TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 10, 2020 – 3:30 o'clock p.m.

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

Dial in #: (669-900-6833) To Listen and Address the Board when called upon: Meeting ID:928 4955 6121; Passcode:655829

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	2 min.	Standard
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	Welcome and Introduction of Newly Elected Board Members: 1) Nina Chaya, M.D. 2) Gigi Gleason 3) Adela Sanchez, RN 4) Leigh Anne Grass, RN	10 min.	Chair
6	October 2020 Financial Statement Results	10 min.	CFO

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

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

	Agenda Item	Time Allotted	Requestor
7	New Business – a) Consideration and possible action to elect Board of Director Officers for calendar year 2021: 1) Chair 2) Vice Chair 3) Secretary 4) Treasurer 5) Assistant Secretary 6) Assistant Treasurer 7) Board Member b) Consideration of proposed 2020 Board Meeting Schedule c) Consideration of Board Member Stipend	 20 min. 5 min. 5 min.	 Chair Chair Chair
8	Old Business – None	--	--
9	Chief of Staff a) November 2020 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on November 23, 2020.	5 min.	COS
10	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Consideration to approve an agreement with the affiliated physicians practicing at Orthopedic Specialists of North County (OSNC) for a joint marketing agreement with TCHD for a term of 24 months, beginning January 1, 2020 through December 31, 2022, for an annual cost of $100,000 and a total cost for the term of $200,000. (2) Consideration to approve an agreement with James Varrell, M.D. P.C., dba InSight Medical Group of California for tele-psychiatry services for a term of 24 months, beginning February 1, 2021 through January 31, 2023 for an annual cost of $288,000 and a total term cost of $576,000. (3) Consideration of an Administrative Services Revenue Agreement between Tri-City Healthcare District (TCHD) and Tri-City Pulmonary Medical Group, APC for $3,755 per month for 12 months beginning December 1, 2020 through November 30, 2021 at an income of $3,755 per month. 4) Consideration of an agreement with Change Healthcare for Nuance PowerScribe upgrade/support for a term of 60 months, beginning January 1, 2021 through December 31, 2025 for a one time cost of $98,550 and an annual cost of $68,900 and a total cost for the term of $443,050.00 (5) Consideration of an agreement with Change Healthcare for PACS upgrade and support for a term of 60 months, beginning January 1, 2021 through December 31, 2025 for a one-time cost of $194,035.34, an annual cost of $50,104.70 and a total cost for the term of $444,558.84.	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	(6) Consideration to authorize the purchase agreement with SHI International, Corp. for a term of one (1) term beginning December 10, 2020 for a cost of $267,275.63, renewing annually. (7) Administrative & Board Committees **A. Policies** **1) Patient Care Services Policies & Procedures** a) Chemotherapy Administration Procedure b) Chemotherapy Patient Intake to the Nursing Units (Direct Admit, Outpatient or Forensic) Procedure c) HIV Testing: In an Occupational Exposure d) Medical Equipment Brought into the Facility e) Nephrostomy Drain, Care of Procedure f) Passy-Muir Speaking Valve Procedure g) Patient Owned Supplied Equipment Brought into the Facility h) Pet Therapy Policy i) Radiation Safety Policy j) Service Animals Policy k) Skin Preparation, Surgical/Procedural Policy l) Surgical hand Asepsis Procedure m) Urine Dipstik Using McKesson Consult 120 Urine Analyzer Procedure n) Y-90 Micropsphere Brachtherapy Patient Management **2) Administrative Policies & Procedures** a) Code Gray – Hostage Response Plan 283 b) Lost and Found Articles 202 **3) Unit Specific – Cardiac Cath Lab** a) Permanent Pacemaker Tray Setup Procedure b) PTCA Setup Procedure c) Se up IAB Catheter Procedure d) Stenting Procedure **4) Unit Specific – Cardiology** a) Stress Echocardiogram b) Echocardiogram Study Alert **5) Unit Specific – Emergency** a) Ketamine for Pain **6) Unit Specific – Infection Control** a) Bloodborne Pathogen Exposure Control Plan b) Ebola Plan Policy c) Prion Diseases: Transmissible Spongiform Encephalopathies IC-6-5 d) Required Reporting IC 12 **7) Unit Specific – Neonatal Intensive Care Unit (NICU)** a) Breast Milk Management in the NICU b) Neonatal Abstinence Syndrome, Management of c) Oxygen Hood: Neonate d) Postural Drainage, Percussion and Vibration of the Neonate (DELETE) e) Standards of Care – NICU		

	Agenda Item	Time Allotted	Requestor
	8) Outpatient Specialty Clinic a) Decontamination and Sterilization of Instruments b) Infection Prevention and Control Activities **9) Pulmonary** a) Pulmonary – Scope of Services b) Respiratory Care Students in the Patient Care Areas **10) Security** a) Storage of Weapons #507 b) Vehicle Jumpstart #234 (DELETE) **11) Surgical Services** a) Safety Measures: Radiation Policy (DELETE) (8) Board Committees **A. Community Healthcare Alliance Committee** Director Chavez, Committee Chair *(No meeting held in December, 2020)* **B. Finance, Operations & Planning Committee** Director Nygaard, Committee Chair Open Community Seats – 0 *(No meeting held in December, 2020)* **C. Audit, Compliance & Ethics Committee** Director Younger, Committee Chair Open Community Seats – 0 *(No meeting held in December, 2020)* (9) Minutes – Approval of: a) November 12, 2020, Regular Meeting b) November 19, 2020, Special Meeting (10) Meetings and Conferences – None (11) Dues and Memberships - (12) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (October, 2020) (d) Reimbursement Disclosure Report – (October, 2020) (e) Seminar/Conference Reports – None		CHAC Comm. FO&P Comm. Audit, Comp. & Ethics Comm. Standard
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard

	Agenda Item	Time Allotted	Requestor
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1 hour	
17	Adjournment		

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2021

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m.
Closed Session (when necessary) to begin at approximately 1:30 p.m.
(depending on agenda items).

