role.~~
~~5 The Employee is to document "chg" in the comment section of the time card. The manager will initial this section.~~
~~6 Shift differential will be paid at the applicable rate for the shift worked.~~

~~C. RELATED DOCUMENT(S):~~
~~1. Administrative Human Resources Policy: Premium Specialty Pay 473~~

~~Pay Practice Manual – Effective 2/20/05 1 of 1~~

Tri-City Medical Center
Oceanside, California

DELETE – incorporated into Administrative Policy: Premium Specialty Pay 473

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE: 02/~~20~~/05 **SUBJECT:** Holiday and Holiday Premiums

REVISION DATE(S): **POLICY NUMBER:** 473.02

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval	03/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TRI-CITY MEDICAL CENTER~~
~~PAY PRACTICE MANUAL~~

~~TITLE: Holiday and Holiday Premiums~~
~~NUMBER: 473.02~~
~~POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473~~
~~EFFECTIVE DATE: 2/20/05~~
~~NUMBER: 473.02 REVISION DATE:~~
~~POLICY REFERENCE: Premium and Specialty Program Pay – AP # 473 RESPONSIBLE PERSON: VP, Human Resources~~
~~APPROVAL:~~

~~A. PURPOSE:~~
~~1. To identify those holidays observed by Tri-City Medical Center and outline the conditions under which eligible employees are paid Holiday Premiums.~~

~~B. ELIGIBILITY:~~
~~1. All Some non-exempt full-time, part-time and per diem employees are eligible.~~
~~2 Designated exempt job codes scheduled on a shift basis may be eligible for holiday premium. Determination is made by the VP, Human Resources /Area Administrator.~~

~~C. OBSERVED HOLIDAYS:~~
~~1. New Year's Day, President's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Day.~~

~~D. PROCEDURES:~~
~~1. Holiday premium will be paid to eligible employees for all hours worked on the actual holiday (all hours worked between 12:01 AM and midnight).~~
~~2. All eligible employees will receive a holiday premium of 50% of the employees base hourly rate for working on the following days; New Year's Day, July 4th, Thanksgiving Day and Christmas Day.~~
~~3. All eligible employees will receive a holiday premium of 10% of the employee's base hourly rate for working the following holidays: Presidents' Day, Memorial Day and Labor Day.~~
~~4. Holiday premiums are paid for hours worked on the actual holiday, not a designated day of observance. (i.e. in cases where the holiday falls on a Saturday and is observed on the preceding Friday, holiday premium pay will be paid only for the hours worked on the actual holiday, Saturday.) In those cases where a holiday falls on a Sunday and is observed on the following Monday, the holiday premium will be paid only on the actual holiday, i.e. Sunday.~~
~~Pay Practice Manual – Effective 2/20/05 1 of 2~~

5. 5. Holiday differential premiums will be paid in addition to other applicable differentials and premium pays (i.e. shift premium).

E. VOLUNTARY NON PAYMENT OF HOLIDAY PREMIUM

11. Employee must have approval from their manager to work a Holiday shift without Holiday Premium.

2 Documentation for Non-Payment of Holiday Premium differential must be on the employee's timecard and signed by the Director or Manager of their area.

Pay Practice Manual – Effective 2/20/05 2 of 2

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

DELETE – change in practice see Patient Care Services Policy: Interpretation and Translation Servics

ISSUE DATE: 02/20/05 **SUBJECT:** Interpreter Premium

REVISION DATE(S): **POLICY NUMBER:** 473.03

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval:	03/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL~~

~~TITLE: Interpreter Premium EFFECTIVE DATE: 2/20/05 NUMBER: 473.03 REVISION DATE: POLICY REFERENCE: Premium and Specialty Pay AP #473 RESPONSIBLE PARTY: VP, Human Resources APPROVAL:~~

~~PURPOSE: To establish payment guidelines for the provision of needed interpreter services to qualifying employees when requested.~~

~~PROCEDURES: Participation as an Interpreter is voluntary. Employees are compensated for interpreting only for services requested and provided outside his/her department. Eligible employees are fluent in English as a second language and can accurately speak, read and readily interpret. Employees who can sign and read sign language are also eligible for interpreter premium. Qualifying employee volunteers must sign an Interpreters Voluntary Participation Sheet and be placed on the interpreters listing maintained by Human Resources. The list is also available in the nursing staff office and PBX. Compensation for interpreter services will be $2.00 per hour (paid in 15 minute increments) and is in addition to the employee's regular rate of pay. Documentation for payment of the Interpreter Premium must be on the employee's timecard and signed by the Director or Manager of the department.~~

~~1~~

~~RELATED DOCUMENT(S):~~

~~2 Administrative Human Resources Policy: Premium Specialty Pay 473~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

DELETE – incorporated into Administrative Policy: Premium Specialty Pay 473

ISSUE DATE: 10/3/04 **SUBJECT:** On-Call and Call-Back

REVISION DATE(S): 07/23/08 **POLICY NUMBER:** 473.04

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval:	03/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TRI-CITY MEDICAL CENTER~~
~~PAY PRACTICE MANUAL~~

~~TITLE: On-Call and Call-BackEFFECTIVE DATE: 10/3/04~~
~~NUMBER: 473.04 REVISION DATE: 7/23/08~~
~~POLICY REFERENCE: Premium & Specialty Pay AP&P #473~~
~~RESPONSIBLE PARTY: VP, Human Resources APPROVAL:~~

~~PURPOSE:~~
~~1. To establish compensation guidelines for employees scheduled to be on-call and able to return to work for designated staffing needs.~~

~~B. ELIGIBILITY:~~
~~1. All non-exempt full-time, part time and per diem employees are eligible.~~

~~C. DEFINITIONS:~~
~~1. On-Call is the process through which employees are scheduled to be available to report to work.~~
~~2. Call-Back is the time an On-Call employee is actually called to return to work or is required to remain after their normal shift but was pre-scheduled to be on-call.~~

~~D. PROCEDURES:~~
~~1) Employees may be placed On-Call in accordance with department director/designee based on staffing requirements of the department.~~
~~2) Employees will be placed On-Call in accordance with department guidelines based on such criteria as rotation, voluntary basis and required skill set.~~
~~1. 3) Acceptance of On-Call shifts may be mandatory in some areas.~~
~~2. While the employee is On-Call, they must be available by telephone or pager and be able to return to work within 30 minutes or within a timeframe approved by the department director if travel time is greater than 30 minutes. During On-Call time, the employee is free to pursue their own personal activities provided they are accessible by telephone or pager.~~

~~5) Where an on-call rate has been established for a position, the On-Call hours will be paid for the duration of a designated On-Call shift.6) Employees who are on Call-Back hours will receive compensation at 1½ times their regular rate of pay for Call-Back hours actually worked regardless of the hours worked during the work week.~~
~~a) Employees who are called back to work will be paid a minimum of two hours of Call-Back pay.~~
~~b) Employees who are on Call-Back hours during evening or night shift will receive~~

applicable shift premium for the Call-Back hours regardless of the number of hours worked on the shift.

c) Employees will not be compensated for travel time to and from the medical center.

7) Employees who are scheduled to be On-Call following the end of their regular shift but due to an assignment (eg, surgical case, procedure or treatment) work beyond the end of their scheduled shift, will be entitled to receive Call-Back pay. In this case, Call-Back pay will only apply to the actual time worked without regard to the 2-hour minimum outlined in 6 a) of this document. Example: Employee normally works a 7:00 AM to 3:30 PM shift. The department rotation had placed the employee On-Call for today beginning at 3:30 PM. At 3:30 PM, the employee was in the middle of a patient treatment and was unable to leave at their normal time. The employee completed the patient treatment at 4:15 PM (45 minutes beyond the end of their normal shift). This employee will be paid Call-Back for the 45 minutes worked into their scheduled On-Call time. The 2-hour minimum does not apply in the case where the employee's regular shift extends into the On-Call period.

8) Call-Back hours will only be paid for designated On-Call shifts and will end when a regular scheduled shift begins. For Example: An employee is scheduled On-Call from 11PM to 7AM and is scheduled for a regular shift beginning at 7AM. The employee is called back and reports to work at 6AM. The employee will receive 1 hour of Call-Back pay at 1 ½ times their regular rate of pay. (from 6-7AM) The two-hour Call-Back minimum does not apply because the employee is scheduled to end the On-Call shift and begin a regular shift at 7:00AM.

9) Cancellation of a scheduled shift and placing an employee On-Call activates the On-Call Pay Practice. An employee is eligible for On-Call pay if they have been flexed off for an entire scheduled shift or portion there of and placed On-Call. Additionally, the scheduled shift (or portion thereof) is considered cancelled. Thus, if an On-Call employee is called back in to work for a canceled but previously scheduled shift, the employee will be eligible for Call-Back pay.

3. 10) An employee may also be "flexed" for an entire shift or a portion thereof and not be placed On-Call; at which time the Call-Back practice does not apply (refer to **Administrative Human Resources Policy:** AP&P# 437 Flex/Float to Activity **437**).

4. 11) When an employee reports to work and begins to earn Call-Back time, the payment of On-Call pay will stop.

5. 12) Call-Back hours worked are considered hours worked for the purpose of computing overtime.

6. 13) On-Call and Call-Back hours shall be noted on the employee's timerecord; totaled separately and approved by the department director/designee.

14) Scheduled On-Call shifts are subject to the provisions of **Administrative Human Resources** Policy: #408,Absences and Tardiness **408**.

15) Exceptions to this policy must be reviewed and approved by the Vice President of Human Resources.

RELATED DOCUMENT(S):

Administrative Human Resources Policy: Absences and Tardiness 408

Administrative Human Resources Policy: Flex/Float to Activity 437

7.1. **Administrative Human Resources Policy: Premium Specialty Pay 473**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PAY PRACTICES

DELETE – incorporated into Administrative Policy: Flex/Float to Activity - 437

ISSUE DATE: 02/20/05 **SUBJECT:** Report In Pay

REVISION DATE(S): **POLICY NUMBER:** 473.06

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval	03/20
Medical Executive Committee:	n/a
Administration Approval:	08/20
Professional Affairs Committee:	n/a
Board of Directors Approval:	

~~TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL~~

~~TITLE: Report In Pay NUMBER: 473.06~~
~~POLICY REFERENCE: Premium and Specialty Program Pay AP #473;~~
~~Flex/Float To Activity AP #437~~
~~EFFECTIVE DATE: 2/20/05 NUMBER: 473.06 REVISION DATE: POLICY REFERENCE: Premium and Specialty Program Pay AP #473;~~
~~Flex/Float To Activity AP #437 RESPONSIBLE PARTY: VP/Human Resources APPROVAL:~~

~~PURPOSE:~~

~~To establish procedures to pay "report in pay" to eligible employees who are placed on HRTO (Hospital Requested Time Off) with insufficient notice and who report to work.~~

~~PROCEDURES:~~

~~1 A department director/designee will attempt to call employees at least one hour prior to the beginning of their shift to notify them if they are being placed on HRTO in accordance with Administrative Policy #437, Flex/Float to Activity.~~

~~2 If the employee is not contacted and reports to work, the employee will be paid two hours of "report in pay" at his/her base pay rate.~~

~~3 The department director/designee may require the employee to stay and work through the two hour "report in pay" period before being released from their shift.~~

~~4 "Report in pay" will be recorded as such on the employee's timecard. Employees who are sent home early on HRTO are not eligible for "report in pay".~~

~~RELATED DOCUMENT(S):~~

~~Administrative Human Resources Policy: Flex/Float to Activity 437~~
~~Administrative Human Resources Policy: Premium Specialty Pay 473~~

~~Pay Practice Manual Effective 2/20/05 1 of 1~~

Tri-City Medical Center
Oceanside, California

DELETE – no longer used

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE: 2/20/05 **SUBJECT:** Special Pay Practices

REVISION DATE(S): **POLICY NUMBER:** 473.08

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval:	10/19
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~**TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL**~~

~~**TITLE: Special Pay Practices EFFECTIVE DATE: 2/20/05 NUMBER: 473.08 REVISION DATE: POLICY REFERENCE: Premium and Special Program Pay AP #473 RESPONSIBLE PERSON: VP, Human Resources APPROVAL:**~~

~~**PURPOSE:**~~

~~To provide Directors with a method to staff emergent staffing vacancies in order to ensure quality patient care in the most cost effective manner available.~~

~~**PROCEDURE:**~~

~~1. The Director may request enactment of a special pay plan by submitting a proposal to their area Vice President for review and submission to the Human Resources Steering Committee for final approval.~~

~~2. The department proposal must include:~~

~~a. Reason for the request~~

~~b. Other measures taken to fill staffing vacancies, including recruitment efforts, current staffing vacancy status and attempts to schedule;~~

~~i. Part time staff~~

~~ii. Per Diem personnel~~

~~c. Anticipated time period for implementation, with specified end date for the special pay request.~~

~~d. Proposed job classification(s) for special pay.~~

~~3. Following final approval by the Human Resources Steering Committee, the Director will inform Payroll (in writing) of the specifications of the plan, time limitations and applicable department and job classifications.~~

~~4. Upon expiration of the approved time limitations, the Director will follow up with Payroll (in writing) to ensure that the special pay is no longer utilized.~~

~~5. Special pay practices will be in effect only for the designated time interval approved.~~

~~6. Extension of the special pay time interval requires area Vice President approval and must be reported to the Human Resources Steering Committee.~~

~~7. Approval will be for specific cost centers and for specific job classifications.~~

~~Pay Practice Manual Effective 2/20/05 1 of 2~~

~~1 Department Director/Clinical Manager approval is required before the beginning of the shift, or before special pay is offered to any employee.~~

~~2 Special pay eligibility must be in excess of any regularly and previously scheduled hours/shifts.~~

~~3 Use of unscheduled PTO, ALB, ELB during a pay period exempts the employee from special pay.~~

~~4 The Department Director/Clinical Manager must sign each line on the time card corresponding to the shift to which special pay applies.~~

~~5 Directors and Clinical Managers are generally exempt from special pay practices.~~

~~Pay Practice Manual Effective 2/20/05 2 of 2~~

Tri-City Medical Center
Oceanside, California

DELETE – use internal Human Resource process

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE: 10/3/04 **SUBJECT:** New Hire Pay Rates

REVISION DATE(S): **POLICY NUMBER:** 475.03

Human Resources Content Expert Approval:	10/19
Administrative Policies & Procedures Committee Approval:	10/19
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~TRI-CITY MEDICAL CENTER PAY PRACTICE MANUAL~~

~~**TITLE:** New Hire Pay Rates~~
~~**EFFECTIVE DATE:** 10/3/04 **NUMBER:** 475.03~~
~~**REVISION DATE:**~~
~~**POLICY REFERENCE: 475** Employee Compensation AP&P# 475~~
~~**RESPONSIBLE PARTY:** Human Resources~~
~~**EFFECTIVE DATE: 10/3/04**~~
~~**REVISION DATE:**~~
~~**APPROVAL:** _____~~

~~**PURPOSE:**~~
~~To ensure that all pay rate offers to external and internal candidates are determined in an equitable, consistent and timely manner.~~

~~**ELIGIBILITY:**~~
~~All internal and external candidates offered full time or part time opportunities for vacant positions within TCMC.~~

~~**PROCEDURES:**~~
~~1) Review the resume and/or application for completeness for all candidates who are under consideration for hire.~~
~~2) Determine applicable months/years of direct and indirect work experience. If the HR Business Partner is unable to determine whether work experience should be counted as direct or indirect, s/he should consult with the Hiring Manager to determine relevance to the position. Indirect eExperience may be credited as either 2 to 1 or 3 to 1 based on past practice and the discretion of the Business Partner and Hiring Manager HR.~~
~~3) Present and prior employers and dates of employment should be entered by the HR Business Partner into the factoring calculator under either direct or indirect experience.~~
~~4) If there are no identified issues, the HR Business Partner will notify the Hiring Manager of the factored pay rate to be offered and note the months of experience that were used in the determination.~~
~~5) If the Hiring Manager approves the factored rate, the HR Business Partner will contact the candidate, make the job offer, schedule a pre employment health screen, and schedule orientation dates. The factoring sheet will be attached with the new hire paperwork.~~
~~6) If the HR Business Partner believes the factored salary is not equitable with the salary of current employees in the same job code and department, and that significant issues may result from offering the factored salary, s/he will discuss the issue with the Hiring Manager and/or the Director of the~~

~~Department.~~

~~for their input.~~

~~New Hire Pay Rates – 10/3/04 1 of 2~~

~~7) If the Hiring Manager does not agree with the **rate,** factored salary and believes offering the salary may create internal equity and/or compression issues, the HR Business Partner will discuss the issue with the Compensation, Benefits/HRIS Director and Employment Services Director **HR Leadership** to determine proper course of action.~~

~~8) Internal candidates being considered for new positions may either be factored using the same process as above or given a percent pay increase/decrease based upon per pay line increase/decrease. Both options should be reviewed as well as the analysis of department equity to determine the best pay solution **appropriate rate.**The Department Director must approve any increases in rates above the determined factored rate but below the midpoint of the pay line range.~~

~~10) No external or internal candidates may be offered a salary above the midpoint of the pay range without Vice President approval.~~

~~11) As new positions are created, the Compensation, Benefits and Compensation Director must secure from the Department Director a new job description and determine the appropriate pay line and job code for the position. Once established, the new position is entered into the calculator by Compensation, and the spreadsheet is updated.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 08/10 **SUBJECT:** Staff Requests Not to Participate in Care

REVISION DATE: 04/12, 04/15 **POLICY NUMBER:** 8610- 480

Human Resources Department Approval:	**02/20**
Administrative Policies & Procedures Committee Approval:	**03/20**
Medical Executive Committee Approval:	**n/a**
~~**Human Resources Committee Approval:**~~	~~**04/15**~~
Administration Approval:	**08/20**
Professional Affairs Committee:	**n/a**
Board of Directors Approval:	**04/15**

A. **POLICY:**

1. It is the policy of the Tri-City Healthcare District (TCHD) to review and approve, as appropriate, employee requests not to participate in specific aspects of patient care due to an employee's religious or cultural beliefs.

B. **PROCEDURE:**

1. TCHD shall make reasonable efforts to accommodate such requests. The accommodation of such requests must not negatively impact patient care.
2. Treatments or procedures generally known to be in conflict with a person's religious or cultural beliefs may include:
   a. Administration of blood and blood products;
   b. Sterilization procedures;
   c. Treatment or procedures designed to bring about the termination of pregnancy;
   d. Organ procurement for transplant; and/or
   e. Withholding or withdrawing of life support or life sustaining measures.
3. Employees shall provide treatment and care to all persons in need without regard to **race, spiritual and religious belief, religious creed (including religious dress and grooming practices), color, national origin, ancestry, ethnicity, socio-economic status, education, social customs, physical disability, mental disability, medical condition (including AIDS and/or HIV status), genetic information, marital status, military and veteran status, sex, gender, gender identity, gender expression, age, sexual orientation, lifestyle, ability to pay, or any other status protected by State or Federal Law** ~~disability, race, creed, color, gender, national origin, lifestyle, or ability to pay.~~
4. Employees shall be given a copy of the Staff Requests Not to Participate in Care policy for review during the new hire processing appointment.
5. An employee who believes that a specific aspect of patient care or treatment is in conflict with ~~his/her~~ **their** beliefs, and who desire not to participate in that aspect of patient care or treatment, shall submit a Staff Request Not to Participate in Care form to ~~his/her~~ **their** supervisor as soon as the employee knows there is a conflict with the employee's belief and the care ~~he/she~~ **they are** ~~is~~ being required to provide.
6. Upon receiving such requests, supervisors, in consultation with appropriate clinical management personnel, shall determine what effect, if any, granting employee requests shall have on the delivery of proper patient care.
7. The Supervisor shall attempt to modify the employee's assignment based on request.

8. If it is determined that employee's requests may be granted without negatively ~~e~~affecting patient care, including treatment, the Supervisor shall grant the request.
   a. Supervisors shall devise specific and appropriate mechanisms to ensure that patient care, including treatment, shall not be negatively affected.
9. If it is determined the employees' request may not be granted, without negatively ~~e~~affecting patient care, including treatment, supervisors shall consult with Human Resources and inform employees that they shall participate in patient care until properly relieved from such duty.
   a. If an accommodation is not possible, the employee shall be permitted to explore other job opportunities within the hospital where an accommodation might be possible.
10. An employee who does not agree to provide appropriate care, treatment or services in an emergency because of religious, cultural or personal beliefs shall be placed on administrative leave from ~~his or her~~ **their** current position, and the incident will be reviewed.
11. **To the extent that any applicable collective bargaining agreement that is consistent with applicable law conflicts with certain provisions of this policy, the collective bargaining agreement for employees covered under that agreement prevails.**

C. **REFERENCED FORM WHICH CAN BE REQUESTED FROM HR:**
   1. **Staff Request Not to Participate in Care Form**

Tri-City Medical Cen

DELETE – no longer needed

Oceanside, California

ADMINISTRATIVE POLICY MANUAL
HUMAN RESOURCES

ISSUE DATE: 07/11 **SUBJECT: Step Progression**

REVISION DATE: 04/12 **POLICY NUMBER: 8610-481**

Human Resources Department Approval:	03/20
Administrative Policies & Procedures Committee Approval:	05/20
Medical Executive Committee Approval:	n/a
~~Human Resources Committee Approval:~~	~~04/15~~
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/15

~~A. PURPOSE:~~

~~1. The purpose of this policy is to provide employees who acquire additional educational, experiential, licensure, or certification requirement to advance from Step 1 to Step 2 in that same job classification. Such step progression will alleviate the need to post a new job opening. Eligible positions will be reviewed periodically. In each job description, the requirements for transition to the next step must be clearly articulated.~~

~~B. POLICY:~~

~~1. In order for an employee to be eligible to progress from Step 1 to Step 2 in his/her job category, he/she must be in the current benefited or per diem position for six months.~~

~~2. The employee must not have any written warnings in his/her file for the previous six months.~~

~~3. In order to advance to the next level of progression, the employee initiates the process described by this Policy and must complete an Employee Transfer Request (ETR).~~

~~4. He/She must also attach any documentation that demonstrates his/her qualifications or eligibility for the position.~~

~~5. The employee must sign an attestation statement to verify the information is accurate.~~

~~6. The employee must also sign an acknowledgement that he/she will adhere to the Service Standards.~~

~~7. Employees advanced under this Policy must adhere to Policy No. 430, monitoring Licenses, Professional Registrations, and Certificates.~~

~~8. Employees covered under a recognized collective bargaining agreement will be subject to the terms and conditions of their respective contract.~~

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 09/16

SUBJECT: ~~Hiring and~~ Employment Policy; Screening Current Employees

REVISION DATE(S): 09/16, 05/17

POLICY NUMBER: 8610 - 485

Human Resources Department~~Content Expert~~ Approval:	**~~05/17~~03/20**
Administrative Policies & Procedures Committee Approval:	**~~05/17~~04/20**
~~Human Resources Committee Approval:~~	**~~05/17~~**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/17**

A. **PURPOSE:**

1. To provide guidance of the Tri-City Healthcare District's (TCHD'S) policy regarding screening current employees.

B. **SCREENING CURRENT EMPLOYEES:**

1. Periodically, but at least on a monthly basis, TCHD shall screen current employees against the:
   a. Office of Inspector General List of Excluded Individuals/Entities (OIG LEIE), and
   b. ~~United States General Services Administration Excluded Parties List System (GSA EPLS)~~ **System For Award Management (SAM)**.

~~2. Periodically, but at least on an annual basis, TCHD shall complete criminal background checks for employees who are assigned to the Crisis Stabilization Unit (CSU), the Security Department and the Behavioral Health Unit (if applicable) or any other employee that floats to the CSU department.~~

~~3.~~**2.** Periodically, but at least on an annual basis, TCHD shall require each employee to certify ~~in writing~~ that the employee:
   a. Has not been charged with or convicted of committing any criminal offense;
   b. Does not have any charges pending for violating any criminal law;
   c. Has not been debarred, excluded or otherwise deemed ineligible for participation in Federal health care programs;
   d. Is not the subject of or otherwise part of any ongoing federal or state investigation; and
   e. Possesses a current professional license, registration, or certification, as applicable, and is in good standing with, and has had no Adverse Action taken by, any and all authorities granting such license, registration or certification, as applicable.

~~4.~~**3.** In the event that the employee cannot provide the certification set forth ~~in Section B.3~~ above, the employee shall provide complete and accurate information with respect to the matters at issue.

~~5.~~**4.** In addition, as specified in Administrative Policy: Pending Debarment, Criminal Charges or Adverse Action against Covered Contractors ~~8750~~-540, employees are required to report any criminal convictions under state or federal law, in writing to the Human Resources Department within five (5) working days of such convictions as per Administrative ~~Human Resource~~ Policy: Coaching and Counseling for Work Performance 424.

C. **RETENTION:**

1. Subject to legal constraints, TCHD shall not knowingly retain any employee if the employee **has one of the following**:
   a. Has been convicted of a criminal offense that has a bearing on the (a) trustworthiness of the employee, or (b) ability of the employee to perform relevant job responsibilities~~; or~~
   b. Has been convicted of committing a health care fraud-related criminal offense~~; or~~
   c. Is currently debarred, excluded or otherwise ineligible for participation in Federal health care programs~~; or~~
   d. Does not have a current professional license, registration or certification as applicable, and/or is not in good standing with, and/or has had Adverse Action taken by, the relevant state authorities that grant such license, registration or certification, as applicable.

D. **DOCUMENTATION:**

1. For employees, documentation shall be maintained in the employee's personnel file consistent with the TCHD's document retention policies.

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

1. Administrative Policy: ~~8750-424-~~Coaching and Counseling for Work Performance **424**
2. Administrative Policy: ~~8750-540-~~Pending Debarment, Criminal Charges or Adverse Action against Covered Contractors **540**

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 09/16

SUBJECT: ~~Hiring and~~ Employment Policy; Pending Charges against Current Employees

REVISION DATE: 09/16

POLICY NUMBER: 8610 - 486

Human Resources Department Approval ~~Date(s)~~:	~~05/16~~03/20
Administrative Policies and Procedures Approval ~~Date(s)~~:	~~09/16~~04/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
~~**Human Resources Committee Approval Date(s):**~~	~~09/16~~
Board of Directors Approval Date(s):	09/16

A. **PURPOSE:**

1. To provide guidance of Tri-City Healthcare District's (TCHD's) policy regarding pending charges against its employees.

B. **DEFINITIONS:**

1. Adverse Action – Adverse action means with respect to a professional license, registration, or certification, any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.
2. Federal health care program – The phrase "Federal health care program" shall have the same meaning as set forth at 42 U.S.C. 1320a-7b(f) and includes, by way of example, Medicare and Medicaid.

C. **ACTION PENDING RESOLUTION OF CHARGES:**

1. If TCHD learns that:
   a. A current employee has been charged with a criminal offense bearing on trustworthiness, or the ability of the employee to perform relevant job responsibilities;
   b. A current employee has been charged with a criminal offense related to health care fraud;
   c. A federal agency has issued a notice proposing to debar, exclude, or otherwise deem the current employee ineligible to participate in any Federal health care program, or;
   d. A state agency or authority has proposed to take an Adverse Action against a professional license, certification or registration of a current employee.
2. Then, pending resolution of the charges:
   a. If the employee is in a position that involves direct responsibility for, or involvement in, patient care or billing any federal, state or private payer, then the employee shall be placed on Administrative Leave.
   b. If the employee is not in a position that involves direct responsibility for or involvement in, patient care or billing any federal, state or private payer, then the employee shall not be appointed to such a position.

D. **DOCUMENTATION:**

1. For employees, documentation shall be maintained in the employee's personnel file consistent with the TCHD's document retention policies.

E. **REFERENCE(S)~~RELATED DOCUMENTS~~:**

1. 42 U.S. Code § 1320a–7b – Criminal penalties for acts involving Federal health care programs.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 09/16

SUBJECT: ~~Hiring and~~ Employment Policy; Conviction/Exclusion/License Revocation of Current Employees

REVISION DATE(S):

POLICY NUMBER: 8610 - 487

Human Resources Department Approval ~~Date(s)~~:	~~05/16~~03/20
Administrative Policies and Procedures Approval ~~Date(s)~~:	~~09/16~~04/20
Medical Executive Committee Approval:	n/a
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
~~**Human Resources Committee Approval Date(s):**~~	~~09/16~~
Board of Directors Approval ~~Date(s)~~:	09/16

A. **PURPOSE:**

1. To provide guidance of the **Tri-City Healthcare District's** (TCHD's) policy regarding the criminal conviction, debarment or exclusion of employees, or revocation of the professional license, certification or registration of an employee.

B. **ACTION FOLLOWING CONVICTION/PROHIBITION/LICENSE REVOCATION:**

1. If a TCHD employee:
   a. Has been convicted of a criminal offense that bears on trustworthiness, or the ability to perform relevant job functions or is related to health care fraud, or;
   b. Has been debarred, excluded or otherwise deemed ineligible to participate in Federal health care programs, then, subject to legal constraints, TCHD shall terminate the employee.
2. If a TCHD employee has had ~~his or her~~ **their** professional license, registration, or certification revoked, cancelled or otherwise removed or nullified, then (assuming that such license, registration or certification is needed to fulfill the duties and obligations of the employee), subject to legal constraints, TCHD shall terminate the employee .

C. **DOCUMENTATION:**

1. For employees, documentation shall be maintained in the employee's personnel file consistent with the TCHD's document retention policies.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
HUMAN RESOURCES

ISSUE DATE: 09/16

SUBJECT: ~~Hiring and~~ **Employment Policy; Employee Requirements to Report Changes in Certification**

REVISION DATE(S):

POLICY NUMBER: 8610 - 488

Human Resources Department Approval ~~Date(s)~~:	~~05/16~~**03/20**
Administrative Policies and Procedures Approval ~~Date(s)~~:	~~09/16~~**04/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
~~**Human Resources Committee Approval Date(s):**~~	~~**09/16**~~
Board of Directors Approval ~~Date(s)~~:	**09/16**

A. **PURPOSE:**

1. To provide guidance of Tri-City Healthcare District's **(TCHD's)** policy regarding the requirement that employees report changes to their last certification regarding criminal acts, Adverse Action, and other events, to TCHD.

B. **GENERAL POLICY:**

1. TCHD employees are required to report any changes to their most recent certification per Administrative Policy: ~~485~~**Employment Policy; Screening Current Employees,** to TCHD immediately.

C. **SPECIFIC POLICY:**

1. As provided in Administrative Policies:
   - **a. Employment Policy; ~~538~~Screening for Eligibility of Prospective Employees/ Covered Contractors 538~~,~~**
   - **b. Employment Policy; ~~and 485~~Screening Current Employees 485**
   - **c. Employment Policy; Pending Charges against Current Employees 486**
   - **d. Employment Policy; ~~through 487~~Conviction/Exclusion/License Revocation of Current Employees~~,~~ 487**

~~1.~~**2.** TCHD screens prospective employees and requires current employees to certify to the absence of criminal activity, exclusion, or Adverse Action, etc.

~~2.~~**3.** In addition, each TCHD employee must report any criminal convictions under state or federal law, in writing to the Human Resources Department within five (5) working days of such conviction as per Administrative ~~Human Resource~~ Policy: Coaching and Counseling for Work Performance **424** ~~424~~.

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

1. Administrative Policy: ~~538 – Hiring and~~ Employment **Policy**; Screening for Eligibility of Prospective Employees **538**
2. Administrative Policy: ~~485 – Hiring and~~ Employment **Policy**; Screening Current Employees **485**
3. Administrative Policy: ~~486 – Hiring and~~ Employment **Policy**; Pending Charges Against Current Employees **486**
4. Administrative Policy: ~~487 – Hiring and~~ Employment **Policy**; Conviction/Exclusion/License Revocation of Current Employees **487**
5. Administrative Policy: ~~424 –~~ Coaching and Counseling for Work Performance **424**

Tri-City Medical Center
Oceanside, California

DELETE – no longer needed, follow Administrative Policy: Policy and Procedure Approval

ADMINISTRATIVE POLICY
PAY PRACTICES

ISSUE DATE: : 10/4/03

SUBJECT: Pay Practice Development

REVISION DATE(S):

POLICY NUMBER: 775

Human Resources Content Expert Approval:	**11/19**
Administrative Policies & Procedures Committee Approval	**11/19**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	
Professional Affairs Committee Approval:	
Board of Directors Approval:	

~~**PURPOSE:**~~

~~To establish procedures to insure "Pay Practice Guidelines" and "Fact Sheets" stay current and in compliance with Board approved pay policies.~~

~~**PROCEDURES**:~~

~~1) The Pay Practice Manual consists of a series of pay practice guidelines on various topics. These guidelines describe procedures and detailed information necessary for payroll and benefits administration.~~

~~2) The development and approval steps follow:~~

~~A. Board of Directors approves pay policies.~~
~~B. Administration approves pay practice manual consisting of pay practice guidelines.~~
~~C. Human Resources, Employee Health and Finance management, create and maintain pertinent procedures/fact sheets.~~

~~3) Human Resources is responsible for administration of the pay policy manual. This includes periodic revisions to existing and new practices and distribution of the manual.~~

~~4) The manual will be available electronically on the TCMC Intranet.~~

~~5) Approval Process for Revisions. All new guidelines or revisions to existing guidelines will be approved by Administration.~~

~~a) Prior to Administration approval, guidelines need to be reviewed by all appropriate areas. These must include Human Resources and Finance. These may include other groups such as AP &P Committee or HR Steering Committee.~~
~~b) Each pay practice guideline will have a primary stakeholder whose responsibility is to keep the guideline current.~~

~~6) Pay Practice Guidelines will be periodically reviewed and updated when required~~

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93

SUBJECT: Contraindication to Cardiac Rehab Exercise

REVISION DATE: 6/97, 6/03, 12/05, 11/07, 12/12,

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	07/20
Medical Executive Committee Approval:	07/20
Administrative Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**
1. To establish contraindications to cardiac rehabilitation exercise.

B. **POLICY:**
1. Patients with one or more of these contraindications shall not be allowed to exercise.

C. **DEFINITIONS:**
1. Contraindications to exercise:
   a. Unstable angina
   b. Resting diastolic blood pressure of greater than 110 mm Hg or systolic BP greater than 210 shall be evaluated on a case by case basis
   c. Orthostatic blood pressure drop of greater than 20 mm Hg with symptoms
   d. Acute systemic illness or fever
   e. Uncontrolled atrial or ventricular arrhythmias
   f. Uncontrolled sinus tachycardia (greater than 120 beats per minute)
   g. Uncompensated congestive heart failure
   h. Glucose level greater than 300 unless cleared by physician (participants primary MD or Cardiac Wellness Medical Director and/or supervising physician)

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT:** Exercise Prescription

REVISION DATE: 12/05, 10/07, 01/08, 12/12

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**07/20**
Medical Executive Committee Approval:	**07/20**
Administrative Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**
1. To establish guidelines for prescribing maximal safe exercise for cardiovascular patients.
2. To establish guidelines for exercise prescriptions that enhances cardiopulmonary endurance, body composition, flexibility, muscular strength and muscular endurance.

B. **POLICY:**
1. The exercise prescription signed by the MD shall allow a patient to begin program at a low level of intensity, increasing to reach target heart rate (THR) or other specified parameters set by patient's physician. The intensity, duration, and type of exercise to be performed shall be determined by the cardiac rehabilitation staff. The cardiac rehabilitation staff shall be responsible for development of the exercise prescription, which shall bear the appropriate signature. The Cardiac Rehabilitation Registered Nurse, Exercise Physiologist, and/or exercise technician is to increase or progress the intensity or workload in order to meet target heart rate. Exercise prescription for Phases II and IV of Cardiac Rehabilitation Programs shall be developed in accordance with the patient's health history and clinical status.

C. **GENERAL GUIDELINES:**
1. Intensity of exercise shall be prescribed not to exceed 85% of the maximal predicted heart rate. Intensity of exercise may be prescribed by heart rate, rating of perceived exertion (RPE) or by METS. The target heart is calculated by calculating 60-80% of maximum heart rate, using the physician approved age-related chart for maximum heart rate.
2. The Rating of Perceived Exertion (RPE) Scale may be used as a valid and reliable indicator of the level of physical exertion during constant intensity exercise to establish exercise prescription intensity.
   a. Patients shall self-monitor the RPE at a specified heart rate until the heart rate – RPE relationship is learned. Then the RPE may be employed as an additional method for regulating intensity.
   b. The intensity of exercise may be prescribed by determining 70% of the patient's maximum predicted heart rate and then selecting activities with energy expenditure in METS at the desired level.
3. Duration of the conditioning phase shall be 30-60 minutes and the patient shall report no undue fatigue an hour after exercise completion.
4. The frequency of exercise sessions shall be 3 times weekly.
5. Progression in the outpatient exercise program is dependent on the patient's functional capacity, clinical status and needs or goals. The heart rate, signs and symptoms are indicators for progression to higher metabolic workloads.
6. The type of exercise performed may include aerobic activities such as walking/running, bicycle ergometer, rowing machine, recumbent bicycle, recumbent stepper, elliptical cross-trainer, arm ergometer, and free weight workouts. With supervising physician approval, patients can

participate in the group strength training classes. Light weights (1 pound each arm up to 10 pounds each arm) with repetitions may be employed to increase muscle strength and endurance. Patients with uncontrolled hypertension, uncontrolled dysrhythmias or poor cardiac reserve are excluded from the weight conditioning, group strength training classes, upright elliptical cross trainer machine, or circuit weight/universal gym.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Exercise Protocol, Phase II**

REVISION DATE: 6/97, 3/03, 01/08, 12/12

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**07/20**
Medical Executive Committee Approval:	**07/20**
Administrative Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**
1. To establish guidelines for exercise protocols that ensures patients safety and efficient equipment usage.

B. **POLICY:**
1. All patients in Phase II of the Cardiac Wellness Program shall follow this procedure for exercise.

C. **GENERAL GUIDELINES:**
1. Cardiac rehabilitation patients shall attend at least 75% of the prescribed exercise sessions, which are held three times a week.
   a. Entry blood pressure, pulse rate, and body weight are recorded on the patient's record
   b. Telemetry monitoring systems are connected and recorded
   c. Warm-up and stretching exercises are performed prior to exercise for 5-10 minutes.
   d. Aerobic capacity and intensity are monitored during peak exercise through measurements of heart rate, blood pressure, and perceived exertion.
   e. The patient is responsible for learning pulse rate monitoring and documentation.
   f. Cool-down and stretching exercises are performed for 5 to 10 minutes.
   g. Exercise modality and intensity, exercise time, exercise blood pressure, exercise pulse rate, and perceived exertion scale are recorded on the patient's record.
   h. Patients are responsible for informing the cardiac rehabilitation staff of any changes in their medical condition, medication changes, signs and symptoms of cardiac insufficiency, and/or any health related information.
   i. Medical Director and/or the supervising physician shall be readily available at all times to review exercise prescriptions, rhythms, answer questions, and assist in emergency situations for Phase II and III patients.
2. Phase II participants shall be asked to attend education lectures (1 ~~per~~ **every other** month) regarding risk factor modification. These lectures shall include, but not be limited to Risk Factor Modification, Nutrition, Exercise, Stress Management, and a session of general questions and answers with ~~a staff physician~~ **staff and dietician**. In addition to the risk factor lectures, a DVD series of risk factor reduction topics, i.e. diabetes management, nutrition, stress reduction and managing heart failure are also available for viewing. A library of education topics is also given to participants on request.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Exercise Protocol, Phase IV**

REVISION DATE: 6/97, 3/03, 01/08, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	07/20
Medical Executive Committee Approval:	07/20
Administrative Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**
1. To establish guidelines for exercise protocols that ensures patient safety and efficient equipment usage.

B. **POLICY:**
1. All patients in Phase IV of the Cardiac Rehabilitation Program shall follow this procedure for exercise.