- January 28, 2021 (Last Thursday)
- February 25, 2021 (Last Thursday)
- March 25, 2021 (Last Thursday)
- April 29, 2021 (Last Thursday)
- May 27, 2021 (Last Thursday)
- June 24, 2021 (Last Thursday)
- July 29, 2020 (DARK)
- August 26, 2021 (Last Thursday)
- September 30, 2021 (Last Thursday)
- October 28, 2021 (Last Thursday)
- November 25, 2021 (No Meeting; Combined with December Meeting)
- December 9, 2021 (Second Thursday in December)

The Board will be meeting "virtually" for the foreseeable future via Zoom during the COVID-19 pandemic.

Special Board Meetings – Special Board Meetings will be scheduled periodically throughout the year for Strategic Planning, Budget Consideration and Orientation to name a few. We will give you as much notice as possible.

Board Committee Meetings: Board Committee meetings have been temporarily suspended during the COVID-19 pandemic.

**** The newly elected Board Chairperson will designate committee assignments**

Proposed Schedule: December 10, 2020
Approved by BOD:

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 11, 2020

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/11/2020 – 10/31/2022)

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 12/11/2020 through 10/31/2022:

- **ALTSCHUH, Lauren MD/Emergency Medicine (TeamHealth)**
- **BETTI, Francesca MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – 1 of 2
November 11, 2020

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2021 -12/31/2022)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2021 through 12/31/2022, 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:

- **AMBO, Stanley, MD/Pediatrics/Active**
- **CHO, Aaron, MD/Radiology/Active**
- **KATO, Kambrie, MD/Teleradiology/Active Affiliate**
- **KYAW, Naing, MD/Nephrology/Active**
- **MAYBERRY, Jennifer, MD/Radiology/Active**
- **MOSTOFIAN, Eimaneh, MD/Obstetrics & Gynecology/Active**
- **NGUYEN, Minh, MD/Internal Medicine/Active**
- **POP, Simona, MD/Family Medicine/Refer and Follow**
- **SHAD, Javaid, MD/Gastroenterology/Active**
- **SINGH, Himani, MD/Oncology/Active**
- **WINE, David, MD/Internal Medicine/Refer and Follow**

RESIGNATIONS: (Effective date 12/31/2020 unless otherwise noted)

Automatic:

- **NOLAN, Frank, MD/Rheumatology**

Voluntary:

- **BROWN, Kaley, PAC/Physician Assistant**
- **FRISHBERG, Benjamin, MD/Neurology**
- **HANLEY, Matthew, MD/Orthopedic Surgery**

Attachment B

- **LIU, Collins, MD/Neurology**
- **MUHTASEB, Talal, MD/Obstetrics & Gynecology**
- **NEAL , Tyler, DO/Orthopedic Surgery**
- **TEDESCO, Anthony, DO/Orthopedic Surgery**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
November 11, 2020

STAFF STATUS CHANGE

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

- **WONG, Amy DPM** — **Podiatry**

ADDITIONAL PRIVILEGE REQUEST (Effective 12/11/2020)

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

- **YUNG, Aaron MD** — **Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 11, 2020

PROCTORING RECOMMENDATIONS

- LIU, Richard, MD — Otolaryngology
- RUIZ, Lizette, MD — Emergency Medicine
- YUNG, Aaron, MD — Cardiology

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 10, 2020
JOINT MARKETING AGREEMENT PROPOSAL

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

Vendor's Name: Affiliated physicians practicing at Orthopedic Specialists of North County (OSNC)

Area of Service: External Affairs

Term of Agreement: 24 months, Beginning, January 1, 2021 – Ending, December 31, 2022

Maximum Totals:

	Annual Cost Not to Exceed
OSNC Physicians	$100,000
Tri-City Healthcare District (TCHD)	$100,000
Agreement Totals:	$200,000

Description of Services/Supplies:

- This agreement establishes a Joint Marketing Agreement between Tri-City Healthcare District and the affiliated physicians practicing at Orthopedic Specialists of North County for the purposes of developing a strategic external affairs program to include marketing, communications, and community engagement activities.
- The total annual expense for this agreement shall not exceed $100,000 for Tri-City Healthcare District, with a total expense of $200,000 over the two-year term of the contract.

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: Aaron Byzak, Chief External Affairs Officer

Motion:
I move that the TCHD Board of Directors authorize the agreement with the affiliated physicians practicing at Orthopedic Specialists of North County (OSNC) for a joint marketing agreement with TCHD for a term of 24 months, beginning January 1, 2021 and ending December 31, 2022 for an annual cost of $100,000 and a total cost for the term of $200,000.