C. **GENERAL GUIDELINES:**
1. Cardiac rehabilitation patients shall attend exercise sessions up to five days per week, their choice.
   a. Entry blood pressure and pulse rate is recorded on the patient's record.
   b. Telemetry monitoring systems are connected and recorded quarterly or more frequently if ordered (i.e., patient is returning to the Cardiac Rehabilitation Program after hospitalization, leave of absence of one month or greater), at participants request or staff's discretion.
   c. Warm-up and stretching exercises are performed prior to exercise.
   d. Aerobic capacity and intensity are monitored during peak exercise through measurements of heart rate and blood pressure.
   e. The patient is responsible for learning pulse rate monitoring and documentation.
   f. Cool-down and stretching exercises are performed for 5 to 10 minutes.
   g. Exercise, pulse rate and perceived exertion scale are recorded on the patient's record.
   h. Patients are responsible for informing the cardiac rehabilitation staff of any changes in their medical condition, medication schedule or any health related information.
   i. Patients are invited to attend any of the group strength training classes, yoga classes, or education lectures.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT:** Patient Discharge Criteria

REVISION DATE: 6/97, 3/03, 10/07, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	07/20
Medical Executive Committee Approval:	07/20
Administrative Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**
1. To establish the requirements for patient discharge from the Cardiac Rehabilitation Program.

B. **POLICY:**
1. All Cardiac Rehab patients shall be evaluated prior to discharge and results of evaluation documented in the participant's medical record.

C. **GENERAL GUIDELINES:**
1. Patients shall be discharged from the Cardiac Rehabilitation Program when the following criteria are met:
   a. Normal hemodynamic responses to exercise, including appropriate blood pressure, normal or unchanged ECG at peak exercise with a stable or medically acceptable ischemic response.
   b. Stable or absent angina.
   c. Stable and/or controlled resting heart rate and blood pressure (i.e., less than 90 beats per minute and 140/90 respectively).
   d. If above criteria is not met, physician shall be informed and an extension to the program shall be requested. If request or authorization for extension is denied, the patient shall be offered a continuation of program on cash basis.
2. Patients shall have adequate muscular strength, endurance, functional capacity and body composition for activities of daily living and occupational needs.
3. Patients shall have satisfactory understanding of the following:
   a. Basic pathophysiology of their cardiovascular disease.
   b. Rational for interventions and lifestyle modifications.
   c. Lifestyle characteristics associated with low risk of coronary artery disease.
   d. Medication information.
   e. Range of safe activities for sexual, vocational and recreational pursuits.
4. Patients shall demonstrate an ability to maintain the exercise prescription within the designed ranges and to recognize signs and symptoms of exertion intolerance, as demonstrated through their exercise session reports.
5. A discharge summary shall be sent to the referring physician upon completion of the program.
6. Supervising physician shall complete a discharge evaluation with patient, which shall include options for continuation of exercise program, outcome results from quality measures, and an education discussion utilizing the health knowledge test.
7. ~~7.~~ Patients shall complete a program evaluation form.
8. **Patients may also be discharged at anytime due to lack of attendance at the discretion of staff.**

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Patient Enrollment Protocol**

REVISION DATE: 6/97, 3/03, 12/05, 01/08, 12/12

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**07/20**
Medical Executive Committee Approval:	**07/20**
Administrative Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

A. **PURPOSE:**
1. To establish guidelines for enrolling new patients into a Cardiac Rehabilitation Program.

B. **POLICY:**
1. Patient must meet criteria for patient selection.
2. Patient's physician will sign referral stating there are no known contraindications to patient exercising at the time of admission.
3. Patient shall sign exercise consent allowing staff to set guidelines for gradually progressive graded exercise.

C. **GENERAL GUIDELINES:**
1. All patients seen by the cardiac rehab staff during their inpatient stay shall be contacted by staff after an appropriate interval of recuperation at home, to find out how the patient is doing and determine interest in our Outpatient Cardiac Rehabilitation program.
2. Patient's physician shall be contacted and admission to Cardiac Rehabilitation requested. Physician approval shall be accompanied by signed referral.~~.~~
3. Insurance authorization shall be obtained by staff members and patient shall agree to be responsible for any difference between amount billed and amount paid by insurance company, as well as any co-payment necessary under their insurance contracted benefits.
~~3.~~**4. If the patient's primary physician or cardiologist does not feel an exercise stress test is necessary or appropriate, the patient's target heart rate shall be determined and monitored by the Cardiac Rehabilitation staff using age determined target heart ranges and/or rest plus 30 beats (if patient is taking beta blocker medication). The patient's perceived exertion shall ot exceed the Borg Scale of 15.**
~~4.~~5. Patient shall come to Cardiac Rehabilitation for intake and a patient history shall be obtained.
   a. Physical, emotional and psychosocial limitations shall be assessed and documented, to ensure maximum benefit and safety of each participant
   b. Relevant medical records shall be obtained and kept as a part of patient's record. These shall include but not be limited to, a discharge summary and recent ECG.
~~5.~~6. ~~Cardiac Rehab staff shall follow "Intake Procedure," attached. (Patient Demographics Entry Form)~~

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVI

DELETE- verbiage included into Patient Enrollment Protocol

ISSUE DATE: 11/88

SUBJECT: Patient Referral

REVISION DATE: 6/97, 3/03, 01/08, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	07/20
Medical Executive Committee Approval:	07/20
Administrative Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

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

~~1. To establish guidelines for patient referral for Cardiac Rehabilitation Program.~~

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

~~1. All patients must be referred to the Cardiac Rehabilitation Program by a physician order after the patient meets the "Criteria for Patient Selection."~~

~~C. **GENERAL GUIDELINES:**~~

~~1. The physician shall sign the referral, indicate a target heart rate, and, if possible, provide recent laboratory results indicating lipid levels.~~

~~2. If the patient's primary physician or cardiologist does not feel an exercise stress test is necessary or appropriate at this time, target heart rate shall be determined and monitored by the Cardiac Rehabilitation staff using age determined target heart rate ranges and/or rest plus 30 beats (if patient is taking a beta blocker medication. The patient's perceived exertion shall not exceed the Borg Scale of 15.~~

~~3. Refer to the following sample "Cardiac Rehabilitation Program Patient Referral Form."~~

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES
~~TRI-CITY MEDICAL CENTER~~
~~POLICY AND PROCEDURE~~

ISSUE DATE: 12/12 **SUBJECT:** Scope of Service

REVISION DATE(S):

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**07/20**
Medical Executive Committee Approval:	**07/20**
Administrative Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

~~Department: Cardiac Wellness Center~~	~~Issue Date: 12/12~~	~~Revision Date: 2/20~~
~~Title: Scope of Services~~		
~~Submitted By: Supervisor of Cardiac Wellness~~		

A. **GOALS:**
1. To provide individualized quality patient care in a safe environment.
2. To produce an optimal reduction of cardiac risk factors and build/maintain optimal physical conditioning
3. To continuously evaluate and improve the service provided.
4. To participate in interdisciplinary care by working closely with other disciplines.
5. To educate participants and their family members about cardiovascular disease

B. **BRIEF DESCRIPTION OF SERVICE:**
1. The Cardiac Wellness Center (CWC) provides progressive exercise, education, and risk factor modification training, under medical supervision, to individuals with or at risk for coronary artery disease. Cardiac rehabilitation services are prescribed and initiated from the perspective of case management for the individual patient. Inherent within case management is giving attention to the patient's needs (including physical, social, psychological, and vocational needs) as well as the patient's family system. The program provides the necessary screening and assessment to ensure appropriate care. Intervention is prescribed in stages during the patient's course of recovery.

C. **METHODS USED TO ASSESS PATIENTS' NEEDS:**
1. Initial patient assessments are performed by the CWC staff during the first monitored exercise and intake appointment. The supervising physician meets with the patient during his/her second monitored visit to create together an individualized treatment plan. Reassessments are performed by the supervising physician ~~after 12 exercise sessions~~ **every 30 days** or when a change in status occurs. The CWC staff assesses the patient's exercise response and any signs and symptoms of cardiac insufficiency at each exercise visit, and adjusts the exercise prescription accordingly.

D. **SCOPE AND COMPLEXITY OF SERVICES:**
1. The program is designed to meet the needs of people of all ages who have CAD or may be at risk for developing CAD. The program is also open to persons who would prefer to exercise

under medical supervision in a gym type setting. A physician referral and clearance is necessary for participation in all program phases. The services provided by the CWC include: Inpatient education and instruction for discharge, home exercise guidelines (phase I) and when to begin the outpatient program (phase II),Outpatient exercise program (phase II and phase IV),ECG monitoring, Medically supervised exercise training sessions, Individualized exercise prescription, Initial, mid-point, and discharge evaluations by the CWC medical director/supervising physician, Blood pressure monitoring, Pre and Post Program outcome measurements, Group classes including strength training, stretching, balance, and yoga for beginners to advanced participants. Program includes Education DVD library, Written educational materials, including take home quizzes, ~~Group organized social events (i.e. Holiday party, summer picnic, Carrillo Ranch fieldtrip, Flower fields fieldtrip).~~ Medicare/Medical covered diagnoses for cardiac rehabilitation include only the following: Stable Angina, Coronary artery bypass graft surgery (CABG), Coronary artery angioplasty (PTCA) and/or coronary artery stent placement, Myocardial infarction (MI), Heart Transplant, and Heart valve repair or replacement surgery.

E. **TYPE AND AGE OF PATIENTS SERVED:**

1. The types of patients seen in the CWC or by the CWC staff fall into different described phases:
   a. **Phase I:** Acute phase, inpatient status, patient is still suffering from acute event **Phase II:** The entry evaluation and achievement of specific safety and behavioral outcomes occur here, as well as close monitoring of HR, BP, and ECG monitoring. This phase is usually covered by insurance and can last 12-36 sessions (3 days per week).
   b. **Phase IV:** This is the maintenance phase. In this phase, patients continue their exercise training and receive necessary and appropriate support from the CWC staff in accordance with their individual needs. This is equivalent to a gym membership and is a self pay program. The age of the population served varies. Anyone can join the program with a signed referral from their physician.

F. **STAFFING AND THE AVAILABILITY OF STAFF:**

1. The CWC is staffed with: Board Certified and CA licensed physicians, Registered nurses, Exercise Physiologists, Exercise Technicians, and Support staff which may include a registered dietician and licensed psychologist. Staffing is dependent upon the needs of the department, which is determined by patient volume and needs under the American Association of Cardiovascular and Pulmonary rehabilitation (AACVPR). AACVPR states cardiac rehabilitation programs must have a staff to phase II patient ratio of 1:4 and a phase IV staff to patient ratio of 1:10. BLS and ACLS are required of all nursing personnel working in the Cardiac Wellness Center. Initial and annual competency requirements for staff are defined and updated on a yearly basis.

G. **ASSESSING DEPARTMENT SERVICES:**

1. The CWC has two locations: the hospital campus in Oceanside and the Tri City Wellness center in Carlsbad. Hours of service are: **Hospital campus** open M-T-TH 7am-~~5~~**3:30**pm and W-F 7am-12 noon. **Carlsbad** opens M-T-TH ~~8:30am~~**8:00am**-~~12 noon.~~**11:00am**

H. **THE EXTENT TO WHICH THE DEPARTMENT'S LEVEL OF CARE/SERVICE MEET PATIENT NEEDS:**

1. The level of care provided by the Cardiac Wellness Center meets the needs of both inpatients and outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

I. **PERFORMANCE IMPROVEMENT**

1. In order to improve patient care, several indicators are monitored to measure care given and effect change. The CWC results are compared to national and/or system-wide benchmarks,

when available, or the department's own historical data. Unmet goals, or measures of no change, are perceived as opportunities for improvement. The CWC patient surveys are designed to measure outcomes and quality of patient care and to seek ways to improve the services offered. The key outcomes measured are: MET level (physical fitness), Diet scores (decreased fat, increased fiber),Body Mass Index and waist circumference (weight loss), Beck inventory (depression), Perception of cardiovascular health, mental health, muscular strength, and flexibility ,Compliance to an exercise program, Program satisfaction/recommendation to others, Satisfaction with education component of program (and improvement in health knowledge), and Confidence in staff's ability/safety of program.

J. **STANDARDS USED BY THE DEPARTMENT IN THE CARE OF PATIENTS:**

1. The policies, procedures, and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include the American Heart Association (AHA), American College of Sports Medicine (ACSM), and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). ~~The CWC (hospital site) is also a~~ **Both locations are** nationally certified cardiac rehabilitation programs through AACVPR. ~~(since 2005).~~

K. **MEDICATION ADMINISTRATION STANDARDS RELATED TO CARE OF THE PATIENT:**

1. Nitroglycerine is kept in a locked drawer at the nurses monitoring station in a box with the expiration date clearly marked. The key to open the drawer is found in the center drawer of the nurses' station. The supervising physician/medical director signs a written standing order for PRN NTG use on the initial patient evaluation treatment plan. Staff assesses and documents the administration/effectiveness and side effects when Nitroglycerine is administered.

Tri-City Medical Center	Emergency Department
PROCEDURE:	**DEATHS OF PEDIATRIC PATIENTS PRONOUNCED IN THE EMERGENCY DEPARTMENT**
Purpose:	Trauma Intervention Program (TIP) Representative if available will provide grief counseling for the family and assist in the coordination for the release of the remains.
~~Supportive Data:~~	~~N/A~~
~~Equipment:~~	~~N/A~~
~~Issue Date:~~	~~Revision Date(s): 09/07; 02/11~~

A. **CRITERIA FOR REFERRAL:**

1. A child could be pronounced dead in the Emergency Department in three (3) major situations; in each of these situations, it is appropriate for a Trauma Intervention Program Representative (TIP) to be involved **as available**.
   a. Traumatic injury.
   b. **Sudden Infant Death Syndrome** (SIDS)/Medical Code.
   c. End stage of chronic illness.

B. **PROCEUDURE:**

1. **Provider shall attempt to introduce the** TIP Representative **to the** ~~shall meet~~ family; **TIP Representative shall explain their**~~introduce~~ role and provide crisis intervention and information as appropriate in response to the family needs.
2. TIP Representative shall **attempt to** keep apprised of patient status and in consultation with physician, ~~shall ensure family is kept~~ **attempt to keep family** informed of patient status and efforts at resuscitation, while assessing family coping on an on-going basis.
3. TIP Representative shall ordinarily accompany the physician when the parents are informed of the status and/or death of the patient and **attempt to** provides crisis intervention, information and education as appropriate to the situation. It is the primary responsibility of TIP to facilitate the grieving process for the family.
4. TIP Representative **will attempt to** ensures that designated staff shall discuss options for organ and tissue donation when appropriate in the grieving process and in accordance with regulatory requirements and hospital protocol.
5. When appropriate, TIP Representative explains the role of the coroner and ensures designated personnel contact the Office of the Coroner.
6. The ~~ANM/~~Charge RN contacts the Administrative Supervisor and the Chaplain to inform them of the death of the patient, whether the patient is a coroners' case, status of organ/tissue donation and status of plans for disposition.
7. ~~The Customer Service Representative shall facilitate reporting requirement and completion of the required paperwork according to regulatory requirements and hospital protocol as needed.~~

C. **GRIEVING PROCESS:**

1. TIP Representative shall **coordinate with the Charge RN to** facilitate identification of appropriate location to allow the family to spend some time with the decedent.
2. TIP Representative shall remain available to the family while they remain with the decedent, responding to any requests, providing grief counseling and support appropriate to the situation.

~~D. APPROVAL PROCESS:~~

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

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/07, 02/11, 02/20	06/20	n/a	07/20	08/20	n/a	

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**SUBJECT:**	**Leave Without Treatment (LWOT), Against Medical Advice (AMA), or Elopement**

REVISION DATE(S): 07/10; 02/11, 08/15

Department Approval ~~Date(s)~~:	**~~10/14~~02/20**
Department of Emergency Medicine Approval ~~Date(s)~~:	**~~11/14~~06/20**
Pharmacy and Therapeutics Approval ~~Date(s):~~	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~01/15~~07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~08/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**08/15**

A. **DEFINITIONS:**

1. To define and provide guidelines for the management and documentation of patients who leave without treatment (LWOT), against medical advice (AMA) or elope.

B. **POLICY:**

1. All patients who request to leave the Emergency Department (ED) prior to evaluation by a **ED** physician or **Allied Health Professional (AHP) and/or ~~Physician's Assistant~~ prior to** completion of treatment will be encouraged to stay.
2. Patients who leave the ED AMA will be requested to sign the appropriate form.
3. Appropriate steps will be taken to **attempt to** locate patients who elope.

C. **PROCEDURES:**

1. Leaving without treatment (LWOT): Patients who have been registered for treatment, but **have** not **been** seen by the ED physician/**AHP ~~or Physician's Assistant.~~** Treatment may or may not have been started in triage.
   a. All patients who express the desire to leave before being seen by the ED physician/**AHP ~~or physician's assistant~~** will be encouraged to stay. As appropriate, a request may be made to the ED physician/**AHP ~~or physician's assistant~~** to speak with the patient.
   b. Patients who leave the ED prior to seeing a physician/**AHP ~~or physician's assistant~~** and have been assessed by the triage nurse or leave before seeing the triage nurse will have an ED clinical record started which will include the following **as possible**:
      i. Name
      ii. Chief complaint
      iii. ~~Admit status~~**Focused Assessment including** /mental status, /airway/, skin
      iv. ~~Triage classification~~**ESI,**/ Registered Nurse signature, /time
      v. Vital signs
      vi. Any treatment started in triage
      vii. When known, the narrative is to include the reason and time the patient left without being seen **and/or when it was discovered as well as attempts to locate the patient.**
      viii. The narrative must explain the reasons for inability to collect any of the above information.
   c. For minors who leave the department prior to seeing a physician/**AHP ~~or physician's assistant:~~**
      i. Every attempt must be made to contact the parents or guardian to inform them of the minor's presence in the ED.

ii. Document the contact or the attempt to contact the parents or guardian.
iii. The exception to the above are minors who are emancipated or on active military duty. Other exceptions are when the complaint involves a sexual disease, pregnancy, sexual assault and drug or alcohol related problems.

d. For patients who are not oriented or who are expressing suicidal/homicidal ideation, consult with the physician on duty to determine if a 5150 hold is appropriate.

e. **Attempt to** ~~H~~have patient~~s~~ sign "~~Withdrawal of Request for Medical Service~~**Left Without Treatment Form**~~.~~".

2. Against Medical Advice (AMA): Patients who have been seen by the ED physician/**AHP** ~~**or phsysician's assistant**~~ and who decide to leave before treatment is completed.

a. When a patient expresses the desire to leave AMA, the ED physician/**AHP**~~**physician's assistant**~~ shall be informed and every effort shall be made to encourage the patient to remain in the ED.

b. The ED physician/**AHP**~~**physician's assistant**~~ must attempt to provide the patient with information regarding the potential consequences of the action to include the risks involved in leaving, the benefits of continuing the treatment, and any alternatives so that the patient can make an informed decision.

c. Whenever a patient demands to leave before treatment is completed or contrary to the advice of the ED physician/**AHP** ~~**physician's assistant**~~, a "Leaving Hospital Against Medical Advice" form shall be completed.

d. If the patient refuses to sign this form, the notation "patient refuses to sign" shall be made in the space provided for the patient's signature. The witness shall sign his/her name, the exact time, and date.

e. A competent adult that is not on any legal hold or court ordered quarantine or detention may not be detained against his/her wishes.

f. Precautions shall be taken to assure the patient leaves the hospital in a safe manner.

g. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to encourage the patient to complete treatment, and any patient discharge instructions that were given.

3. Elopement – non-5150: Patients who have been seen by the physician/**AHP** ~~**or physician's assistant**~~ and left the ED without informing staff.

a. When it is discovered that a patient has left the ED without informing the staff, the ED ~~AUM and/or~~ Charge RN shall be notified immediately. The patient's family, primary physician, Manager/Director or ~~Operations~~ **Administrative** Supervisor shall be notified as appropriate.

b. Attempts shall be made to locate the patient. Hospital security and/or law enforcement shall be notified as appropriate.

c. Documentation on the patient's chart shall include a summary of the events that led to the incident, attempts to locate patient, and who was notified of the patient's elopement.

D. DOCUMENTATION

1. Documentation on the patient's chart shall include a summary of the events surrounding the incident, attempts to locate patient, and who was notified of the event.

E. FORMS:

1. AMA Form (8723-1001-Englis~~g~~h and 8723-1003-Spanish)
2. LWOT Form (7010-1027~~6~~-English)

F. REFERENCES:

1. California Hospital Association, *EMTALA – A Guide to Patient Anti-Dumping Laws, 8th ed.* (2012)
2. Title 22, California Code of Regulations, Section 70707(b)(10)

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**SUBJECT: Notification: Patient Follow-up**
REVISION DATE(S): 08/10; 02/11	~~**POLICY NUMBER: 7010-011**~~
Emergency Department Approval:	**02/20**
Department of Emergency Medicine Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	

A. **DEFINITIONS:**

1. Patients will be notified when additional treatment, studies or medications are required.

B. **POLICY:**

1. ~~**POLICY for**~~ **Radiograph Procedures:**
   - a. **All Emergency Department (ED) radiology studies are read in real time by either the in-house Radiologist or Stat Rad Radiologist.**
   - ~~The Emergency Department (ED) **physician/Allied Health Professional (AHP)** physician or physician assistant will provide a preliminary and/or final x-ray report on all images not read by the Radiologist.~~
   - ~~1.~~**b. All Stat Rad readings are over-read by the in-house Radiologist the following day. In the event of a discrepancy, the Physician/Allied Healthcare Professional (AHP) will be notified by the Radiologist and**~~Physicians to~~ **will** review ~~all x-ray interpretation~~**these** discrepancies **to determine the need for follow up.** ~~Interpretation disagreements will be referred for further evaluation and the discrepancy will be referred to an ED physician/AHP or physician assistant.~~
   - ~~2.~~**c.** Physician/**AHP** to evaluate and recommend intervention if necessary:
     - ~~a.~~**i.** If intervention is not necessary, **documentation is entered in the electronic health record (EHR) that the discrepancy is not clinically significant.** ~~file in ED.~~
     - ~~b.~~**ii.** If **the discrepancy is determined to be clinically significant**~~intervention necessary~~, **the Physician/AHP will** ~~fill out call back form and~~**contact the patient to** inform patient of discrepancy and recommendations, **and will document this in the EHR.**

~~3.~~2. ~~**POLICY for Bacteriology**~~ **Microbiology (**~~**Lab**~~**Culture) Results:**

- a. **All positive cultures performed in the ED are electronically tracked in Cerner.**
- b. **Emergency Department nurses review this worklist and screen out those for whom appropriate treatment had already been started.**
  - i. **All other positive cultures are referred to the Emergency Department (ED) physician/Allied Health Professional (AHP) for further action.**
  - ii. **The Emergency Department (ED) RN documents their action(s) in the EHR**
- c. **Positive blood cultures are reported immediately by the lab to the Physician/AHP working in the ED.**
  - i. **The Emergency Department (ED) physician/Allied Health Professional (AHP) reviews all positive blood cultures and determines the need for follow up.**

1) **The patient is contacted and recommendations are given.**
2) **The Emergency Department (ED) physician/Allied Health Professional (AHP) documents their action(s) in the EHR**

d. **The electronic worklist of all other positive cultures is reviewed daily by the AHP in the ED.**
   i. **For positive cultures that are determined to require a treatment change, the Emergency Department (ED) physician/Allied Health Professional (AHP) will contact the patient regarding these recommendations.**
      1) **The Emergency Department (ED) physician/Allied Health Professional (AHP) documents their action(s) in the EHR**

~~1. The ED secretary or designee will review lab reports on positive cultures and then give to ED physician /AHP or physician assistant for evaluation.~~

~~2. The ED physician/AHP or physician assistant is to evaluate and recommend intervention if necessary.~~

~~a. All positive blood cultures require follow up if patient is not admitted.~~
~~b. If intervention is not necessary, file in ED.~~
~~c. If intervention necessary, fill out call back form and inform patient of discrepancy and recommendations.~~

4.3. **~~POLICY for~~ Electrocardiograms (EKG) Results:**

a. All EKGs performed on patients in the Emergency Department are to be read by the ED **Physician /AHP**~~physician or physician assistant~~. **Their preliminary**~~is~~ reading shall be noted ~~on~~ **in** the Emergency Department **physician/AHP documentation**~~chart~~.

b. **An electronic** copy of the EKG is ~~recorded~~ **maintained in the EHR**~~in the Cardiology Department where the formal reading of EKGs is performed.~~

c. A Cardiologist **from the EKG panel will review all EKGs and** will report to the Emergency Department **physician/AHP** any significant abnormality.
   i. **The** ~~in the EKG he/she is reading and the~~ Emergency Department records will be reviewed by the ED physician**/AHP** ~~or physician assistant~~ to ~~make certain~~**ensure that** the appropriate ~~therapy was administered~~**evaluation was performed**~~d~~.
   ~~i.~~**ii. If a change in evaluation/management is indicated, The Emergency Department (ED) physician/Allied Health Professional (AHP) will contact the patient, and document their action(s) in the EHR**~~HER~~.

~~C. APPROVAL PROCESS:~~

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

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE: **SUBJECT: Pediatric Patients, Care of**

REVISION DATE(S): 09/07; 02/11 ~~**POLICY NUMBER: 7010-007**~~

Emergency Department Approval:	**02/20**
Department of Emergency Medicine Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval Date:	

A. **DEFINITIONS:**

1. To establish guidelines for the care of pediatric patients.

B. **POLICY:**

1. Emergency care is provided to all patients presenting with an injury or an illness, regardless of age.
2. It is important to recognize the child's developmental age and how that influences the child's reaction to an illness.

Infancy	A time of trust development. Attachment to parent figures occurs and separation causes great protest. Parents should be allowed to stay with their infant whenever possible.
Toddlers	Developing autonomy and have a fear of mutilation. Their reactions to intrusive procedures can be physically aggressive, such as screaming, hitting, pushing, and running away are typical.
Preschoolers	A sense of omnipotence. They are able to utilize some self-control during pain and may feel ashamed when unable to maintain it.
School Age	Industrious and are challenged by their physical and cognitive abilities. Maintenance of privacy and control are important. Pride in independence can inhibit school-age children from seeking support, although they shall accept it if offered.
Adolescence	A state of conflict. Independence, sense of self, and peer relationships are paramount. Privacy during examination and opportunities for and encouragement of their questions should be provided.

C. **PROCEUDURE:**

1. All pediatric patients shall have their weight taken and documented on the medical record. A head circumference may be obtained if indicated.
2. All pediatric patients shall be assessed and have a full set of vital signs taken **including height and weight on arrival**. Reassessments shall be done on patients **with a change of provider, at shift change, and every 2 hours or more often as** appropriate to their chief complaint.
3. When a pediatric patient is discharged, the parents or legal guardian shall have the discharge plan of care explained. **On discharge, t**~~T~~hey shall receive an instruction sheet and **any** physician referrals**.**

D. **DEVELOPMENTAL AGE CONSIDERATIONS WHEN TREATING PEDIATRIC PATIENTS:**

1. Infant (Birth to 12 months)

a. Developmental Considerations:
   i. Trust versus mistrust
   ii. Need to have basic needs met
   iii. Attachment to primary caretaker
   iv. Oral Stage
   v. Limited ability to communicate
b. Major Fears
   i. Separation anxiety
   ii. Stranger anxiety
c. Interventions
   i. Minimize separation from parents.
   ii. Use security objects (e.g., stuffed animal, blanket) if separation is unavoidable.
   iii. Prepare parents for procedures and allow them to –comfort infant.
   iv. Use soothing voice and gentle touch.
   v. Provide distraction with brightly colored toys.

2. Toddler (1 – 3 years of age)
   a. Developmental Considerations:
      i. Autonomy versus shame and doubt
      ii. Seeks independence
      iii. Negativism
      iv. Threatened by changes in routine
      v. Curious explorer
      vi. Sensorimotor cognition
      vii. Limited ability to communicate, reason, and understand time
      viii. Little concept of body integrity
   b. Major Fears
      i. Separation anxiety
      ii. Stranger anxiety
      iii. Lack of familiar environment and routines
      iv. Bodily injury
   c. Interventions
      i. Minimize separation from parents.
      ii. Use security objects if separation is unavoidable and assure toddler of parent's return.
      iii. Provide parents with information and allow expression of concerns and feelings.
      iv. Encourage toddler to make choices and participate in care when possible.
      v. Limit use of restraints and allow as much mobility as possible.
      vi. Allow for verbal (crying) and motor (kicking) protesting.
      vii. Tell toddler immediately before a procedure that it will occur and explain it in simple terms.
      viii. Provide praise.

3. Preschool Age (3 –5 years of age)
   a. Developmental Considerations:
      i. Initiative versus guilt
      ii. Conscience formulation
      iii. Feelings of being punished
      iv. Preoperational cognition, egocentric, magical thinking
      v. Inquisitive
      vi. Acquiring better language skills
   b. Major Fears
      i. Separation anxiety
      ii. Mutilation and bodily injury
      iii. Accidents and illnesses are punishment
   c. Interventions:

i. Minimize separation from parents. If separation is unavoidable, assure child of parents' return.
ii. Encourage child to make choices and participate in care when possible.
iii. Be realistic and truthful, explaining at child's level of understanding.
iv. Reinforce that accidents and illnesses are not punishment.
v. Give explanations before procedures through role play, use of puppets and dolls, and letting child handle safe hospital equipment.
vi. Allow expression of feelings and concerns through play, drawings, and verbalization.
vii. Use adhesive bandages liberally; child may fear that all his or her blood will leak out.

4. School Age (6 – 12 years of age)
   a. Developmental Considerations
      i. Industry versus inferiority
      ii. Sense of mastery
      iii. Concrete cognition
      iv. Active learners
      v. Well-developed language skills and concept of time
      vi. Concerns about body image
   b. Major Fears
      i. Mutilation and pain
      ii. Accidents and illnesses are punishment
      iii. Death
      iv. Concerns about body image
   c. Interventions:
      i. Involve parents in care.
      ii. Encourage child to participate in care when possible.
      iii. Explain procedures in advance using models, drawings, or other audiovisual materials.
      iv. Respect child's modesty.
5. Adolescent (13 – 18 years of age)
   a. Developmental Considerations:
      i. Identify versus role confusion
      ii. Can deal with reality
      iii. Abstract cognition
      iv. Reasoning becomes more logical and idealistic
      v. Rapid mood swings
      vi. Rapidly changing body image
   b. Major Fears:
      i. Loss of control and independence.
      ii. Threat of change in body image
      iii. Restriction of physical activities
      iv. Rejection from peers
      v. Death
   c. Interventions:
      i. Encourage adolescent to make choices and participate in care when possible.
      ii. Give realistic and truthful explanations.
      iii. Use body diagrams or models to explain procedures.
      iv. Respect adolescent's need for privacy.
6. Involve parents in care, but **attempt to** give adolescent time alone with health care professional to ask questions, clarify information, and discuss concerns

E. **MANIFESTATIONS OF STRESS IN PARENTS OF CRITICALLY ILL CHILDREN:**

Stress Reaction	~~Explanation~~Presentation

1. Reduced ability to utilize information	Parents repeat the same questions to different staff members as they seek information and explanations. Parents need repetition and consistent information because they may not hear the information when they are given it the first time.
2. Decreased ability to think clearly and problem solve.	Parents feel confused and are unable to organize their thoughts and prioritize their concerns.
3. Reduced ability to master tasks.	Parents lose their ability to function and mobilize their own resources.
4. Decreased sense of personal effectiveness	Parents experience feelings of loss, incompetence, failure, helplessness, and guilt. Need to be told what they can do.
5. Reduced ability to make effective, constructive decisions	Parents may distort facts and events and fill in the gaps with exaggerated information. This can affect the parents' ability to make decisions regarding the child's care.
6. Heightened or decreased sensitivity to self	Parents may become easily irritated and preoccupied with personal somatic complaints, or they may be unaware of their own physical needs.
7. Decreased sensitivity to environment	Parents may lose touch with events happening around them and miss subtle cues and pieces of information.

~~F. **APPROVAL PROCESS:**~~
~~1. Emergency Department Medical Director~~
~~2. Board of Directors~~

Tri-City Medical Center	Emergency Department
PROCEDURE:	**TRANSFER OF PEDIATRIC PATIENTS** ~~7010-012~~
Purpose:	To provide a procedure for transporting pediatric patients from the Emergency Department to an appropriate facility.
~~Supportive Data:~~	~~N/A~~
~~Equipment:~~	~~N/A~~
~~Issue Date:~~	~~08/07~~ ~~Revision Date(s): 08/07; 02/11~~

A. **PROCEDURE:**

1. Non Acute Transfer:
   a. Call Rady-Children's (RC) Operator.
      i. If surgical reason, Unit Secretary to ask **if** Surgeon available to accept a transfer.
      ii. Emergency Department (ED) Physician to discuss reason for surgical intervention at RC with available Surgeon.
      iii. When transfer is accepted **and Bed is assigned:**~~:~~
         1) Call ~~Balboa~~ Ambulance Service for transfer.
         2) Providers to complete patient **electronic** record.
         3) Unit Secretary to prepare transfer paperwork and supporting records, e.g. film **CDs**, ECG, lab results.
         ~~3)~~**4) RN to call report to receiving unit.**
   b. Additional transfer locations based on insurance are Palomar, Kaiser, and Naval Hospital.
2. Critical Transport:
   a. Unit Secretary to call the CHET Team at 1-858-277-3404.
   b. ED Physician to discuss patient stability, needs and interventions performed and/or in progress.
   c. CHET Team to communicate mode of arrival: Air or Ground transport.
   d. Unit Secretary to notify Security for all air transports to prepare for the helicopter landing.
   e. If Rady-Children's is unable to accept the transfer, the ~~ANM~~/Charge Nurse or designee shall call the most appropriate pediatric facility until a site is able to accept the patient.

~~C. **APPROVAL PROCESS:**~~

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

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/07, 02/11, 02/20	06/20	n/a	07/20	08/20	n/a	

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE 5/04~~	~~SUBJECT: Care Coordination~~
~~REVISION DATE: 6/07~~	~~POLICY NUMBER: 301~~
~~REVIEW DATE: 6/07, 3/10, 10/11~~	~~APPROVAL: 5/04, 7/07, 5/10, 10/11~~

ISSUE DATE: 05/04	**SUBJECT:** Care Coordination
REVISION DATE(S): 05/04, 07/07, 05/10, 10/11	**POLICY NUMBER:** 301

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To ensure the coordination of services for each patient.

B. **POLICY:**
1. The primary nurse/clinician assigned to the patient is responsible for providing coordination of patient care involving all health care team members and overseeing the plans of care. ~~They are accountable to the nursing supervisor and to the leadership team at large.~~ In therapy only cases, the therapist will assume the oversight, and coordination for the patient. Timely and ongoing communication is the responsibility of each team member, and will be appropriate to the needs and the abilities of the patient and relevant to the care provided.

C. **PROCEDURE:**
1. Each patient will be assigned a clinician (nurse or therapist) ~~by the clinical supervisor~~ upon admission. The nursing manager or rehab supervisor will assign the case to a clinician based on the patient's need and level of care required (acuity), geographic area (zip code), and qualifications of agency personnel needed.
2. Rehab Therapists and Social Services will provide care in coordination with the primary nurse/clinician assigned.
3. The primary nurse/clinician coordinates a goal directed ~~patient's~~ plan of care with all disciplines and provides oversight of the CHHA assigned to the case.
   a. Maintains communication with all disciplines by:
      i. Multidisciplinary team conference
      ii. Voice mail
      iii. Verbal discussion
      iv. Faxing of information
      v. Written communication
   b. Oversees scheduling of nursing and CHHA's to assure frequency/duration, overall coordination of care and consistency. Maintains regulatory compliance by assuring CHHA Supervisory visits are done in a timely manner.
   c. Maintains communication with the physician for oversight of plan of care and patient status.
   d. Ensures for proper communication and hand-off between the different levels of care.

4. ~~4)~~ The **Nurse Manager, Quality Manager and/or Director** assists the primary nurses in **development of** plans of care for complex patients and provides oversight **and clinical guidance as needed**~~of agency productivity standards~~.
   ~~a. Participate in PI/QI activities.~~
   ~~b. Participate in infection control surveillance. Monitors indwelling catheters (Foleys) and logs all Urinary Tract Infections.~~
   ~~c. Monitors LUPAs and puts them in the log book~~
   ~~d. Maintains the patient acuity levels and contacts patients in the event of a disaster.~~
5. Agency personnel will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and home visits. Documentation of all communications will be included in the clinical record on an interdisciplinary communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.
6. When patients require more than one service from the agency, the primary nurse/clinician will be responsible for cooperative care planning in order to assure that goals, actions, and the inter-relationship of services is not duplicated.
7. ~~All p~~**P**atients **may**~~will~~ be case conferenced at the beginning of service, recertification, resumption of care and whenever there is a significant change in patient condition or environment **and/or a complex or non-compliant patient**. Written evidence of care coordination will be found on the interdisciplinary communication form or Case Conference Summary forms in the patient's clinical record. All agency personnel involved in patient care~~, including those providing contracted services,~~ will have access to the plan of care to ensure coordination and continuity

~~D. PROCESS~~

~~1. Each interdisciplinary team meets once a week. The case manager prepares a patient census that includes date, name, address, date of birth, onset of service and primary physician. A copy is kept in the case conference binder and a copy with acuity rating placed on the disaster clipboard. Team members are responsible, when requested, for reviewing the conference census list and care plans of patients they have scheduled for conference and being prepared to discuss their patient's status. Problems that staff or patients are experiencing are discussed along with potential discharge or transfers. Any patient not scheduled for review may be discussed at the request of any member of the interdisciplinary team at any time.~~
~~Each member of the team completes an interdisciplinary conference note when appropriate which is filed in the patient's medical record. The case conference note may be signed by the supervisor in attendance or the facilitator. The clinical record of case conferences establishes that effective reporting and coordination of patient care does occur. The DPCS or designee maintains overall responsibility for the patient conference.~~

Tri-City Medical Center
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 11/05~~	~~SUBJECT: CRITICAL LAB VALUES~~
~~REVISION DATE: 1/06, 10/08, 12/10~~	~~POLICY NUMBER: 406~~
~~REVIEW DATE: 7/06, 11/06, 10/08, 2/11~~	~~APPROVAL: 1/06; 11/06, 11/07, 10/08, 3/11~~

ISSUE DATE: 11/05	**SUBJECT: Critical Lab Values**
REVISION DATE(S): 01/06; 11/06, 11/07, 10/08, 03/11	**POLICY NUMBER: 406**

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/11**

A. **PURPOSE:**
1. To define the acceptable time between ordering and reporting critical lab values and between the availability of the value and the receipt by the Agency clinician.

B. **POLICY:**
1. It is the policy of Tri-City Home Health **(TCHC)** to report **all** ~~panic~~ **critical** lab values when received from the laboratory within 30 minutes or sooner to the ordering physician. ~~The Agency has determined that the following tests are deemed critical labs: Platelets, Vancomycin level, PT-INR and Potassium.~~

C. **CRITICAL~~PANIC~~ VALUES:**
1. Critical values are laboratory results which indicate a condition likely to require prompt clinical intervention. All abnormal critical tests are considered panic values.
2. Panic lab value reports are taken only by LVN's and/or RN's during business hours, Monday through Friday and by a RN after business hours.
3. Critical lab "panic values" are received by phone from the laboratory and are documented in the patient note section in EMR. It is the expectation of the Agency that labs will call TCHC with panic values. If the Agency is not called regarding a panic value, ~~a Quality Review Report (QRR)~~ **unusual occurrence report** will be written and follow up will be conducted.
4. Items to be documented in the EMR are as follows:
   a. Time Received
   b. Time reported to the MD
   c. MD notified and name
   d. Verbal read back of lab values
5. The Home Health clinician will take appropriate action when directed by physician.
6. This may require a phone call to the patient or care giver to increase, decrease or stop dosage of medication.

~~The Manager of Quality and Outcomes or designee will review the panic values reported each quarter to assess timeliness of reporting and complete documentation. Appropriate action and education will be provided to staff when necessary.~~

D. **CRITICAL TESTS:**
1. Critical tests within normal limits are not considered panic values.

2. Critical tests are performed within 24 hours of receipt of the order or when a specific time is indicated by the ordering physician.
3. The reporting time for non-panic critical test values is 2-3 working days and is faxed to the agency by various laboratories.
4. The critical test results are faxed to the ordering physician within 1-3 hours of receipt.
5. Copies of the results and fax confirmation are given to the Patient Flow Coordinator/Clinical Supervisor and medical records after the fax confirmation has been received.