TCHD Board of Directors
DATE OF MEETING: December 10, 2020
Tele-Psychiatry Services Proposal

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

Vendor's Name: James Varrell, M.D., P.C.,
dba InSight Medical Group of California, a California Professional Corporation

Area of Service: Emergency Department and Medical / Surgical Floors

Term of Agreement: **24 months, Beginning, February 1, 2021 – Ending, January 31, 2023**

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$24,000	$288,000	$576,000

Description of Services/Supplies:

- InSight plus Regroup will provide on-demand tele-psychiatry services for the Emergency Department and medical / surgical floors
- Ongoing Program Support and Management - Clinical / QA, Operational and Technology
- All Physicians to be Credentialed by Tri-City Medical Staff Department

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

Person responsible for oversight of agreement: Candice Parras, Chief Patient Care Services

Motion:
I move that the TCHD Board of Directors authorize the agreement with James Varrell, M.D., P.C., dba InSight Medical Group of California for tele-psychiatry services for a term of 24 months, beginning February 1, 2021 and ending January 31, 2023 for an annual cost of $288,000, and a total cost for the term of $576,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 10, 2020
ADMINISTRATIVE SERVICES REVENUE AGREEMENT

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

Name: Tri-City Pulmonary Medical Group, APC & Tri-City Healthcare District (TCHD)

Term: 12 months beginning December 1, 2020 through November 30, 2021

Maximum Totals:

	Revenue Totals:
Space Rent	$938
Services & Equipment	$2,817
Total Monthly Revenue:	$3,755
Total Term Revenue:	**$45,060**

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director-Business Development / Steve Dietlin, Chief Executive Officer

Motion:
I move that the TCHD Board of Directors authorize the administrative services revenue agreement between Tri-City Healthcare District (TCHD) and Tri-City Pulmonary Medical Group, APC for $3,755 per month for 12 months and a total term revenue of $45,060.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 10, 2020
Change Healthcare Nuance Powerscribe Upgrade Support PROPOSAL

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

Vendor's Name: Change Healthcare (Nuance)

Area of Service: Radiology Powerscribe (Voice Recognition)

Term of Agreement: 60 months, Beginning, January 1, 2021 – Ending, December 31, 2025

Maximum Totals:

One-Time Cost	Annual Cost	Total Term Cost
$98,550.00	$68,900.00	$443,050.00

Description of Services/Supplies:

- Current Powerscribe near end-of-life but unable to be upgraded on current PACS version 11.9. Proposal includes platform upgrade and 5 years hardware/software support.

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

Person responsible for oversight of agreement: (Mark Albright / Scott Livingstone)

Motion:
I move that the TCHD Board of Directors approve an agreement with Change Healthcare for Nuance Powerscribe upgrade/support for a term of 60 months, beginning Jan. 1, 2021 and ending Dec. 31, 2025 for a one-time cost of $98,550.00 & an annual cost of $68,900.00, and a total cost for the term of $443,050.00.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 10, 2020
Change Healthcare PACS upgrade/support PROPOSAL

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

Vendor's Name: Change Healthcare (McKesson)

Area of Service: Radiology PACS

Term of Agreement: 60 months, Beginning, January 1, 2021 – Ending, December 31, 2025

Maximum Totals:

One-Time Cost	Annual Cost	Total Term Cost
$194,035.34	$50,104.70	$444,558.84

Description of Services/Supplies:

- *Current PACS software version 11.9 is end-of-life June 2021 and must be upgraded to 14.1.*
- Contract included upgrade and 5 years of hardware/software support. The quoted price includes a $50K discount of implementation services.

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

Person responsible for oversight of agreement: (Mark Albright / Scott Livingstone)

Motion:
I move that the TCHD Board of Directors approve an agreement with Change Healthcare for PACS upgrade and support for a term of 60 months, beginning January 1, 2021 and ending December 31, 2025 for a one-time cost of $194,035.34, an annual cost of $50,104.70, and a total cost for the term of $444,558.84.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 10, 2020
SHI International, CORP.

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

Vendor's Name: SHI International, Corp.

Area of Service: Microsoft Enterprise Licenses & Software Assurance

Term of Agreement: Annual software subscription 12/10/2020 – 12/09/2021, renewed annually

Maximum Totals:

Services	Annual Cost	Total Term Cost
Annual software subscription	$267,275.63	$267,275.63

Description of Services/Supplies:
Tri-City operates many systems that require Microsoft Enterprise Licenses. Software Assurance is a comprehensive Volume Licensing program that allows Tri-City to continue to use licenses already purchased and deploy licenses off site (like the clinics) without having to purchase additional licenses. This contract would be renewed annually

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

Person responsible for oversight of agreement: Mark Albright & Scott Livingstone

Motion:

I move that the TCHD Board of Directors authorize the purchase agreement with SHI International, Corp for a term of one (1) year, beginning December 10, 2020 for a cost of $267,275.63, renewing annually.

ADMINISTRATION CONSENT AGENDA
December 1st, 2020

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Chemotherapy Administration Procedure	3 year review, practice change	Forward to BOD for approval
2. Chemotherapy Patient Intake to the Nursing Units (Direct Admit, Outpatient or Forensic) Procedure	3 year review, practice change	Forward to BOD for approval
3. HIV Testing: In an Occupational Exposure	3 year review	Forward to BOD for approval
4. Medical Equipment Brought into the Facility Policy	3 year review	Forward to BOD for approval
5. Nephrostomy Drain, Care of Procedure	3 year review, practice change	Forward to BOD for approval
6. Passy-Muir Speaking Valve Procedure	3 year review, practice change	Forward to BOD for approval
7. Patient Owned Supplied Equipment Brought into the Facility Policy	DELETE	Forward to BOD for approval
8. Pet Therapy Policy	3 year review, practice change	Forward to BOD for approval
9. Radiation Safety Policy	3 year review, practice change	Forward to BOD for approval
10. Service Animals Policy	3 year review, practice change	Forward to BOD for approval
11. Skin Preparation, Surgical/Procedural Policy	3 year review, practice change	Forward to BOD for approval
12. Surgical Hand Asepsis Procedure	Practice change	Forward to BOD for approval
13. Urine Dipstik Using McKesson Consult 120 Urine Analyzer Procedure	NEW	Forward to BOD for approval
14. Y-90 Micropsphere Brachytherapy Patient Management Procedure	NEW	Forward to BOD for approval
Administrative Policies & Procedures		
1. Code Gray - Hostage Response Plan 283	3 year review	Forward to BOD for approval
2. Lost and Found Articles 202	3 year review, practice change	Forward to BOD for approval
Unit Specific Policies & Procedures		
Cardiac Catheterization Lab		
1. Permanent Pacemaker Tray Setup Procedure	3 year review, practice change	Forward to BOD for approval
2. PTCA Setup Procedure	3 year review, practice change	Forward to BOD for approval
3. Set up IAB Catheter Procedure	3 year review, practice change	Forward to BOD for approval
Stenting Procedure	3 year review, practice change	Forward to BOD for approval
Cardiology		
1. Stress Echocardiogram	Practice change	Forward to BOD