Tri-City Medical Center
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

~~ISSUE DATE: 5/14/04~~	~~SUBJECT: Late Entry Documentation~~
~~REVISION DATE: 8/06, 7/07~~	~~POLICY NUMBER: 405~~
~~REVIEW DATE: 7/07, 5/08, 3/11~~	~~APPROVAL: 5/04, 11/07, 8/08, 3/11~~

ISSUE DATE: 05/04	**SUBJECT: Late Entry Documentation**
REVISION DATE(S): 05/04, 11/07, 08/08, 03/11	**POLICY NUMBER: 405**

Home Health Care Approval:	**06/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval:	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/11**

A. **PURPOSE:**
1. To define acceptable late documentation in the medical record.

B. **POLICY:**
1. It is the policy of the Agency to accept late documentation regarding pertinent patient information when all criteria are met.

C. **PROCEDURE:**
1. A late entry for additional information regarding a patient on a certain date is acceptable with the following conditions:
   a. All late entries must be headed as "late entry" and dated with date of the late entry.
   b. The late entry must be signed by the clinician making the entry.
   c. A late entry made on the same day must include the time the late entry is made.
   d. A continuation note may be used for a late entry but must reflect the date of the original visit date.
   e. A late entry or change may never be recorded on a signed physician order.

Tri-City Health Care District
Oceanside, Califo

DELETE – follow Administrative Policies regarding Protected Health Information

~~UNIT SPECIFIC POLICY~~
HOME HEALTH C/

~~ISSUE DATE : 5/04~~
~~REVISION DATE: 7/04, 4/08~~
~~REVIEW DATE: 1/05, 10/05, 1/07, 4/08, 11/08, 12/09, 10/10, 1/11, 6/12~~

~~SUBJECT: MEDICAL RECORD SECURITY~~

~~APPROVAL: 7/04, 1/07, 11/07, 4/08, 2/09, 2/10, 3/11~~

ISSUE DATE: 05/04

SUBJECT: MEDICAL RECORD SECURITY

REVISION DATE(S): 07/04, 01/07, 11/07, 04/08, 02/09, 02/10, 03/11

POLICY NUMBER: 304

Home Health Care Approval:	06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. **PURPOSE:**~~
~~1. To comply with security requirements of the patient medical file.~~

~~B. **POLICY:**~~
~~1. The Agency is responsible for the security of the patient's medical record and will take all precautions necessary to protect the medical record.~~

~~C. **PROCEDURE:**~~
~~1. All completed Medical Records will remain in the Home Health Medical Record office. It is the expectation of the Agency that a medical record will be complete, with all essential components, within seven (7) days. An out card with name and date will be filled out if the medical record is removed for any reason by any individual.~~
~~2. Drop files (temporary chart containers located in the Medical Record office) may be used if necessary for clinical notes.~~
~~3. The Home Health and Hospice Offices are locked at all times with a safety code, which is changed after Home Health or Hospice personnel terminates employment or if there is any reason to believe that unauthorized persons have obtained the door code.~~
~~4. In addition, the Medical Record department will be locked when the administrative office is unoccupied.~~
~~5. Record Retention:~~
~~a. Title 22 Regulations require health records of each discharged adult patient shall be kept for a minimum of seven years following discharge of the patient.~~
~~b. When the Agency stores medical records in a contracted off site location, the following requirements shall apply:~~
~~i. Timely accessibility of stored records on a 24 hour basis, 7 days per week.~~
~~ii. Records are organized and systematically maintained.~~
~~iii. Protection of the clinical records from loss, destruction, or unauthorized use.~~
~~iv.A. A current written agreement with the storage facility.~~

Tri-City Medical Center	~~Distribution: Supervisors, RN's, LVN's Nursing~~ Home Health Care
PROCEDURE:	**PROCEDURE FOR USE OF THE HOME CARE VISIT BAG**
Purpose:	To prevent cross contamination in the field
~~Supportive Data:~~	
Equipment:	Visit bag and its contents
Issue Date:	09/96

A. **DEFINITIONS:**

1. ~~To protect supplies inside the bag from contamination, keep antibacterial soap and paper towels in a separate compartment for easy access. If the bag has an outer pocket, it is preferred to keep these items there. This will prevent the need for reaching into the bag with unwashed hands. An alternate is alcohol hand sanitizer or disinfectant hand wipes.~~**To prevent and control the transmission of pathogenic micro-organisms through the management and usage of the visit bag referred to as "Bag Technique". The principles of "Bag Technique" minimally include the following: Hand hygiene, bag placement, and bag placement during interim storage, cleaning the interior and exterior surfaces of the bag, maintenance of equipment and supplies stored in the bag and management of equipment and supplies removed from the bag.**

B. **PROCEDURE:**

~~1. Select an area which will be convenient to your work area and to the water supply, and which will give you ample space for your supplies. Select a clean area. Avoid upholstered furniture or patient's bed.~~

~~a. Always select a clean area.~~
~~b. Place bag on chosen surface.~~
~~c. Remove hand hygiene supplies from outer pocket of bag.~~
~~d. Open bag.~~
~~e. Remove other items which will be needed during the visit. Place them on a clean area.~~
~~f. Close the bag and keep closed during the visit. If additional supplies are needed during the visit, hand hygiene before removing supplies from the bag.~~
~~g. Give care. Clean any supplies which will be placed back into the clean zippered area of the bag with a low level disinfectant: i.e.: 70% alcohol, 1:10 stabilized bleach solution. May use PDI Germicidal wipes provided by agency.~~
~~h. Hand hygiene; replace supplies in outer pocket of bag.~~
~~i. Tidy up work area. Remind family of next visit date.~~
~~j. All supplies kept in bag should be kept clean. Bag and B.P. cuff (when not kept in bag) should be cleaned monthly and when visibly soiled. Launder washable materials with hot soapy water and thoroughly wipe with a hospital approved low level disinfectant such as 70% alcohol or 1:10 bleach dilution.~~
~~k. All dated supplies should be checked and replaced if needed.~~

1. **Select a visibly, clean dry, flat surface when possible avoiding upholstered furniture or patient's bed. Place non-wheeled visit bag on chosen surface that will give you ample space for your supplies using the disposable water-resistant surface barrier under the bag or hang it on a doorknob or on a hanger over a door.**
2. **When a wheeled rolling bag is used, the bag should remain on the floor. If the bag has a large front flap, it should be opened in a manner that does not permit the front flap to have direct contact with the floor.**
3. **The visit bag should be placed on a visibly clean, dry surface inside the vehicle during transport to and from patients.**
4. **To protect supplies inside the bag from contamination and for ease of access, keep hand hygiene products and supplies stored in the outer pocket of the visit bag.**

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/96, 8/98;7/99, 7/00, 03/04, 01/06, 03/08, 08/12, 04/19, 06/20	n/a	07/20	08/20	n/a	

5. Hand hygiene is the most important infection prevention activity when implementing "Bag Technique". Perform hand hygiene before entering the visit bag.
6. Remove items which will be needed during the visit and place them on a visibly clean, dry, flat surface.
7. Do not re-enter the visit bag without performing hand hygiene. If gloves are worn, perform hand hygiene and then re-enter the visit bag. Never go back into the visit bag with "used" gloves.
8. Close the visit bag and keep closed during the visit. If additional supplies are needed during the visit, perform hand hygiene before removing supplies from the bag and/or re-entering the bag.
9. Clean any supplies which will be placed back into clean zippered area of the visit bag with a low level disinfectant: i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipe provided by agency.
10. Clean droid/tablet with low level disinfectant" i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipes provided by agency.
11. The visit bag should not be taken into patient's home when the patient is known to be colonized or infected with a multidrug-resistant organism (e.g., Methicillin-resistant S. Aureus or C. difficile), the patient is on transmission-based precautions the patient's home is infected with bedbugs, pests or grossly contaminated with human or pet excrement and/or at the staff member's discretion.
12. When the visit bag is not brought into the patient home, the items needed for the encounter should be placed in a disposable double bag and these items should be placed on the disposable, water-resistant surface barrier in the home. The outer disposable bag should be left in the patient's home, and the equipment carried out after being cleaned and disinfected in the inner disposable bag.
13. Wipe bag when visibly soiled with a low level disinfectant: i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipes provided by agency. Wash visit bag minimally on a monthly basis in the wash machine and dry in the dryer on high heat for a full cycle.
14. All dated supplies should be checked and replaced if needed.
15. All visit bags used for Tri City Home Care will be provided by the agency.

~~C. If the patient has a communicable disease, or the environment is very unsanitary, then the bag should not be carried into the home. A small amount of supplies may be taken in a paper or plastic bag on each visit.~~

~~D. If nursing bag is purchased by the licensed nurse, approval will be documented by supervisor/educator on equipment issue form. Approval is based on durability, ability to disinfect and presence of outer pocket.~~

~~Issued:~~	~~Reviewed:~~	~~Revised:~~	~~Approved: 9/96~~
~~09\96~~	~~8/98,7/00, 3/04,1/06,3/08~~	~~8/96;8/98;7/99;7/00;3/04; 1/06, 3/08, 8/12~~	

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 04/05	**SUBJECT:** Credentialing Standards for Vertebral Augmentation
REVISION DATE(S): 05/11	**POLICY NUMBER:** 8710-534

Department Approval:	~~06/17~~05/20
Credentials Committee Approval:	~~06/17~~06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**

1. The following criteria shall be used in credentialing physicians who request privileges in vertebral augmentation procedures:
   a. Didactic education in the diagnosis and treatment of patients with spine fractures and or deformity of the spine resulting from osteoporosis or tumors;
   b. Training in the technical aspects of the performance of vertebral augmentation;
   c. Proctoring;
   d. Compliance with reappointment criteria.

B. **CREDENTIALING CRITERIA:**

1. Initial Criteria:
   a. The applicant must be either an MD or DO.
   b. The applicant must have completed an ACGME/AOA-accredited residency program and possess board certification or board eligibility in Orthopedic Surgery, Neurosurgery, Neuroradiology, or Radiology and one of the following:
      i. Fellowship Training in Spine Surgery or Interventional Radiology or;
      ii. Current Competence* in spine surgery or interventional spine procedures (*provide documentation of ten (10) cases in past two years, without significant complications)
   c. The applicant must be trained in fluoroscopy and have a valid Fluoroscopy Supervisor and Operator permit.
   d. The applicant must have completed training in vertebral augmentation. Evidence of this training may be provided via either a certificate of completion from the applicant's vertebral augmentation training program or letter of reference from the director/chief of spine surgery or interventional radiology where applicant currently or most recently has practiced.
2. Proctoring Criteria:
   a. Five (5) cases performed during the first two year appointment will be proctored by a member of the TCMC Medical Staff with unsupervised vertebral augmentation privileges.
3. Reappointment Criteria:
   a. Five (5) vertebral augmentation procedures annually performed during the reappointment cycle (10 cases total) with acceptable success and complication rates (Refer to Possible Complications for Vertebral Augmentation).

C. **REFERENCE(S):**

1. Clinical Privilege White Paper: Procedure 201, Balloon Kyphoplasty;
2. Clinical Privilege White Paper: Procedure 30, Percutaneous Vertebroplasty
3. Palomar Hospital Privileging Criteria for Percutaneous Vertebroplasty and/or Balloon Assisted Vertebroplasty (Kyphoplasty)

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

1. Possible Complications for Vertebral Augmentation

Possible Complications for Vertebral Augmentation:

1. Clinical Complications:
   a. Death (0%)
   b. Permanent (duration > 30 days) neurological deficit (other than radicular pain):
      1) Osteoporosis (0%)
      2) Neoplasm (5%)
   c. Transient (duration < 30 days) neurological deficit (other than radicular pain) or radicular pain syndrome (either permanent or transient):
      1) Osteoporosis (5%)
      2) Neoplasm (10%)
   d. Symptomatic pulmonary cement embolus (0%)
   e. Symptomatic epidural venous cement embolus (5%)
   f. Infection (0%)
   g. Fracture of rib or vertebrae (5%)
   h. Significant hemorrhage or vascular injury (0%)
   i. Allergic or idiosyncratic reaction (1%)

2. Technical/Procedural Complications:
   a. Failure to obtain proper informed consent (0%)
   b. Cement embolus to pulmonary vasculature without clinical sequela and estimated volume > 0.25 ml (5%)
   c. Cement embolus to epidural veins without clinical sequela and producing > 10% spinal canal compromise or estimated volume > 0.25 ml (10%)

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 07/01

SUBJECT: Criteria for Granting Moderate and Deep Sedation/Analgesia Privileges to Non-Anesthesiologists

REVISION DATE(S): 12/07, 05/09, 02/10, 11/12

POLICY NUMBER: 8710 – 517

Medical Staff Department Approval Date:	~~02/17~~10/19
Department of Anesthesiology Approval Date:	~~03/17~~03/20
Credential Committee Approval Date:	~~04/17~~06/20
Pharmacy and Therapeutics Approval Date:	n/a
Medical Executive Committee Approval Date:	~~06/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval Date:	~~07/17~~ n/a
Board of Directors Approval Date:	07/17

A. **APPLICABILITY:**

1. This policy applies to the use of sedation and analgesia in all hospital departments and areas except as stated below:
   a. This policy does not apply to patients who have an anesthesiologist providing sedation because anesthesiologists are governed by the standards of care established by the Department of Anesthesiology. This policy does not apply to patients who are mechanically ventilated and whose cardiovascular and respiratory status are continuously monitored by the same monitoring devices as specified per the Patient Care Services procedure "Deep Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures and documented according to protocol. This policy does not cover patients who receive anxiolytic or analgesic agents, which are administered routinely to alleviate pain and agitation (e.g., sedation for treatment of insomnia, post-operative analgesia).

B. **DEFINITION OF SEDATION:**

1. Monitored Anesthesia Care (MAC): Anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia. Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC.
2. Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.
3. Moderate Sedation/Analgesia: ("Conscious Sedation") A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
4. Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
5. Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified

practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

C. **PRIVILEGES:**

1. Privileges for Moderate and Deep Sedation will be granted pursuant to this policy. The non-anesthesiologist physician administering the Deep Sedation must be different from the individual performing the diagnostic or therapeutic procedure.
2. Privileges for Minimal Sedation are part and parcel of individual departmental privileges, and anesthesia privileges are granted within the Anesthesiology Department only.

D. **REQUIREMENTS FOR MODERATE SEDATION PRIVILEGES:**

1. Initial applicant competency shall be demonstrated by:
   a. Successful completion of an ACGME/AOA accredited residency in a relevant medical specialty or Licensed by the Physician Assistant Committee of the Medical Board of California.
   b. Procedural sedation must be part of core content of specialty.
   c. Pass Moderate Sedation Credentialing Examination with a grade of 80% or better.
   d. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Moderate Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures."
2. Proctoring: Two (2) moderate sedation cases proctored by a Medical Staff member with unsupervised moderate sedation privileges or an anesthesiologist.
3. Reappointment:
   a. Pass moderate sedation credentialing examination with a grade of 80% or better.
   b. Demonstrate competency by documented completion of three (3) cases of moderate sedation every two (2) years with no significant issues resulting in inability to rescue patient as identified by quality improvement activities/peer review mechanism established by the Medical Staff.
   c. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Moderate Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures".

E. **REQUIREMENTS FOR DEEP SEDATION PRIVILEGES (Effective for privileges initially appointed or reappointed effective upon 9/2012 approval of policy):**

1. Initial applicant competency shall be demonstrated by:
   a. One of the following:
      i. Recent (within two years) completion of an ACGME residency or fellowship training with documented inclusion of deep sedation; OR
      ii. Recent (within six months) completion of an ACCME-approved (or equivalent for dental, oral surgical and podiatric continuing education) deep sedation educational program, which includes the safe administration of sedative and analgesic drugs used to establish a level of deep sedation, and rescue of patients who exhibit adverse physiologic consequences of a deeper-than-intended level of sedation, and subject areas as recommended by the American Society of Anesthesiologists; OR
      iii. Board certified/board eligible in Emergency Medicine and documentation of twenty (20) cases of deep sedation/airway management/intubation in the previous two years.
   b. Completion of a Deep Sedation exam with score of 80%
   c. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Deep Sedation/Analgesia Used during Therapeutic or Diagnostic Procedures."
   d. Current unrestricted DEA registration including schedules II-IV.
   e. Current ACLS certification (Emergency Medicine Department physicians exempt).
2. Proctoring: For initial appointees pursuant to (i) and (iii) immediately above, two (2) cases

proctored by a Medical Staff member with unsupervised Deep Sedation privileges or an anesthesiologist. For initial appointees pursuant to (ii) immediately above, ten (10) days proctored by a Medical Staff member with unsupervised Deep Sedation privileges or an anesthesiologist.

3. Reappointment:
   a. Continuing medical education in the delivery of anesthesia service.
   b. Completion of Deep Sedation Exam with a score of 80% or better.
   c. Demonstrate competency by documented completion of three (3) deep sedation/airway management/intubation cases every two (2) years with no significant issues. If the required number of cases is not performed, the physician will be required to undergo proctoring.
   d. Read and be familiar with Tri-City Medical Center Patient Care Services Procedure "Deep Sedation/Analgesia Using during Therapeutic or Diagnostic Procedures."
4. Note: Deep sedation privileges for Emergency Medicine physicians meeting the above criteria includes the treatment of pediatric patients.

F. **REFERENCES:**

1. Advisory on Granting Privileges for Deep Sedation to Non-Anesthesiologist Sedation Practitioners, ASA, October 20, 2010

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 10/04	**SUBJECT:** Election Process of Member(s) at Large for the Medical Executive Committee
REVISION DATE(S): 04/08, 08/12, 04/17	**POLICY NUMBER:** 8710 – 531

Department Approval:	~~07/17~~07/20
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~08/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **PURPOSE:**

1. To provide direction for the nomination and election process for the Member(s) at Large position on the Medical Executive Committee.

B. **PROCEDURE:**

1. All Active Medical Staff members of may submit their names to the Medical Staff Office two months prior to the June General Staff Meeting.
2. Interested Active Medical Staff members are required to complete a Conflict of Interest form before being added to the ballot.
3. Candidates will be provided the opportunity to speak at the General Staff Meeting.
4. Voting will be by ballot.
5. A quorum of voting members is required to elect Members-at-Large.
6. Each voting member will be allotted two votes. A member may vote twice for any one candidate or vote once for any two candidates or withhold one or both votes.
7. For a Member-at-Large to be elected, the candidate must be the candidate receiving the most votes. If there are two vacancies being elected, then the candidates receiving the highest and second highest number of votes cast will win.
   a. If one or both of the available Member-at-Large Medical Executive seats are not filled, the seat(s) will remain vacant.
8. Vacant seat(s) after original appointment on the Medical Executive Committee shall remain vacant until the next June General Medical Staff Meeting.
9. Members-at-Large will serve a two year term and no member shall serve more than two successive terms.

Tri-City Health Care District
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 03/08	**SUBJECT:** Focused Professional Practice Evaluation / Proctoring
REVISION DATE(S): 06/08, 02/10, 04/10, 05/10	**POLICY NUMBER:** 8710 - 542

Department Approval:	~~06/17~~05/20
Credentials Committee Approval:	~~06/17~~06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**

1. To ensure members of the Medical Staff can carry out the privileges they request in a competent, safe manner.

B. **DEFINITION(S):**

1. Proctoring: The observation of a physician's practice over a sufficient period of time to judge his or her competence to perform the procedures(s) in question, and then, if required, assists in developing an educational program to bring the practice up to acceptable standards. This may include a specialist with recognized expertise to work with a physician on-site. The expert may work interactively on designated procedures to assist, critique, and educate in identified areas of deficiency.
2. Prospective: Whereby the proctor previews the care to be administered to a patient.
3. Concurrent: Whereby the proctor observes clinical care being administered in real time.
4. Retrospective: Whereby the proctor reviews the care given to the patient after it has been administered.
5. Competence: Refers to a person's ability to perform a particular activity to a prescribed standard or a desirable outcome. There are particular qualities on which competency is based, including knowledge (education/training), traits, skills, and abilities.
6. Knowledge: Involves understanding certain facts and procedures. This is evidenced by completion of educational and training requirements. On-the-job experience – including feedback from peers, in-service training, and continuing education – enhances knowledge.
7. Traits: Characteristics that predispose a person to behave or respond in a certain way (e.g., self-control, self-confidence, the ability to take criticism, and the ability to get along with others).
8. Skill: The capacity to perform specific privileges/procedures. It is based on both knowledge and the ability to apply that knowledge. Skills can be gained by hands-on training using anatomic models or real patients or through role-play exercises. For instance, a surgeon learning to use a laser may use animal tissue in hands-on training rather than a human subject.
9. Abilities: The attributes that a person has acquired through previous experience. Because abilities are gained or developed over time, they are more easily retained than knowledge and skills. They also include the abilities with which a person is born.
10. Focused Professional Practice Evaluation: As defined in Medical Staff Policy #509, Professional Practice Evaluation.

C. **GENERAL PROVISIONS:**

1. Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of

proctoring in accordance with the applicable departmental proctoring requirements. Such proctoring will generally include a period of Level I proctoring in accordance with the Bylaws and Rules and Regulations, unless additional circumstances appear to warrant a higher level of proctoring. Each appointee or a recipient of new clinical privileges shall be assigned a department where performance of an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chairman of the department, or the chairman's designee, during the period of proctoring specified in the department's Rules and Regulations, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that departments chairman or his designee. The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

a. a report signed by the chairman of the department/division to which the member is assigned describing the type and number of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department/division, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the privilege to which the appointment was made; or

b. a report signed by the chairman of the other department(s)/division(s) in which appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

c. For practitioners who do not have sufficient activity at the hospital to meet proctoring requirements, as determined and under the direction by either the department/division Chairman, 50% of required cases from another Joint Commission accredited facility may be used to fulfill proctoring requirements in accordance with departmental/division proctoring policies.

2. A Focused Professional Practice Evaluation shall be used in at least the following situations:

a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation / proctoring in accordance with the Bylaws and the Rules and Regulations of the department/division in which the applicant or member will be exercising those privileges.

b. In special instances, focused professional practice evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area.

c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused professional practice evaluation may be imposed.

d. As otherwise defined in the Bylaws or Medical Staff Policy #509.

e. Nothing in the foregoing precludes the use of other proctoring tools, as deemed warranted by the circumstances.

D. **PROCTORING:**

1. Overview of Proctoring Levels:

a. Level I: Proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges or infrequently used existing privileges in accordance with the Bylaws and the Rules and Regulations.

b. Level II: Proctoring is appropriate in situations where a practitioner's competency or performance is called into question, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to

providing services, but is permitted to proceed without the proctor if one is not available). (Focused Professional Evaluation)

c. Level III: Proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level III proctoring, that practitioner is afforded such procedural rights as provided in Bylaws, Article VII, Hearings and Appellate Reviews.

2. Overview of Proctoring Procedures:
   a. Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
   b. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
   c. In the event that the new applicant has privileges at a Joint Commission accredited hospital where members of Tri-City Medical Center's Medical Staff are familiar with the member to be proctored, and familiar with that Joint Commission accredited hospital's peer review standards, privileges and proctoring information from that Joint Commission accredited hospital may, at the discretion of the department or division chair, be acceptable to satisfy a portion of the focused professional practice evaluation / proctoring required.
3. Proctor: Scope of Responsibility:
   a. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the department/division, the Medical Executive Committee and the Governing Board. Selection of appropriate proctor(s) is defined within each respective Department/Division Rules and Regulations.
   b. When additional privileges are added after completion of initial proctoring, proctoring volumes shall be determined by the Department/Division Chairperson on a privilege-by-privilege basis.
   c. The intervention of a proctor shall be governed by the following guidelines:
      i. A medical staff member who is serving as a proctor does not act as a supervisor of the practitioner he or she is observing. His or her role is to observe and record the performance of the practitioner being proctored, and report his or her evaluation to the department/division chair.
      ii. A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner being proctored.
      iii. In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor acting in good faith should be deemed a Good Samaritan within the "Good Samaritan" laws of the State of California.
4. Completion of Proctoring:
   a. The practitioner shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:
      i. A report signed by the department/division chair describing the types and numbers of cases observed and the evaluation of the practitioner's performance, a statement that the practitioner appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of Medical Staff membership, and has not exceeded or abused the prerogatives of the medical staff category to which the appointment was made; and if applicable,
      ii. A report signed by the Chair of such other department(s) in which the practitioner may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the practitioner's performance and a statement

that the practitioner has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments/divisions.

b. For such situations where the practitioner has satisfactorily completed proctoring requirements after the Medical Executive Committee has convened, the Department/Division Chairperson has the discretion to release the practitioner from further proctoring and the file will be furnished to the next MEC meeting.

5. Effect of Failure to Complete Proctoring:

a. Failure to Complete Necessary Volume
Any practitioner undergoing Level I proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules and Regulations shall be deemed to have voluntary withdrawn his or her request for the relevant privileges, and he or she shall not be afforded the procedural rights provided in the Bylaws, Article VII, Hearings and Appellate Reviews. However, the department/division has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in the Bylaws, Article VII, Hearings and Appellate Reviews.
Level II – Volumes for this level must be completed in accordance with the recommendations from the department/division Chair/Chief. (Initiation of a focused review as defined by Medical Staff policy #509)

b. Failure to Satisfactorily Complete Proctoring
If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, at the discretion of the department/division Chair/Chief, proctoring may be extended until competency can be ascertained.

c. Effect on Advancement
The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Bylaws, Article V, Section 5.3-2 or 5.3-3, if proctoring is not completed thereafter within a reasonable timeframe.

E. PROCEDURE:

1. Upon Board approval of a Medical Staff member's privileges, the following shall occur:
   a. Record privileges in the credentialing database.
   b. Create a proctoring file for all privileges requiring proctoring (as indicated by the departmental Rules and Regulations).
   c. Mail proctoring letter explaining proctoring requirements, applicable proctoring forms, and current privileges to Medical Staff member.
   d. Load practitioner's proctoring requirements into the credentialing database.
2. Completed proctoring forms may be submitted to the Medical Staff Office via the locked Proctoring box located on the Surgery unit (must be checked at least weekly). The Medical Staff Office maintains the key to the locked box.
3. Upon receipt of completed proctoring forms, the Credentialing Specialist shall
   a. review the form for completeness and relevancy to the practitioner's privileges currently on a "Proctoring" status.
4. Log proctored cases into the credentialing database.
5. Print a proctoring report from the database to initiate proctoring release process for completed requirements of applicable privileges.
6. To release a practitioner from proctoring status:
   a. Ensure the correct number of completed proctoring forms are assembled in the appropriate practitioner's proctoring file.
   b. Generate the following forms for review and approval by the Department/Division, Credentials Committee, Medical Executive Committee, and the Board of Directors:
      i. Proctoring Evaluation Approval Form

ii. Proctoring Approval Flowsheet

7. Upon Board approval of releasing a practitioner from proctoring, the Credentialing Specialist shall:
   a. Update the practitioner's privileges in the credentialing database.
   b. Send a letter to the practitioner indicating the privileges that have been released from proctoring and a copy of their updated privileges.
   c. Upon releasing a practitioner 100% from proctoring, the contents of the proctoring file are placed in the practitioner's credential file under the proctoring section (behind the privilege section).

F. **REFERENCE(S):**
1. Joint Commission 2016 Medical Staff Standards
2. Title XXII

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 9/03

SUBJECT: Quality Review Process for Teleradiologists

REVISION DATE(S): 09/07, 08/12

POLICY NUMBER: 8710 – 525

Department Approval:	~~07/17~~05/20
Credentials Committee Approval:	~~11/17~~06/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~07/20
Administration Approval:	08/20
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. Ensure tracking and monitoring of the performance of teleradiologists.

B. **POLICY:**

1. A system shall be in place for tracking and trending individual teleradiologists.

C. **PROCEDURE:**

1. Preliminary reports are ~~received daily from StatRad via fax during the hours of 10:00 pm to 7:00 am. A member of North County Radiology Medical Group (NCRMG) administrative staff files the preliminary report with the patient's film jacket.~~ **completed daily from StatRad via hospital PACS System during the hours of 10:00 pm to 7:00am.**
2. The on-site radiologist shall review the interpretation and record agreement or disagreement noting minor or major variance. The variances for all teleradiologists are tracked **on an ongoing basis** and given to the Medical Staff Office ~~on a monthly basis~~ for statistical analysis. Copies of the StatRad preliminary reports are kept on file.
    a. If the on-site radiologist records minor or major variances, he/she shall record the results on the preliminary report form and note in the final report. Clinically significant variances are reported to the Emergency Department staff **or ordering provider. Clinically significant variances include all category 4 discrepancies as defined by the ACR guidelines and any category 3 discrepancies based on the discretion of the Radiolpgist and clinical severity.** All cases with ~~major~~ **clinically significant** variances shall be forwarded to the Imaging Quality Assurance (QA) Officer for review and sent through the ~~Imaging Division QA~~ **Department of Imaging QA peer review** process.
3. The StatRad preliminary report with the noted discrepancy shall be ~~faxed to~~ **entered in the** StatRad QA ~~department.~~ **website.**
4. ~~A spreadsheet is on file tracking the teleradiologists, volume of reports, turnaround time, average time, and variances on a daily basis.~~ **Access to the teleradiology's website is readily available for tracking the teleradiologists volume of reports, turnaround time, average time, and variances as needed. Report volume and discrepancy data is provided by the Imaging Department staff as requested by the Medical Staff office for the Ongoing Physician Practice Evaluation (OPPE) process**
5. The Chief of ~~Imaging Division~~ **the Department of Imaging** assures the quality and appropriateness of patient care provided by the teleradiologist.
6. A deviation rate of ten percent (10%) or greater ~~for any teleradiologists~~ **from the overall group average for any individual teleradiologist (in category 3 and 4 discrepancies)** shall trigger

a ~~complete quality review~~ **further review by the Department of Imaging chair.** ~~by the Imaging Division.~~

Tri-City Medical Center	Women and Newborn Services ~~Manual~~ Neonatal Intensive Care Unit (NICU)

PROCEDURE: CUE-BASED FEEDING

Purpose: ~~1. To provide a standardized protocol for feeding premature infants ≥ 33 weeks post conceptual age (PCA). Feedings will be based on the infant's behavior, assessment by the caregiver regarding readiness to feed, nipple feeding quality assessment, as well as feeding induced stress cues.~~

To provide a developmentally supportive, individualized infant-driven feeding plan based on feeding readiness cues exhibited by infants and to promote a positive experience during which infants are active participants in the feeding process.

A. **POLICY:**

1. Feedings will be started only once ordered by a Physician/Allied Health Professional (AHP). The protocol guidelines will promote safe, functional, nurturing, and developmentally appropriate feedings for medically stable premature infants.

B. **CONSIDERATIONS:**

1. Implementation of oral nipple feedings in a healthy infant begin between 32 and 34 weeks. Infants may be able to successfully breastfeed at an earlier gestational age.

a. Awake states and quiet alert states support behavioral and physiological ability breast or nipple feed.

2. Feedings need to be a safe, positive experience for infants. They need to be developmentally appropriate for the gestational age and ability of each infant.

~~1.~~3. Parent involvement and education are needed during the feeding process so parents can gain competence in feeding their infant.

~~B.~~C. **PROCEDURE: INFANT-DRIVEN FEEDING SCALE (IDFS) ASSESSMENT**

1. Criteria for use:
   a. Infant is ≥ ~~33~~32 weeks post ~~conceptual~~ **menstrual** age (PM~~C~~A).
   b. Infant is medically stable.
   c. Stable respiratory status
2. Ordering and scoring Infant-Driven Feeding
   a. A feeding readiness assessment score of 1 to 2 at least 5 times in a 24 hour period will alert the nurse to pursue an order for infant driven feeding.
   b. Feeding readiness is assessed and scored **prior to each feeding time.**
      i. If readiness assessment score is 1 or 2 the infant may attempt to PO feed (breast or bottle).
      ii. If readiness assessment score is 3-5, the infant should be gavage fed the full volume of the feeding.
         1) If parent present, recommend skin to skin or holding during gavage feeding.
   c. Breastfeeding infant
      i. If mother plans to **breasfeed** ~~Dry Breastfeed (DBF)~~ defer the first oral feeding to her.
      ~~i.~~**ii. The preterm infant will have pre- and post-weight measurements until breastfeeding is well established. Complete feeding via gavage as needed.**
      ~~ii. Educate the mother to empty the breast by pumping until milk is no longer being expressed, and to do this within 10 minutes of the DBF session.~~
      ~~iii. Non-nutritive sucking on an empty breast may be offered to a stable infant if there is a physician/LIP order.~~

Department Review	Perinatal Collaborative Practice ~~Division of Neonatology~~	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09, 6/11, 8/12, 03/20	12/15, 03/20	02/16, 07/20	n/a	02/16, 07/20	08/20	03/16, n/a	03/16

~~iv.~~iii. Refer to lactation consultants and occupational therapist (OT) as needed.

~~v.~~iv. ~~If mother plans to DBF, staff should encourage mother to DBF each feeding~~ **If mother is breastfeeding, do not offer bottle for a protected amount of time (48-72 hours)** ~~(when scoring 1 or 2) for a protected amount of time. (For example, the first 72 hours)~~ During this protected time no bottles should be ~~given~~ **offered** to the infant **unless bottle feeding has been agreed to by parents.** ~~After each DBF the infant may be gavage fed according to IDF breastfeeding algorithm.~~

~~vi. After the protected breastfeeding window, the healthcare team should discuss whether to continue exclusive DBF or include bottle feeding as well.~~

~~vii. Supplementation after DBF should be done via gavage feeding until the gavage tube is removed for ad lib feeding. A bottle may then be used.~~

d. Bottle Feeding Infant
   i. Schedule first **bottle** feeding with the parents when possible so that the parents can participate.
   ii. When feeding, the infant should be swaddled with hands close to face, knees and legs tucked up for added postural support and head in neutral position.
   ~~iii. When initiating feeding gently offer infant a taste of EBM or formula to warn infant that a feeding is going to begin. Lightly drag the nipple from the nose to the chin and put a couple drops of EBM or formula on the tongue.~~
   ~~iv.~~iii. ~~PO feedings should be limited to the time when the infant is actively engaged.~~ When infant displays stress cues or is no longer displaying alertness, hunger cues, adequate tone, and autonomic stability, the feeding should be stopped and the remainder gavaged.
   ~~v.~~iv. The most effective feeding usually occurs within the first 20 minutes. With few exceptions, the feeding should not exceed 30 minutes.
   ~~vi.~~v. The RN/OT should offer feeding techniques as needed to facilitate a safe and timely suck/swallow/breathe pattern.

e. Assessment and Documentation of Feeding Quality
   i. After each PO feeding document in the electronic health record (EHR)
      1) Readiness assessment score
      2) Feeding method
      3) Interventions
      4) Stress cues displayed
      5) Feeding quality assessment score

f. Percentage of Oral Feeding Intake
   i. Once PO feedings are initiated the multidisciplinary team will track the percentage of PO volume from total expected volume for each 24 hour period.
      1) Percent of PO feeding will be reported to oncoming shift and in daily rounds.
      2) Once the infant is able to take 80% of total volume PO with consistent Nipple Quality scores of 1-2, a shift minimum feeding volume will be ordered by the Physician/AHP.
      ~~3) After the infant has taken full feeding volume for 24 hours the NG tube may be removed and the Neonatal Intensive Care (NICU) multidisciplinary team will discuss transitioning the infant to ad lib on demand feedings.~~
      ~~4)~~**3)** Weight gain/loss will be monitored.
      ~~5)~~**4)** Infant will demonstrate adequate weight gain and feeding quality prior to discharge.

g. Parent Education
   i. Parents will be encouraged to participate in as many feedings as possible.
   ii. Parents will be educated on the transition to oral feedings.

iii. Parents will be educated on the use of the Infant-driven feeding scale/cue based feeding.
iv. The RN/OT will be a resource for parents while they are feeding their infant.

~~C.~~D. **ASSESSMENT SCALES/ALGORITHM:**

~~1. Infant-Driven Feeding Breastfeeding Algorithm~~
~~a. DBF 0-5 minutes (Quality Score 1-5): Gavage full feeding volume~~
~~b. DBF 5-10 minutes (Quality Score 1-3): Gavage 2/3 full feeding volume~~
~~c. DBF 10-15 minutes (Quality Score 1-3): Gavage 1/3 full feeding volume~~
~~d. DBF >15 minutes (Quality Score 1-3): Do not gavage feeding~~

~~2.~~1. Infant-Driven Feeding Scale Readiness Assessment
a. 1- Alert or Fussy prior to care. Rooting and/or hands to mouth behavior. Good tone.
b. 2-Alert once handled. Some rooting or takes pacifier. Adequate tone.
c. 3-Briefly alert with care. No hunger behaviors. No Change in tone.
d. 4-Sleeping throughout care. No hunger cues. No change in tone.
e. 5-Significant change in HR, RR, O2, or work of breathing outside of safe parameters.

~~3.~~2. Infant-Driven Feeding Scales Quality Assessment
a. 1- Nipples with a strong Coordinated SSB throughout feed.
b. 2- Nipples with strong coordinated SSB but fatigues with progression.
c. 3- Difficulty coordinating SSB despite consistent suck.
d. 4- Nipples with a weak/inconsistent SSB. Little to no rhythm.
e. 5- Unable to coordinate SSB pattern. Significant change in HR, RR, O2, work of breathing outside safe parameters of clinically unsafe swallow during feeding.

~~4.~~3. Infant-Driven Feeding Scales Interventions
a. Modified Side lying: Position infant in inclined side lying position with head midline to assist with bolus management.
b. External Pacing: Tip bottle downward/break seal at breast to remove or decrease the flow of liquid to facilitate SSB.
c. Specialty Nipple: Use nipple other than standard for specific purpose i.e. nipple shield, slow-flow, Haberman.
d. Cheek Support: Provide gentle unilateral support to improve intra oral pressure.
e. Frequent burping: Burp infant based on behavioral cues not on time or volume completed.
f. Chin support: Provide gentle forward pressure on mandible to ensure effective latch/tongue stripping if small chin or wide jaw excursion.
g. Increase FiO2 of Flow Rate: Increase FiO2 5-10% higher than baseline FiO2 requirements during feeding in order to provide necessary support throughout feeding.

~~D.~~E. **REFERENCES:**

~~1. Ludwig, S.; Waitzman, K.A. (2013). 7 Risky Mistakes NICUs Make with Oral Feeding Every Day. Infant-Driven Feeding LLC.~~
~~2. Ludwig, S.; Waitzman, K. A. (2007). Changing Feeding Documentation to Reflect Infant Driven Practice. Newborn & Infant Nursing Reviews. 7(3). 155-160.~~

1. **Beauman, S. S., & Bowles, S. (Eds.). (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th ed.). Chicago, IL: National Association of Neonatal Nurses.**
2. **Kenner, C., & McGrath, J. M. (Eds.). (2010). *Developmental care of newborns & infants: a guide for health professionals* (2nd ed.). Glenview, IL: National Association of Neonatal Nurses.**

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 3/11 **SUBJECT: Continuum of Care**

REVISION DATE(S): 03/17/2020

Department Approval:	**03/17**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval;	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Medical treatment is often specialized, focusing and/or targeting only the condition for which the patient presents. This results in fragmentation of medical care that can sometimes adversely affect the progress and well being of the person seeking medical attention. Treatment of a patient must be all-inclusive to the extent possible or feasible and must consider such factors as:
   a. California Department of Corrections and Rehabilitation (CDCR) Primary Care Physician (PCP) **and San Diego Sheriff's Department**
   b. Insurance
   c. Physicians currently involved in care
   d. Other underlying illnesses/conditions being treated
   e. Current treatment regimens
   f. Medical services utilized by the patient

B. **POLICY:**

1. The Request for Services (RFS) along with any medical records are faxed to the Clinic from the institution for review prior to treatment.
2. The physician treating the patient will communicate his/her recommendations for the plan of care on the Request for Services document from the institution.
3. Initial assessment of the patient will be conducted in such a way as to yield pertinent information that may impact the plan of care (Admission Assessment, History and Physical)
~~3.~~**4.** **All patients will be given an individualized plan of care that will be coordinated with the patient's CDCR or San Diego Sheriff's Department PCP (as well as any other physician/medical agents/agencies involved with patient care) after the initial visit, and periodically as indicated.**
~~4.~~**5.** The clinical staff will work to incorporate other aspects of care discovered during the admission process, notifying the Clinic physician of issues that may require medical intervention.