ADMINISTRATION CONSENT AGENDA
December 1st, 2020

CONTACT: Candice Parras, CPCS

		for approval
2. Echocardiogram Study Alert	NEW	Forward to BOD for approval
Emergency		
1. Ketamine for Pain	NEW	Forward to BOD for approval
Infection Control		
1. Bloodborne Pathogen Exposure Control Plan	1 year review, practice change	Forward to BOD for approval
2. Ebola Plan Policy	3 year review, practice change	Forward to BOD for approval
3. Prion Diseases: Transmissible Spongiform Encephalopathies IC 6-5	3 year review, practice change	Forward to BOD for approval
4. Required Reporting IC 12	3 year review, practice change	Forward to BOD for approval
Neonatal Intensive Care Unit (NICU)		
1. Breast Milk Management in the NICU	2 year review, practice change	Forward to BOD for approval
2. Neonatal Abstinence Syndrome, Management of	2 year review, practice change	Forward to BOD for approval
3. Oxygen Hood; Neonate	2 year review, practice change	Forward to BOD for approval
Postural Drainage, Percussion and Vibration of the Neonate	DELETE	Forward to BOD for approval
5. Standards of Care - NICU	2 year review, practice change	Forward to BOD for approval
Outpatient Specialty Clinic		
1. Decontamination and Sterilization of Instruments	3 year review, practice change	Forward to BOD for approval
2. Infection Prevention and Control Activities	3 year review	Forward to BOD for approval
Pulmonary		
1. Pulmonary - Scope of Services	3 year review, practice change	Forward to BOD for approval
2. Respiratory Care Students in the Patient Care Areas	3 year review	Forward to BOD for approval
Security		
1. Storage of Weapons 507	3 year review, practice change	Forward to BOD for approval
2. Vehicle Jumpstart 234	DELETE	Forward to BOD for approval
Surgical Services		
1. Safety Measures: Radiation Policy	DELETE	Forward to BOD for approval

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**CHEMOTHERAPY ADMINISTRATION**
Purpose:	To outline the chemotherapy competent nurse's responsibility when administering a chemotherapeutic agent: A. Notification of a Chemotherapy Order B. Safe Handling C. Requirements Prior to Administering a Chemotherapeutic Agent D. Patient Preparation E. Documentation F. Administrating Intravenous and Intramuscular Chemotherapy I. IV Push II. IV Continuous or Intermittent III. Intramuscular and Subcutaneous G. Administering Oral Chemotherapy
Supportive Data:	See References
Equipment:	See Equipment Lists for specific administration methods

A. **NOTIFICATION OF A CHEMOTHERAPY ORDER:**

1. All inpatient units must notify the oncology unit's **Charge Nurse**~~Assistant Nurse Manager (ANM)~~ or designee when a chemotherapy order has been written for a patient on a unit other than the oncology unit. Notification must be done as soon as the order is written and no later than a 12-hour notice. The oncology unit must be notified so staffing can be adjusted appropriately for patient safety.
2. Nursing must notify Pharmacy via phone and by scanning the chemotherapy orders as soon as possible when a chemotherapy order is received.

B. **SAFE HANDLING:**

1. Many drugs used in the treatment of cancer (i.e., chemotherapy) are considered to be hazardous to health care workers. The term hazardous refers to drugs/chemicals that require special handling because of potential health risks. Therefore, it is imperative that those who work with chemotherapy drugs adhere to this procedure, the pharmaceutical companies' recommendations, the ~~Material~~ Safety Data Sheet**(SDS)** that pertains to the particular hazardous agent and ~~the~~ Tri-City Healthcare District~~'s~~ (TCHD) policies including but not limited to:
   a. Patient Care Services (PCS) Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
   b. PCS Procedure: Disposal of Chemotherapy Waste~~.~~
2. Transporting Chemotherapy Agents:
   a. Transport syringes containing chemotherapy in a sealed container, with the luer lock end syringe capped.
   b. All chemotherapy agents will be placed in a leak proof sealable bag labeled "Chemotherapy" and then placed in the designated impervious carrying receptacle that is also labeled "chemotherapy" before agent can be transported.
   c. The nurse transporting a chemotherapy agent will carry a spill kit at all times in case of a potential chemotherapy spill.
   d. In case of an accidental spill or exposure please see PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids procedure as well as the PCS Procedure: Disposal of Chemotherapy Waste.
3. Transporting patients ~~that are~~ receiving intravenous chemotherapy:

Patient Care Services Content ~~Department~~ Review	Clinical Policies and Procedures	Nurse Executive Committee	Division of Oncology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09,8/09,8/10,11/13, 5/16, 10/19	6/16, 10/19, 01/20, 03/20	07/16, 10/19, 04/20	07/16, 09/20	6/16, 05/20	08/16, 10/20	12/20	09/16, n/a	1/07, 08/09, 8/10;7/13, 09/16

a. Transporting a patient ~~that is~~ receiving intravenous chemotherapy should be avoided if at all possible due to ~~the~~ potential risk of a chemotherapy spill, extravasation at the IV site and physiological complications associated with chemotherapy administration.
b. If a patient must be transported to another department the nurse must carry a chemotherapy spill kit at all times. The nurse must ensure ~~that~~ the IV site, IV bag(s) and IV lines that are connected to the chemotherapy and the patient are visible and secure to prevent extravasation and spillage of the chemotherapy agent during transport.