C. **PROCEDURE:**

1. Physician Collaboration: Clinic physicians will collaborate with the patient's California Department of Corrections and Rehabilitation (CDCR) **or San Diego Sheriff's Department** Primary care physicians (PCP) after initial visit. CDCR **or San Diego Sheriff's Department** PCP will receive a dictated medical report via fax from Medical Records.
2. Hospital Admission: Direct hospital admissions from the clinic will be conducted according to hospital procedure. Prior to sending a patient to the hospital, the clinic will contact the Inpatient **Progressive Care Unit**~~Forensic Unit~~ RN by phone to initiate the Direct Admission. The RN in the

OP Clinic will provide report to the RN in the Inpatient Unit to include patient medical information, reason for admission and admission orders, if obtained.

~~2.~~3. **Documentation of the recommendations for care will be addressed in the physician's notes. A copy of all correspondence will be maintained in the medical record,as well as provided in a patient envelope and sent with the patient back to the institution.**

~~3.~~4. Notification to the Institution: The institution will be contacted by the RN or treating physician to inform the CDCR **or San Diego Sheriff's Department** PCP or authorized personnel of the admission to the hospital.

Tri-City Medical Center
Oceanside, California

DELETE: No longer needed

OUTPATIENT SPECIALITYSERVICES CLINIC ~~FORENSICS CLINIC~~

ISSUE DATE: 05/11 **SUBJECT:** Diagnostic Tests

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	na
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Timely reporting of diagnostic test results is an important aspect of planning or changing the course of treatment.~~

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

~~1. Diagnostic tests relevant to the diagnosing and planning of the patient's care will be included in the medical record in a timely manner.~~

~~2. Ancillary/diagnostic testing may include:~~

~~a. Cardiology~~
~~b. Laboratory~~
~~c. Radiology~~
~~d. Vascular lab~~

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

~~1. The clinician will track/review all test results and have available for the physician to review prior to seeing the patient.~~

~~2. The clinician will notify the physician of significant findings as directed by the physician (telephone or fax) and document the communication on the CDCR Nursing Communication Note.~~

~~3. All results are available for physicians and clinical staff to review in Cerner.~~

~~4. If the physician is unavailable for critical or significant values, the patient's primary physician or available physician at the institution will be notified.~~

~~5. Critical/significant values will be given to the Clinic physician or designee for follow up when physicians involved in the care of the patient are not available.~~

~~6. Results will be faxed to the California Department of Corrections and Rehabilitation (CDCR) Primary Care Physician (PCP).~~

Tri-City Medical Cent
Oceanside, California

OUTPATIENT FORENSIC CL

DELETE. Follow Medical Staff Policy: Medical Record Documentation Requirements, #8710-518

ISSUE DATE: 05/11

SUBJECT: History and Physical

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Familiarity with the patient's medical history and current health status is essential to the plan of care developed for each patient seen at the Clinic. The initial process in the program consists of a thorough documentation of the patients' medical history and a physical examination. Factors to the chief complaint are the main emphasis of this process.~~

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

~~1. As part of the initial evaluation, the physician will complete a history and physical documenting on the physician's notes and dictate a report incorporating the elements of the history and physical dictation outline as designated below:~~

~~a. Chief Complaint~~
~~b. History of Present Illness~~
~~c. Review of Systems~~
~~d. Physical Examination~~
~~e. Assessment and Plan~~

~~2. As part of the preparation for surgery, a pre-operative history and physical will be done that meets the following conditions:~~

~~a. The H&P must be done prior to the procedure/admission, per hospital policy~~
~~b. If the H&P was done more than 7 days prior to the date of the surgery, the primary care physician or designee must complete the interim H&P note before admission/surgery.~~
~~c. The patient must have medical clearance prior to any surgical procedure.~~

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

~~1. The physician will perform the initial exam and medical history review.~~
~~2. Any staff physician, primary physician, or designee may do the pre-operative H&P and clear the patient medically for surgery.~~
~~3.~~1. ~~The findings will be documented on the appropriate forms and dictated according to hospital policy/procedure.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE:	**05/11**	**SUBJECT:**	**Hospital Admission from the Outpatient Services Clinic**
REVISION DATE(S):	**01/13**		

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval;	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. This policy delineates the procedure for an unplanned admission to the hospital directly from the Clinic.

B. **POLICY:**

1. Patient admissions to the hospital from the Clinic will be done in a safe and efficient manner.
2. The physician will document the recommendation to admit the patient on the Request for Services Form and notify the California Department of Corrections and Rehabilitation (CDCR) **or San Diego Sheriff's Department** Officers that accompanied the patient.
3. The RN ~~or LVN~~ will contact the institution advise them of the admission.
4. The Clinic will provide pertinent medical, demographic and treatment information to the hospital immediately upon admission. Information from clinic record will be available to providers within the Medical Center.

C. **PROCEDURE:**

1. Upon evaluation by the physician, if admission is deemed necessary, orders for admission will be generated.
   a. The physician will have the RN or Medical Assistant contact the institution to notify them of the unplanned admission (if the patient is not triaged to the ED).
   b. If the institution concurs, the patient will be admitted under the care of the physician who saw the patient in the clinic.
   c. The Inpatient ~~Forensic Unit RN/ANM~~ **Progressive Care Unit Charge Nurse or Progressive Care Unit Clinical Nurse Manager** will be notified ~~immediately~~ by the RN about the pending admission.
   ~~d. The Inpatient Forensic Unit Nurse Manager will also be notified of the admission via email by the Clinic Manager, RN, or Medical Assistant.~~
   ~~e.~~**d.** The RN will provide a verbal report to ~~the Inpatient Forensic Unit~~ **Progressive Care Unit** RN to ensure continuity of care.
   ~~f.~~**e.** The RN will act as liaison between the hospital and the institution for any questions that might arise about the unplanned admission.
   ~~g.~~**f.** After admission, the RN **or the Charge RN** in ~~the~~ Progressive Care Unit ~~in~~ **the Progressive Care Unit** will act as the liaison between the hospital and the institution for any questions or updates.
   ~~h.~~**g.** The surgeon and/or the surgeon's office will be contacted to schedule any surgical procedures planned during the hospital admission.
   ~~i.~~**h.** The patient will be kept in the Clinic and closely monitored until the ~~Inpatient Forensic~~**Progressive Care** ~~u~~**U**nit is ready to receive the patient.

~~j.~~**i.** The RN or Medical Assistant will coordinate the transfer of the patient to ~~the Inpatient Forensic~~ **the Progressive Care** Unit with the CDCR **or San Diego Sheriff's** Officers who will transport the patient to the ~~hospital Inpatient Forensic~~ **Progressive Care** ~~u~~nit.

~~k.~~**j.** If the patient is unstable and cannot be admitted immediately to ~~the Inpatient Forensic unit,~~ **Progressive Care Unit,** the patient will be transferred via CDCR **or San Diego Sheriff's** Officers or ambulance to the Emergency Department after the Emergency Department Charge Nurse has been notified.

Tri-City Medical Center
Oceanside, California

DELETE. Follow Pateint Care Services Policy: Code Blue Response Plan

OUTPATIENT FORENSIC CLIN

ISSUE DATE: 05/11 **SUBJECT:** Medical Emergencies

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. Sudden and unexpected medical events may occur at any time. To minimize adverse/detrimental affects to the patient, prompt/immediate response from competent and qualified staff is required. This policy outlines the process by which the clinic remains current and capable to respond effectively to medical emergencies.~~

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

~~1. The provision for emergent care in the Clinic will remain current through the appropriate certification and practice of its staff members.~~

~~2. All clinical staff will maintain current CPR certification and be competent in:~~

~~a. Identifying emergency situations~~

~~b. The proper notification/communication process~~

~~c. Palpating pulses~~

~~d. Maintaining an adequate airway~~

~~e. The use of oxygen therapy~~

~~f. Performing adequate chest compression~~

~~3. Response to an emergency by the clinical staff will be limited to basic CPR~~

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

~~1. Once a valid emergency situation has been identified, other clinic staff members will be called immediately to assist.~~

~~a. Each California Department of Corrections and Rehabilitation Officer that is stationed in the exam room with the patient will use their whistle should an emergency arise to alert the staff.~~

~~b. The support staff (or any available staff member) will dial 911.~~

~~c. Basic CPR will be administered until the advanced emergency team has arrived.~~

~~d. The support staff, with the assistance and direction from the clinical staff, will be responsible for coordinating the advanced emergency responder traffic.~~

~~e. The support staff will also maintain order in the clinic and be available for questions from the institutions, etc. while adhering to all applicable privacy and confidentiality policies and regulations.~~

~~f. The RN or Medical Assistant will coordinate the clinic's emergency response activity and remain with the patient until EMS arrives.~~

~~g.~~a. ~~The RN or Medical Assistant will notify the institution(s) of the emergency and where the patient or patients are transferred to.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11 **SUBJECT:** Medical Record Review

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. Documentation of assessment findings, procedure/treatment, etc. and appropriate signatures must always be included in the medical record. Pursuant to the hospital policy, the following defines the process used to identify incomplete records and the steps taken to correct deficiencies in the Clinic.

B. **POLICY:**

1. All charts will be reviewed by the RN or Medical Assistant for incomplete information after each clinic visit prior to transferring to the health information department of the hospital to be scanned into the Cerner system.
2. Incomplete records will be returned to the appropriate clinician for completion.
3. The quality management/improvement process will be utilized as needed to improve the compliance with record completion.

C. **PROCEDURE:**

1. The RN or Medical Assistant will review the medical record for incomplete information before the patient is discharged from the clinic.
2. The RN or Medical Assistant will communicate the findings to the appropriate person(s).
3. When indicated, the physician or clinician will be notified of the findings to be completed within 24 hours. The completed record will be sent to the health information department for scanning into Cerner for that specific patient encounter.
4. The clinician will be responsible for ensuring that the record is completed.
   a. The RN will work collaboratively with the Medical Assistant to achieve record completion.
5. The hospital's medical staff rules and regulations will be followed to complete the medical record.
   a. If the physician does not complete the record within 24 hours, the clinic staff will contact the physician to inform him/her to complete the record.
   b. If the physician does not complete the record within 72 hours after the initial notice the medical director or designee will be notified and they will contact the physician.
   c. Identified patterns of record deficiencies will be reported to the Medical Staff Office for review.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11 **SUBJECT: Patient Instructions**

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. The instructions for the patient will be outlined **and documented** in a clear understanding ~~documented~~ on the Request for Services (RFS) and dictated into the medical report after each clinic visit by the physician **or written in the physician's progress note located in the patient's medical record.**.

B. **POLICY:**

1. All patients receiving treatment at the Clinic will have the recommendations clearly written on the RFS that is provided to the institutions to review and approve any recommendations outlined by the physician.

C. **PROCEDURE:**

1. The physician will write physician orders and/or recommendations on the RFS after each visit as well as dictate those orders in his/her medical report.
2. The recommended next appointment date and time will be included on the RFS.
3. The original copy of the RFS will be given to the CDCR **or San Diego Sheriff's Department** Officer who accompanied the patient.
4. A copy of the RFS will remain a permanent part of the medical record.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11

SUBJECT: Physician Orders / Request for Services

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. This policy defines the circumstances in which a Request for Services from the institution is received by the Clinic and after the TCMC physician evaluates the patient and initiates an order.

B. **POLICY:**

1. Only physicians/healthcare professionals granted hospital medical staff privileges may provide written, telephone or verbal orders for patients being seen at the Clinic.
2. The clinical staff will take orders only from the Clinic physician.
3. Any treatment/procedure may not be performed without the physician's written, verbal or telephone instruction *unless* defined by policy and/or falls within the scope of nursing practice, as mandated by the State of California.
4. Orders for patients not being seen by the physicians at the Clinic may not be accepted or implemented by the clinical staff unless they are from the physicians at the institutions that is documented on the Request for Services (RFS).
5. Hospital policy will be followed when implementing physician's orders.

C. **PROCEDURE:**

1. When the physician is on site, orders will be written and signed by the physician after each clinic visit. These orders are recommendations per California Department of Corrections and Rehabilitation and will be dictated into their medical report.
2. Verbal orders may be taken by the licensed clinical staff at the direction of the clinic physician caring for the patient. The verbal order will be called to the institution for approval. If approval is not given at that time, the physician must indicate this order on the RFS and dictate it into his/her medical report with the reason for the order.
3. All orders/recommendations will be documented on the RFS.
4. All physician orders will be noted by a registered nurse according to hospital policy.
5. If the physician determines the patient will require surgery he/she will complete the PRE-OP orders at the time of the visit.
6. PRE-OP orders will be given to the RN to hold until approval for surgery is received **and surgery date is received from surgeon's office**.
7. The RN in the clinic will communicate the orders to the RN at the institution via fax so said orders can be completed prior to the admission date for surgery.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11 **SUBJECT:** **Receiving of Patients into the Clinic**

REVISION DATE(S): 01/13

Department Approval:	**03/20**
Medical Staff Department or Division:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/20**
Administration Approval;	**08/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Establishing Clinic scheduling and receiving of patient:
   a. Provides for orderly, efficient approach to patient visits
   b. Minimizes patient waiting periods
   c. Allows for adequate time for evaluation/treatment
   d. Defines a uniform approach to scheduling for staff members
   e. Assigns responsibilities to avoid duplication of effort

B. **POLICY:**

1. Patients will be scheduled appropriately; allowing adequate time between visits to prevent prolonged waiting time for all patients.
2. **Requests for S**scheduling of patients will be directed by the California Department of Corrections and Rehabilitation (CDCR) **or**~~and~~ **San Diego Sheriff's Department and** coordinated by the Clinic staff.

C. **PROCEDURE:**

~~1. Patient Arrival at the Clinic~~
   ~~a. CDCR Officers will be instructed to notify the Clinic upon arrival by using the call system at the rear entrance of the Clinic.~~
   ~~b. Clinic staff will identify the CDCR Officers and patients by the intercom/monitor system and allow access into the Clinic.~~

~~2.~~**1.** Schedule Order
   a. Patients will be seen according to their scheduled appointment~~.~~**, and order of arrival**
   b. If the clinic session is running behind, the clinic staff will notify the CDCR **or San Diego Sheriff's** Officers.~~ who, in turn, will inform the waiting patients.~~.

~~3.~~**2.** Follow-up Appointments
   a. The recommendation for follow up will be outlined on the Request for Services document. The CDCR Officers will be given the original and a copy will be maintained in the chart.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11 **SUBJECT:** Scope of Services

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **POLICY:**
1. The Outpatient Forensic Clinic provides outpatient treatment for inmates who are incarcerated within the California Department of Corrections and Rehabilitation (CDCR) **and the San Diego Sheriff's Department**. These ~~are~~ patients are seen with various diagnoses, to include diabetes, rental failure, peripheral vascular disease, hypertension, and many other chronic illnesses.
2. Telemedicine is also part of the Outpatient **Speciality Services Clinic** ~~Forensic Clinic~~. Telemedicine allows the physician's to see patients at the institutions via teleconferencing.

B. **AGE POPULATIONS:**
1. The program has been designed to meet specific medical needs of the **incarcerated** adult population.

C. **TYPES OF PATIENTS:**
1. The patients seen in the Clinic are inmates who are incarcerated within the CDCR **and San Diego Sheriff's Departent** who come to us from area institutions with underlying illnesses including, but not limited to:
   a. Age-related illnesses
   b. A variety of chronic illness, such as diabetes and its complications
   c. Multiple medical problems
   d. Auto-immune illnesses and their complications, such as vasculitis
   e. Post-traumatic injuries
   f. Vascular diseases, such as arterial and venous insufficiency
   g. All extremity conditions
   h. Skin problems
   ~~h.~~**i. Cancer illnesses**

D. **CARE AND SERVICES PROVIDED:**
1. The services provided by the Clinic include, but are not limited to management and treatment including:
   a. Consultations
   b. History & Physicals for Surgeries
   c. Wound debridement
   d. Skin problems
   e. GI assessments
   f. Orthopedic assessments
   ~~f.~~**g. Oncology services**
   ~~g.~~**h.** Vascular assessment
   ~~h.~~**i.** Nutritional assessment
   ~~i.~~**j.** Infection control

E. **HOURS OF SERVICE:**

1. The Clinic is open 5 days per week, Monday through Friday, 7:00 AM to **3:30**~~5:00~~ PM.

F. **STAFFING PLAN:**

1. The Clinic is staffed with:
   a. Medical staff members whose disciplines may include orthopedic surgery, general surgery, gastroenterology, vascular surgery, ENT, plastic surgery, cardiology, emergency medicine, podiatry, internal medicine, infectious disease, endocrinology, radiology,**urology,** nephrology, oncology, or dermatology. Qualified practitioners are selected based on:
      i. Proven skills in a relevant discipline
      ii. Medical and specialty experience
      iii. Established reputation in the medical community
      iv. Hospital staff privileges
      v. Ability to perform the requirements of the service to be rendered
   b. Clinic staff members include a full-time **Clinical Nurse** Manager, qualified RN, Medical Assistant /Clinical Referral Assistant, and Medical Director. The type and number are selected based on qualifications, experience and clinic needs. Clinic needs are determined by the number of scheduled patients in the program, the type and the acuity of patients, the type of service required by the patients and the overall requirements of the clinic. The members of the staff may include registered nurses, licensed vocational nurses, medical assistants, and clerical staff.

G. **PLAN FOR IMPROVING QUALITY OF CARE:**

1. The quality management program is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the Center. The key elements of the program are:
   a. Medical Director review of patient charts
   b. Collection of meaningful data
   c. Selection of measurable indicators
   d. A valid method of data collection, management and storage
   e. Analysis of the data by qualified persons
   f. Reporting to pertinent hospital personnel and committees/teams

H. **STANDARD AND PRACTICE GUIDELINES:**

1. The policies, procedures and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include professional practice guidelines and standards such as the American Society of Plastic Surgeons, American Medical Directors Association, American College of Foot and Ankle Surgeons, Agency for Healthcare Research and Quality, American College of Radiology, American Academy of Family Physicians, American Association of Clinical Endocrinologists, American Academy of Orthopaedic Surgeons, American College of Physical Medicine and Rehabilitation, and the Centers for Disease Control and Prevention.

I. **COMPETENCY/EDUCATION:**

1. Qualifications for the clinical staff of the program include:
   a. Clinical competency, as determined by level of care provided
   b. Current State license, where applicable
   c. Current BLS, where applicable
   d. Credentialing by the medical staff, where appropriate
2. Competency of the staff is based on:
   a. Education and training (licensing, certification and credentialing as appropriate)
   b. Ability to demonstrate the necessary skills to perform assigned duties
   c. Years of experience

d. Ability to communicate effectively with the medical staff, patients, and the California Department of Corrections and Rehabilitation (CDCR) **and San Diego Sheriff's Department**.

3. Allied health professionals will either be hospital employees or be credentialed by the medical staff services, as permitted by Medical Staff Bylaws.

Tri-City Medical Center
Oceanside, California

OUTPATIENT ~~FORENSIC CLINIC~~SPECIALITY SERVICES CLINIC

ISSUE DATE: 05/11 **SUBJECT:** Standards of Care and Practice

REVISION DATE(S): 01/13

Department Approval:	03/20
Medical Staff Department or Division:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/20
Administration Approval;	08/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. Standards of care and practice must be delineated with the following objectives in mind:
   a. Provide patients with an understanding of the services provided by the Clinic.
   b. Have competent care providers when being treated at the Clinic.
   c. Define the standards of care and practice as required by governing and oversight bodies such as the California Department of Public Health (CDPH), The Joint Commission, and California Department of Corrections and Rehabilitation (CDCR).

B. **POLICY:**
1. All clinical staff will follow the California Nurse Practice Act and ANA Standards of Care and Practice in the delivery of patient care.
2. The Clinic will operate according to the established standards, which addresses all aspects of care.
3. The standards of care and practice will be consistent with care and practice standards and mission of the hospital but will be specifically designed for the outpatient services provided at the Clinic.
4. Standards will be developed collaboratively with other relevant disciplines to maintain constancy in the level of care provided throughout the institution.
5. All activities including treatment plans, policies and procedures, documentation and performance improvement measures will correlate with the approved standards of care and practice.