C. **REQUIREMENTS PRIOR TO ADMINISTERING A CHEMOTHERAPEUTIC AGENT:**

~~1. All inpatients receiving IV chemotherapy for the first time are required to have an Oncology Patient Care Education Rounding completed 24 - 36 prior to the first chemotherapy dose. See the PCS Policy: Oncology Patient Care Education Rounding Policy.~~

~~2.~~**1.** At the Outpatient Infusion Center a physician must be on the premises at all times **when**~~if~~ chemotherapy is being infused into a patient(s).

2. Process for verifying chemotherapy

a. IV, IM and SQ

i. First verification requires Chemotherapy Competent RN/Chemotherapy Competent RN or Chemotherapy Competent RN/ Pharmacist

ii. Second verification Chemotherapy Competent RN/ Chemotherapy Competent RN or TCHD RN

iii. Exception ED IM Methotrexate Administration – ED RN/ED RN

b. Oral Chemotherapy

i. First dose of medication new to the patient requires a Chemotherapy Competent RN /TCHD RN

ii. Doses the patient has taken previously may be checked by two TCHD RNs

3. **Non-PO** Chemotherapy may only be administered by a **Chemotherapy Competent Registered Nurse** (RN) **with the exception of IM methotrexate administration for ectopic pregnancy in the Emergency Department which may be administered by any ED Nurse.** A Chemotherapy Competent RN is defined by the following requirements:
   a. Has taken and passed an Oncology Nursing Society approved chemotherapy course.
   b. Has completed Chemotherapy Administration competency validation by a TCHD chemotherapy competent nurse (see example Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist or Outpatient Infusion Center Skills Checklist).
   c. Completes Chemotherapy Administration competency annually
4. A **TCHD approved consent form for chemotherapy administration** ~~Chemotherapy Consent form~~ must be signed by the patient or designee prior to the administration of the chemotherapy regimen **for all non-PO and first dose new PO chemotherapy**.
5. For chemotherapy orders see PCS Policy: Chemotherapy Prescribing, Processing and Preparations.

D. **PATIENT PREPARATION:**

1. Set up continuous pulse oxi~~y~~metry for all patients receiving monoclonal antibodies.
2. Explain to the patient and family/caregivers who will administer the chemotherapy, the route, and the planned sequence of events.

E. **DOCUMENTATION:**

1. The administering Chemotherapy Competent **RN**~~Nurse~~ will **document**~~complete~~ **the**~~a~~ **chemotherapy verification in the electronic health record (EHR)** ~~Cerner Chemotherapy Administration AdHoc Form~~ on every **non-PO** chemotherapy agent administered.
2. All chemotherapy agents ~~will~~ require a second electronic signature by a Chemotherapy Competent RN verifying accuracy of the chemotherapy agent and order ~~on the Chemotherapy Administration AdHoc Form~~ (Verification #1) and the ~~Cerner~~ **electronic Medication Administration Record** (eMAR) by using their **EHR**~~Cerner~~ password (Verification #2).

a. Off unit **non-PO** chemotherapy Verification #1 can be witnessed by the floor pharmacist if a second ~~c~~Chemotherapy **Competent RN** ~~nurse~~ is not available.

F. **ADMINISTERING INTRAVENOUS (IV), INTRAMUSCULAR (IM) AND SUBCUTANEOUS (SQ) CHEMOTHERAPY**

1. IV, IM and SQ chemotherapy orders and agents will be verified twice for accuracy before administration. ~~Accuracy will be determined by verifying:~~
2. **VERIFICATION # ~~1 - Chemotherapy Nurse/Chemotherapy Nurse~~**
   a. Verification for accuracy will be completed by two Chemotherapy Competent RNs when the chemotherapy agent arrives on the unit and documented in the **EHR** ~~Cerner Chemotherapy Administration AdHoc Form~~.
      i. **A floor Pharmacist/ Chemotherapy Competent RN can do the #1 verification if two Chemotherapy Competent RNs are not available on the off unit areas.**
      ~~i.~~ii. **Exception ED IM Methotrexate Administration – ED RN/ED RN**
   b. Verification #1 will be determined by verifying:
      i. Date /Time of Administration
      ii. Patient Name
      iii. Chemotherapy Agent
      iv. Dose
      v. Diluent~~s~~-/Volume (~~i~~if applicable)
      vi. Rate of ~~A~~administration (~~i~~if applicable)
      vii. Route
      viii. Patient's ~~H~~height and ~~W~~weight
      ix. Patient's body surface area (BSA)- (~~i~~if applicable)
      x. Area under the curve (AUC) (if applicable)
3. **VERIFICATION #2~~- Chemotherapy Nurse/ Chemotherapy Nurse or TCHD RN- (IV, IM and SQ Chemo Only)~~**
   a. At the patient's bedside a second verification for accuracy will be completed and documented on the electronic medication administration record (EMAR)
   b. Verification #2 will be determined by verifying ~~the 7 rights~~ the following per the PCS Policy: Medication Administration:
      i. Verify correct:
         1) Patient
         2) Dose
         3) Time
         4) Medication
         5) Route/-Rate (if applicable)
         6) Documentation
         7) Reason
4. All intravenous **Vesicant Chemotherapy** will **only** be administered via a **Central Venous Catheter** and should **never** be administered peripherally.
   a. Exception- Paclitaxel may be administered via peripheral IV if the IV site is visually assessed every 15 minutes for signs and symptoms of extravasation (Inpatient ratio would be 2:1).
5. All intravenous chemotherapy will be administered through an Alaris IV pump using the oncology profile and specific guardrail for the chemotherapy agent **if available**.
6. Peripheral **Non-Vesicant** Chemotherapy Administration:
   a. Start a new peripheral IV if site is more than 24 hours old.
   b. Avoid flexion joint sites.
   c. Preferably select a large vein between wrist and elbow.
   d. Avoid veins in the hand, wrist and antecubital fossa, **if possible**.
   ~~e. Tape IV site so it can be monitored.~~
7. Extravasation Prevention

a. Blood return must be checked prior to administration of any chemotherapy agent.
   i. Vesicants: Verify blood return and IV patency prior to, during and post administration of a vesicant.
b. Inspect IV site for signs and symptoms of the following before administration:
   i. Peripheral
      1) Redness
      2) Inflammation
      3) Infiltration
      4) Patient comfort level at IV site
   ii. Central Venous Catheters (CVC)
      1) Erythema
      2) Swelling
      3) Drainage
      4) Leakage
      ~~5) Venous thrombosis of the ipsilateral chest (CVC located in the chest region).~~

8. Verify that the patient has signed a TCHD approved consent form for chemotherapy administration **for all non-PO chemotherapy administration and first dose new PO chemotherapy**.
9. Don personal protective equipment (PPE) in the following order before spiking a pre-filled chemotherapy IV bag or when manipulating a syringe that contains a chemotherapy agent:
   a. Face shield or splash goggles
   b. ~~N-95~~**surgical** mask
   c. First pair of chemo gloves
   d. Chemo gown with the cuffs over the first pair of gloves
   e. Second pair of chemo gloves over the cuffs of the gown
10. **Procedure:**
   a. **IV Push**
      i. Don two pair of chemotherapy safe gloves.
         1) Examine the chemotherapy pre-filled IV syringe for leakage or damage in the medication room before administration.
      ii. Complete Verification #1.
      iii. Assemble equipment.
         1) Extravasation Kit
         2) PPE (face shield or splash goggles, ~~N95~~**surgical** mask, chemotherapy gown, 2 pairs of chemotherapy gloves). It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
         3) Chemotherapy puncture- proof waste disposal container
         4) Leak-proof bag marked "Chemotherapy Waste"
         5) Plastic –backed absorbent pad
         6) Sterile gauze
         7) ~~3~~ Alcohol Prep Pads
      iv. Review all manufacturer~~'s~~ recommendations ~~(located in the TCHD Drug Formulary or package insert)~~ pertaining to the administration, pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
      v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow PCS Procedure: Chemotherapy Extravasation.
      vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent ~~(Patient information located in Micromedix and educational pamphlets located on 2 Pavilion)~~ , chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
         1) Extravasation

a) Burning
b) Pain
c) Heat
d) Ulceration
e) Swelling

2) Signs and symptoms of hypersensitivity and anaphylaxis
a) Uneasiness
b) Tightness of the chest
c) Shortness of breath-with or without wheezing
d) Hives or rash
e) Local or generalized itching
f) Periorbital or facial edema
g) Lightheadedness or dizziness

vii. IV Chemotherapy shall be administered with no other IV medications or IV fluids running except for the mainline compatible IV fluid used during the IV push chemotherapy administration.

viii. Label the IV pump and the IV push chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.

ix. Inspect IV site and check patient's IV for blood return.

x. Don PPE in the following order before administration:
1) Face shield or splash goggles
2) ~~N-95~~**surgical** mask
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves
5) Second pair of chemo gloves over the cuffs of the gown

xi. Place plastic –backed absorbent pad under the patient's arm to prevent drug contact with patient's skin.

xii. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will complete the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.

xiii. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
1) Outpatient Infusion Center will document on the EMAR.

xiv. Using the alcohol prep pads, clean the patient's IV access port three times

xv. Wrap sterile gauze around IV ports during IV push to reduce the potential for spraying

xvi. Inject drug into distal port of IV with free flowing solution at the prescribed rate (minimum of 100mL/hour). Verify blood return every 2-3 mL of drug administration.

xvii. Flush line with 10-20mL of IV solution between administration of drugs or prior to discontinuing IV.
1) Prevents incompatibility reaction and avoids exposure to anti-neoplastic agents.

xviii. Dispose of syringes in the puncture proof container labeled "Chemotherapy Waste".

xix. Recheck IV lines to be sure lines are leading to patient and are connected to the correct IV port.

xx. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
1) Outer pair of gloves
2) Chemo gown

3) Face Shield or splash goggles
4) ~~N-95~~**Surgical** mask
5) Final pair of gloves

xxi. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials.