C. **PROCEDURE:**
1. The clinic manager, director and the clinical staff of the Clinic are responsible for developing the standards of care and practice.
2. The hospital format is utilized and defines the:
   a. Standard of care as the expected outcome
   b. Standard of practice as the scope of service, the person responsible, and the timeframe for completion
3. All policies and procedures will be developed/revised utilizing the established standards.
4. The performance improvement (PI) efforts will incorporate the standards in the PI activities.
5. The designated clinic team will review the standards annually.
~~6. The Standards of Care and Practice – see attachment.~~

D. **REFERENCE~~Attachment~~:**
1. **American Nurses Association** Standard of Care & Practice

Community Healthcare & Alliance Committee (No meeting held in July & August, 2020)

Finance, Operations & Planning Committee
(No meeting held in July & August, 2020)

Audit, Compliance & Ethics Committee
(No meeting held in
July & August, 2020)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

June 11, 2020 – 6:00 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 6:00 p.m. on June 11, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky Chavez
Director Leigh Anne Grass
Director Julie Nygaard
Director RoseMarie V. Reno
Director Larry W. Schallock
Director Tracy Younger

Absent was Director George Coulter

Also present were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief Nurse Executive
Roger Cortez, Chief Compliance Officer
Susan Bond, General Counsel
Mark Yamanaka, M.D., Chief of Staff
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 6:08 p.m. via teleconference with attendance as listed above.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

3. Approval of agenda.

   It was moved by Director Nygaard to approve the agenda as presented. Director Schallock seconded the motion. The motion passed (6-0-0-1) by a roll call vote with Director Coulter absent.

4. New Business

   a) Review, discussion and action regarding the Operating and Capital Budgets for Fiscal Year 2021.

Mr. Rivas presented the Operating and Capital Budgets for Fiscal Year 2021 for the Board's review and consideration of approval. He reviewed the following:

- Key Indicators
- Financial Statements
  - Statement of Revenue and Expenses
  - Balance Sheet
  - Statement of Cash Flows
  - Summary Explanations of Statement of Revenue and Expenses, Balance Sheet and Statement of Cash Flows
- Capital Budget
  - Capital Budget Executive Summary
  - Capital Equipment and Renovations Summary

Mr. Rivas highlighted some of the Key Indicators including Average Daily Census (ADC) and Average Length of Stay (ALOS). He noted one important metric is Productive FTEs per Adjusted Occupied Bed. Key Ancillary Departments include ED Visits and surgeries which are expected to rebound.

Mr. Rivas provided an overview of the Fiscal 2021 budget which forecasts Excess Revenue Over Expenses (EROE) of $245,000. This projected EROE improvement of $15.8 million over the projected Fiscal 2020 results is expected to be realized through a combination of revenue increases from increased patient volume, service line strategic initiatives and continued expense management and workforce control. The budget anticipates capital acquisition and renovation investment of approximately $11.8 million.

Total Operating Revenue is budgeted to increase by $6.4 million over Fiscal Year 2020.

Mr. Rivas reviewed expense categories that are budgeted to incur significant changes in Fiscal 2021 which included Salaries and Related Expenses, Supplies and Pharmaceutical Expense, Physician Fees, Depreciation and Amortization. He reported non-operating income is expected to decrease by $7.5 million in FY2021 due primarily to the grant Tri-City received from the CARES act related to COVID-19 for the loss of revenue and increase in expenses.

Directors asked questions throughout Mr. Rivas's presentation which Mr. Rivas and Mr. Dietlin addressed.

Mr. Dietlin emphasized that the proposed budget is based on our best knowledge as of today and could be negatively impacted by a number of factors including a major COVID-19 surge, the community's willingness to seek inpatient surgeries and procedures as well as any federal, state or local government rulings.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors approve the Operating and Capital Budgets for Fiscal Year 2021 as presented in the Operating & Capital Budgets. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES: Directors: Chavez, Grass, Nygaard, Reno, Schallock and Younger

NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter**

5 Comments from Members of the Public

There were no comments from members of the public.

6. Adjournment

It was moved by Director Nygaard and seconded by Director Chavez to adjourn the meeting at 6:41 p.m. The motion passed (6-0-0-1) with Director Coulter absent.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

June 25, 2020 – 3:30 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 3:30 p.m. on June 25, 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
Candice Parras, Chief, Patient Care Services
Dr. Gene Ma, Chief Medical Officer
Susan Bond, General Counsel
Anna Aguilar, Vice President/Human Resources
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 3:35 p.m. via teleconference with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Chavez to approve the agenda as presented. Director Younger seconded the motion. The motion passed unanimously (7-0) via roll call vote.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the June 25, 2020 Regular Board of Directors Meeting Agenda.

The following individuals requested the right to speak on Item 12. Comments from Members of the Public:

- Edmundo Garcia, CNA Labor Representative
- Cathy Cronce, RN/Chair Clinical Practice Counsel

4. Introduction of Candice Parras, Chief, Patient Care Services.

Mr. Steve Dietlin, CEO welcomed Ms. Parras into her new role. He stated Ms. Parras will continue oversight of the Emergency Department along with her new role as Chief of Patient Care Services. Mr. Dietlin commented on Ms. Parras' vast experience both in the ICU and as a former Chief Nurse Executive.

Ms. Candice Parras stated everyone has been very supportive and she looks forward to serving the District in her new role.

5. May, 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 - $20,843
- Operating Expense - $24,425
- EBITDA – ($1,774)
- EROE – ($2,982)

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 132
- Adjusted Patient Days – 7,393
- Surgery Cases – 432
- ED Visits – 3,306

6. 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.

Mr. Rivas explained this is a resolution that is a statutory requirement that sets an appropriation limit for the District. He further explained it is a calculation that sets the maximum amount the District could collect in tax revenue and is based on cost of living and population statistics. Special Districts have an apportionment of the 1% property tax that is collected and the resolution reflects the maximum Tri-City could receive.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors 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. 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**

b) **Consideration to certify a recognized Employee Organization as the exclusive bargaining representative for the following classification of employees in Rehab Services and to accrete these into the existing SEIU-UHW Contract:**

1) Speech Pathologist
2) Speech Pathologist, Lead

Ms. Anna Aguilar, Vice President/Human Resources reported SEIU-UHW requested to be recognized as the exclusive representative for all regular, part time and per diem employees in the Speech Pathology Classification. On June 24, 2020, authorization cards were verified and it was determined that SEIU exceeded the majority designation for the seven (7) Speech Pathologists.

Director Schallock called for a point of order. He requested clarification on whether the Lead Speech Pathologist was included in the card count. Ms. Aguilar responded that the Speech Pathologist Lead has been removed and is not included in the card count.

It was moved by Director Schallock that the TCHD Board of Directors certify the results of the card check to determine the majority of employees within the technical classification voted to be represented by SEIU-UHW to include the following classification of employees in Rehab Services to accrete these into the existing SEIU-UHW contract: Director Nygaard seconded the motion.

1) Speech Pathologist

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**

The motion passed unanimously (7-0) by a roll call vote.

7. Old Business – None

8. Chief of Staff

a) Consideration of June 2020 Credentialing Actions and Reappointments Involving the Medical Staff and as recommended by the Medical Executive Committee on June 22, 2020.

On behalf of Dr. Yamanaka, Dr. Gene Ma, Chief Medical Officer presented the June 2020 Credentialing actions for the Board's consideration which included ten (10) new physicians and 31 reappointments.

There were no questions or comments by Board members.

It was moved by Director Nygaard to approve the June 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on June 22, 2020. 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**

b) Consideration of Rules & Regulations:

1) Department of Pediatrics
2) Department of Family Medicine

Dr Ma also presented the Department of Pediatrics and Department of Family Medicine Rules and Regulations for the Board's consideration.

It was moved by Director Chavez to approve the Department of Pediatrics and Department of Family Medicine Rules & Regulations as presented and recommended by the Medical Executive Committee on June 22, 2020. 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 Schallock to approve the Consent Agenda. 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. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

11. Comments by Members of the Public

Chairperson Grass recognized Edmundo Garcia, CNA Labor Relations Representative, Cathy Cronce, RN and Chair of the Clinical Practice Counsel and Adela Sanchez, RN with Labor & Delivery who welcomed Ms. Parras into her new role and spoke about the positive changes they have witnessed thus far. The speakers also commented on the need to listen to nurse's concerns regarding safe staffing, dedicated break nurses and sufficient PPE for all front-line workers.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO gave a brief report on the COVID-19 pandemic and the steps the hospital is taking to ensure the health and safety of our staff and patients. He also provided an update on the hospital's testing capabilities related to COVID.

Mr. Dietlin also commented on the loss in revenues since the pandemic began in March and the need for voluntary and non-voluntary furloughs to offset some of those losses.

Mr. Dietlin expressed his appreciation to the Medical Staff, nursing staff, all employees, the Foundation and the community as a whole for their support and contributions during this healthcare crisis.

13. Board Communications

Director Coulter had no comments.

Director Younger expressed her appreciation to all who participated in last week's peaceful demonstration.

Director Younger welcomed Chief of Patient Care Services, Candice Parras to her new role.

Director Chavez also welcomed Ms. Candice Parras to her first Board meeting and to her new role. He commented on the high level of professionalism by our leadership team during this pandemic. Director Chavez stated he is also interested in hearing what the organization is doing to ensure the mental health of our healthcare professionals during this pandemic.

Director Schallock welcomed Ms. Candice Parras and wished her success in her new role. He noted the positive comments from staff and looks forward to moving forward as a team.

Director Schallock reported *Oceanside Magazine* ran a segment *entitled Oceanside's Finest Tri-City Medical Center's Employees*" and focused on the extraordinary efforts from staff who go above and beyond the call of duty.

Lastly, Director Schallock stated Mr. Jeff Marks, President of the Auxiliary is not going to seek a second term. He expressed his appreciation to Mr. Marks and all the

Auxilians and looks forward to the time the volunteers are able to return and serve the hospital.

Director Reno welcomed Ms. Candice Parras and applauded her for accepting the challenge.

Lastly Director Reno expressed her appreciation to Mr. Dietlin and the team for their efforts in bringing our Leapfrog rating up to a "B" and commented that we are well on our way to an "A' rating

Director Nygaard also welcomed Ms. Candice Parras to her new role as Chief of Patient Care Services.

14. Report from Chairperson

Chairperson Grass had no comments.

15. Move to adjourn

It was moved by Director Chavez and seconded by Director Reno to adjourn the meeting. The motion passed unanimously (7-0) by a roll call vote.

16. There being no further business Chairperson Grass adjourned the meeting at 4:14 p.m.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

July 3, 2020 – 4:00 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 4:00 p.m. on July 3, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky Chavez
Director Leigh Anne Grass
Director Julie Nygaard
Director Larry W. Schallock
Director Tracy Younger

Absent was Director RoseMarie V. Reno and Director George W. Coulter

Also present via teleconference were:

Steve Dietlin, Chief Executive Officer
Scott Livingstone, Chief Operations Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief Nurse Executive
Dr. Gene Ma, Chief Medical Officer
Jeremy Raimo, Senior Director, Business Development
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 4:15 p.m. via teleconference with attendance as listed above.

2. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the Board Agenda. There were no public comments.

   There were no members of the public wishing to speak.

3. Approval of agenda

   It was moved by Director Younger to approve the agenda as presented. Director Nygaard seconded the motion. The motion passed (6-0-0-2) by a roll call vote with Directors Coulter and Reno absent.

4. Oral Announcement of Items to be discussed during Closed Session

Chairperson Grass made an oral announcement of the items listed on the July 3, 2020 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets with various disclosure dates,

5. Motion to go into Closed Session

It was moved by Director Younger and seconded by Director Chavez to go into Closed Session at 4:17 p.m. The motion passed (6-0-0-2) by a roll call vote with Directors Coulter and Reno absent.

6. At 4:55 p.m. the Board returned to Open Session with attendance as previously noted.

7. Report from Chairperson on any action taken in Closed Session.

Chairperson Grass reported the Board in Closed Session reviewed and discussed proposed new services and programs and took no action.

8. New Business

a) Consideration for approval of a physician recruitment agreement with Dr. Richard Liu for an expenditure not to exceed $27,500 in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors find it in the best interest of the communities served by the District to approve an expenditure, not to exceed $27,500 in order to facilitate this Otolaryngology physician practicing medicine in the communities served by the District. This will be accomplished through a physician recruitment agreement with Dr. Richard Liu to Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Reno**

b) Consideration for approval of a physician recruitment agreement with Dr. Paul Lizotte for an expenditure not to exceed $510,000 in order to facilitate this Internal Medicine physician practicing medicine in the communities served by the District.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors find it in the best interest of the communities served by the District to approve an expenditure, not to exceed $510,000 in order to facilitate this Internal Medicine Physician practicing medicine in the communities served by the District. This will be accomplished through a

physician recruitment agreement with Dr. Paul Lizotte to practice in a location within the District approved by TCHD. Director Nygaard seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter, Reno**

c) Consideration for approval of a physician recruitment agreement with Dr. Lenzy Stephenson for an expenditure not to exceed $220,000 in order to facilitate this Family Practice physician practicing medicine in the communities served by the District.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors find it in the best interest of the communities served by the District to approve an expenditure, not to exceed $220,000 in order to facilitate this Family Medicine physician practicing medicine in the communities served by the District. This will be accomplished through a physician recruitment agreement (not to exceed a one-year income guarantee with a two-year forgiveness period) with Dr. Lenzy Stephenson to practice in a location within the District approved by TCHD. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter, Reno**

d) Consideration for approval of a physician recruitment agreement with Dr. Marius Viseroi for an expenditure not to exceed $55,000 in order to facilitate this Pulmonary/Critical Care physician practicing medicine in the communities served by the District.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors find it in the best interest of the communities served by the District to approve an expenditure, not to exceed $55,000 in order to facilitate this Pulmonary/Critical Care physician practicing medicine in the communities served by the District. This will be accomplished through a physician recruitment agreement with Dr. Marius Viseroi to practice in a location within the District approved by TCHD. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter, Reno**

e) Consideration for approval of a physician recruitment agreement with Dr. Aaron Sze-Long Yung for an expenditure not to exceed $942,500 in order to facilitate this Interventional Cardiologist physician practicing in the communities served by the District.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Schallock that the Tri-City Healthcare District Board of Directors find it in the best interest of the communities served by the District to approve an expenditure, not to exceed $942,500 in order to facilitate this Interventional Cardiologist physician practicing medicine in the communities served by the District. This will be accomplished through an independent physician recruitment agreement with Dr. Aaron Sze-Long to practice in a location within the District approved by TCHD. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter, Reno**

f) Consideration for approval, execution and delivery of agreements and documents necessary or advisable to extend the 1206(b) Primary Care Clinic including a professional services agreement and lease agreement.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Younger that the Tri-City Healthcare District Board of Directors approve execution and delivery of agreements and documents necessary or advisable to extend the 1206(b) Primary Care Clinic including a Professional Services Agreement and lease agreement. Director Chavez seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**

ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Coulter, Reno**

g) Consideration for approval, execution and delivery of agreements and documents necessary or advisable to open a 1206(b) Oncology Clinic.

Director Coulter indicated that he had joined the meeting.

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Younger that the Tri-City Healthcare District Board of Directors approve execution and delivery of agreements and documents necessary or advisable to open a 1206(b) Oncology Clinic. Director Coulter seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Reno**

h) Consideration for approval to execute lease and sublease agreements for 3907 Waring Road, Suite 3

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Chavez that the Tri-City Healthcare District Board of Directors approve execution of a lease and sublease agreement for 3907 Waring Road, Suite 3, Oceanside. Director Younger seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Reno**

i) Consideration for approval to execute a lease agreement for 115 North El Camino Real, Oceanside, CA

The Chairperson opened the floor for discussion regarding any questions on the proposed transaction.

It was moved by Director Nygaard that the Tri-City Healthcare District Board of Directors approve execution of a lease agreement for 115 North El Camino Real, Oceanside. Director Schallock seconded the motion.

The vote on the motion was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Reno**

9. Adjournment

It was moved by Director Chavez and seconded by Director Schallock to adjourn the meeting at 5:12 p.m. The motion passed (6-0-0-1) by a roll call vote with Director Reno absent.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

Volume

Performance compared to prior year: Better | Same | Worse

Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	16												16
FY19	16	19	18	31	30	15	20	19	24	15	18	24	16

Mazor Robotic Spine Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	13												13
FY19	9	8	9	12	7	5	11	9	11	5	8	11	9

Inpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	9												9
FY19	9	16	11	11	12	13	10	8	6	7	7	5	9

Outpatient DaVinci Robotic Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	30												30
FY19	19	23	27	33	31	24	27	29	21	14	18	34	19

Major Joint Replacement Surgery Cases (Lower Extremities)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	13												13
FY19	33	33	23	31	35	31	26	29	20	12	18	12	33

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	-	-	-	-	-	-	-	-	-	-	-	-	-

Acute Rehab Unit - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	12.9												12.9
FY19	6.2	4.5	7.7	7.0	5.0	3.0	7.1	7.7	9.0	7.0	9.3	11.5	6.2

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	12.2												12.2
FY19	9.4	10.3	13.4	9.7	9.5	9.4	7.8	10.7	10.0	6.3	8.8	7.4	9.4

Hospital - Average Daily Census (ADC)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	142.5												142.5
FY19	143.4	143.6	150.6	143.2	144.0	160.2	153.9	149.3	137.6	124.0	132.0	139.3	143.4

Deliveries

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	161												161
FY19	168	171	156	159	146	159	153	136	124	113	133	139	168

Inpatient Cardiac Interventions

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	10												10
FY19	7	8	7	17	14	10	13	10	7	5	10	0	7

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	9												9
FY19	7	5	12	6	11	9	14	8	13	5	4	0	7

Open Heart Surgery Cases

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	2												2
FY19	9	5	2	8	5	5	4	8	5	4	4	2	9

TCMC Adjusted Factor (Total Revenue/IP Revenue)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD
FY20	1.88												1.88
FY19	1.85	1.89	1.91	1.86	1.86	1.79	1.80	1.80	1.81	1.69	1.81	1.84	1.85

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
FY21	51.1												51.1	48-52
FY20	52.8	56.4	59.2	61.2	61.9	62.6	61.5	58.7	53.1	50.5	56.4		52.8	

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
FY21	107.1												107.1	75-100
FY20	93.0	89.9	90.8	98.4	92.8	85.5	88.5	94.3	88.9	97.3	105.5		93.0	

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
FY21	($1,489)												($1,489)	($2,862)
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)	($4,467)	$1,921	($2,982)		($476)	

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
FY21	-6.12%												-6.12%	-12.38%
FY20	-1.65%	-1.66%	-2.71%	-1.08%	-3.91%	-3.75%	-2.85%	-2.69%	-17.32%	9.94%	-14.31%		-1.65%	

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
FY21	($191)												($191)	$ (1,673)
FY20	$686	$681	$412	$683	$62	$128	$367	$551	($3,164)	$3,159	($1,774)		$686	

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
FY21	-0.78%												-0.78%	-7.24%
FY20	2.38%	2.30%	1.47%	2.36%	0.24%	0.46%	1.22%	2.02%	-12.27%	16.35%	-8.51%		2.38%	

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
FY21	5.38												5.38	7.02
FY20	7.04	6.80	6.21	6.90	6.58	6.44	6.71	6.82	7.02	7.27	5.61		7.04	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	
FY21	$59.5												
FY20	$52.4	$44.8	$43.7	$45.6	$38.2	$31.9	$35.2	$35.8	$34.8	$51.2	$62.3		

Tri-City Medical Center

ADVANCED HEALTH CA FOR YOU

Building Operating Leases
Month Ending July 31, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	47,418.30	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	Approx 10,218	$2.58	(a)	28,313.71	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)	19,810.00	07/01/20	06/30/30	**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	$2.50	(a)	16,592.85	07/01/17	06/30/22	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,011.00	04/01/20	03/31/21	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,172	$2.15	(a)	6,330.29	07/01/20	04/30/21	**TCMC Cardiology Clinic** 3907 Waring Road, Suite 3 Oceanside, CA 92056	7590
Melrose Plaza Complex, LP c/o Five K Management, Inc. P O Box 2522 La Jolla, CA 92038 V#43849	Approx 7,347	$1.35	(a)	10,707.03	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	Approx 4,760	$4.12	(a)	27,850.00	10/01/12	10/01/22	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	13,356.32	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	07/31/20	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**$181,143.50**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7095	CPMA MEMBER CME ONLINE MEETING	63020 EXP	229.00	83324	BRIAN BOBICK MD
7420	CST RENEWAL	111119 EDU	155.00	83739	NICHOLE ANN RYKOSKI
8340	ASPEN CONFERENCE	21020 EDU	425.00	83104	PATRICIA MATTHEWS

**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.