b. **IV Continuous or Intermittent**

i. Donning two pair of chemotherapy gloves, examine the Chemotherapy pre-filled IV bag and tubing for leakage or damage in the medication room before administration.
ii. Complete Verification #1.
iii. Assemble equipment for use during administration.
1) Extravasation Kit
2) Personal Protective Equipment (PPE) (Face shield or goggles, ~~N-95~~**surgical** mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
3) Chemotherapy puncture proof waste disposal container
4) Leak-proof bag marked "Chemotherapy Waste"
5) "Chemotherapy" identification stickers
6) Disposable plastic –backed absorbent liner
7) Plastic tape
8) 3 Alcohol Prep Pads
iv. Review all manufacturer's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, IV fluid compatibility, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
v. Extravasation is a possible risk from vesicant administration. If extravasation occurs, the nurse must take immediate action. Follow TCHD's Chemotherapy Extravasation Procedure.
vi. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent ~~(Patient information located in Micromedix and educational pamphlets located on 2 Pavilion)~~, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
1) Extravasation
a) Burning
b) Pain
c) Heat
d) Ulceration
e) Swelling
2) Signs and symptoms of hypersensitivity and anaphylaxis
a) Uneasiness
b) Tightness of the chest
c) Shortness of breath-with or without wheezing
d) Hives or rash
e) Local or generalized itching
f) Periorbital or facial edema
g) Lightheadedness or dizziness
vii. IV Chemotherapy shall be administered on a single Alaris IV pump with no other IV medications or IV fluids running except for the mainline compatible flush bag for the IV chemotherapy agent.
viii. Don PPE in the following order before administration:
1) Face shield or splash goggles
2) ~~N-95~~**surgical** mask
3) First pair of chemo gloves
4) Chemo gown with the cuffs over the first pair of gloves

5) Second pair of chemo gloves over the cuffs of the gown

ix. Prime all IV tubing with a compatible IV fluid before administering the chemotherapy intravenously if not already done by pharmacy.

x. At the patient's bedside, program the Alaris pump using the appropriate chemotherapy drug guardrail profile with the witnessing second Chemotherapy Competent **RN**~~Nurse~~ (preferred) or TCHD RN.
   1) Power on the Alaris IV pump and select **New Patient**.
   2) Select the **Oncology Profile.**
   3) Enter the patient's **medical record number**.
   4) Select Channel letter that will be used.
   5) Select **Guardrail Drugs**.
   6) Select the appropriate chemotherapy agent to be administered from the Alaris Oncology Drug Guardrail List.
   7) Verify and confirm correct dosing program.
   8) Review **Clinical Advisory Warning** on the Alaris IV pump and **Confirm** when read.
   9) Input the **Drug Amount**, **Diluent Volume**, **BSA** (if applicable). Verify dose and select **Next.**
   10) Input **Rate** and Volume to be infused (**VTBI**).

xi. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy IV bag per the PCS Policy: Medication Administration.
   1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician~~s~~ order.

xii. Complete Verification #2 including verification of the Alaris infusion guardrail set up and rate as well as the chemotherapy agent for accuracy at the patient's bedside and complete the witness section on the medication barcode scanning device (see verification #2).
   1) Outpatient Infusion Center will document on the EMAR.

xiii. Label the IV pump and the IV chemotherapy bag with a TCHD approved "Chemotherapy" identification sticker before administration.

xiv. Inspect IV site and check patient's IV for blood return.

xv. Use disposable plastic –backed absorbent liner under the IV

xvi. Using the alcohol prep pads, clean the patient's IV access port three times.

xvii. Securely attach the IV tubing to the patient's venous access device or, if using a secondary set, to the primary tubing

xviii. Tape the two IV connections together

xix. Review dose and then select **Start** to begin infusion on the Alaris pump.

xx. When infusion is complete, don PPE as instructed.

xxi. Dispose of contaminated IV tubing and IV bags in a sealed chemotherapy waste bag and place in a puncture- proof chemotherapy waste container

xxii. Remove PPE in the following order and place in a chemotherapy waste bag and seal:
   1) Outer pair of gloves
   2) Chemo gown
   3) Face Shield or splash goggles
   4) ~~N-95~~**Surgical** mask
   5) Final pair of gloves

xxiii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

c. **<u>Intramuscular (IM) and Subcutaneous (SQ)</u>**

i. Donning two pair of chemotherapy gloves, examine the chemotherapy pre-filled ~~IV~~ syringe for leakage or damage in the medication room before administration.

ii. Compete Verification #1 .
iii. Assemble equipment for use during administration.
    1) PPE (Face shield or goggles, ~~N-95~~**surgical** mask, chemotherapy disposable gown, two pairs of chemotherapy gloves).
    2) Chemotherapy puncture- proof sharps waste container
    3) Leak-proof bag marked "Chemotherapy Waste"
    4) "Chemotherapy" identification sticker
    5) Appropriate size sterile needle (Use smallest needle possible)
    6) 2x2 gauze pads
    7) Alcohol Prep Pads
    8) Band-Aid
iv. Review all manufacture's recommendations pertaining to the administration (located in the TCHD Drug Formulary or package insert), pre-medication, labs and potential side effects of the specific chemotherapeutic agent before agent is administered.
v. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent ~~(Patient information located in Micromedix and educational pamphlets located on 2 Pavilion)~~, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:
    1) Signs and symptoms of hypersensitivity and anaphylaxis
        a) Uneasiness
        b) Tightness of the chest
        c) Shortness of breath-with or without wheezing
        d) Hives or rash
        e) Local or generalized itching
        f) Periorbital or facial edema
        g) Lightheadedness or dizziness
vi. Label chemotherapy syringe with a TCHD approved "Chemotherapy" identification sticker before administration.
vii. Don PPE in the following order before administration:
    1) Face mask or Splash Goggles
    2) ~~N-95~~**Surgical** mask
    3) First pair of chemo gloves
    4) Chemo gown with the cuffs over the first pair of gloves
    5) Second pair of chemo gloves over the cuffs of the gown
viii. Remove cap and connect sterile needle of the appropriate size for administering the drug.
ix. Do not expel air from the syringe or prime the needle.
x. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
    1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physicians order.
xi. Complete Verification #2 and complete the witness section on the medication scanning device.
    1) Outpatient Infusion Center will document on the EMAR.
xii. Review the manufacturers injection site recommendation
xiii. Cleanse injection site with alcohol prep pads
xiv. After administering the drug, do not re-cap and do not message injection site.
xv. Place the syringe with the needle attached directly into the puncture- proof chemotherapy waste container.
xvi. Remove PPE in the following order and place in a chemotherapy waste bag and seal

1) Outer pair of gloves
2) Chemo gown
3) Face Shield or splash goggles
4) ~~N-95~~ **Surgical** mask
5) Final pair of gloves

xvii. See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated materials

xviii. Monitor injection site **post injection**~~every hour~~ for signs and symptoms of infection and bleeding ~~post injection~~.

xix. Educate patients going home after injection to assess the injection site **after return home**~~twice a day~~ for bleeding and signs and symptoms of infection.

G. **ADMINISTERING ORAL CHEMOTHERAPY**

1. Oral Chemotherapy may **not** be **crushed, scored** or **capsules opened** on the nursing units. All oral chemotherapy agents that need to be altered in this manner must only be done by the pharmacy in a controlled environment. If patient is unable to take the chemotherapy agent orally in a whole form and an alternative route (Nasogastric tube, gastric tube etc.) is available, notify the pharmacy as soon as possible (ASAP) so alterations can be made to the original medication form so the agent can be administered safely.

2. **Procedure**

a. **Oral Chemotherapy**

~~Verify that the patient has signed a TCHD approved consent form for chemotherapy administration.~~

i. Complete Verification #1 .

1) Oral chemotherapy **that the patient has not taken previously** must be initially checked for accuracy on the first dose by ~~two cChemotherapy Competent RNs~~nurses using the Verification #1 and all subsequent doses can be checked by a c~~Chemotherapy Competent RN~~nurse and a TCHD RN following the PCS Policy: Medication Administration 7 rights (see Verification #2).**a Chemotherapy Competent RN and a TCHD RN.**

~~1)~~**2) All oral chemotherapy that the patient has taken previously may be checked by two TCHD RNs. A Chemotherapy Competent RN may be requested for additional education for any new PO chemotherapy orders that the patient has not been on previously.**

ii. Assemble disposal equipment for use during administration

1) Personal Protective Equipment (PPE)
2) Two pairs of chemotherapy gloves.
3) If administering an oral chemotherapeutic agent that is in a liquid or powder form, a face shield or goggles, ~~N-95~~**surgical** mask, and chemotherapy disposable gown is recommended. It is recommended to wear a face shield anytime there is a potential for chemotherapy splashing.
4) Leak-proof bag marked "Chemotherapy Waste"

iii. Review all manufactures recommendations pertaining to the administration, pre-medication, labs and potential side effects (located in the TCHD Drug Formulary or package insert), of the specific chemotherapeutic agent before agent is administered.

iv. Educate patient on the procedure, reason for wearing protective garments, potential side effects of the agent ~~(Patient information located in Micromedix and educational pamphlets located on 2 Pavilion)~~, chemo safety for body fluids and when to notify the nurse for signs and symptoms of:

1) Hypersensitivity and anaphylaxis
   a) Uneasiness
   b) Tightness of the chest

c) Shortness of breath-with or without wheezing
d) Hives or rash
e) Local or generalized itching
f) Periorbital or facial edema
g) Lightheadedness or dizziness

v. Assess patient's ability to swallow prior to administration
vi. Don two chemotherapy gloves before handling the oral chemotherapy agent and during administration.
vii. Using the medication barcode scanning device at the patient's bedside, scan the patient and the ordered chemotherapy per the PCS Policy: Medication Administration.
1) Outpatient Infusion Center will do the verification of the medication by using the 2 patient identifiers and verify the medication matches the physician's order).
viii. Complete Verification #2 and complete the witness section on the medication barcode scanning device.
1) Outpatient Infusion Center will document on the EMAR.
ix. Dispose of all materials that came into contact with the chemotherapeutic agent (i.e. medication cup, manufacturer's container or packaging) in a leak-proof chemotherapy waste bag and seal
1) See PCS Procedure: Disposal of Chemotherapy Waste for proper disposal of contaminated material.

H. RELATED DOCUMENTS:

~~1. Acute Care Services (ACS) 2 P Advanced Oncology- Chemotherapy Addendum Nursing Skills Checklist~~
~~2. Outpatient Infusion Center Skills Checklist~~
~~3.~~1. PCS Policy: Chemotherapy Prescribing, Processing and Preparations
~~4. PCS Policy: Oncology Patient Care Education Rounding~~
~~5.~~2. PCS Policy: Medication Administration
~~6.~~3. PCS Procedure: Chemotherapy Exposure, Spills and Handling of Contaminated Linen with Chemotherapeutic agents and Bodily Fluids
~~7.~~4. PCS Procedure: Chemotherapy Extravasation
~~8.~~5. PCS Procedure: Disposal of Chemotherapy Waste

I. REFERENCES

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2. National Institute for Occupational Safety and Health, (2004). Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings, Retrieved from the NIOSH website at http://www.cdc.gov/niosh/docs/2004-165/#c
3. Oncology Nursing Forum: Vol.39, No.1 (Jan 2012) Revisions to the 2009 American Society of Clinical Oncology/Oncology Nursing Society Chemotherapy Administration Safety Standards: Expanding the Scope to Include Inpatient Settings
4. Oncology Nursing Society, (20194). Chemotherapy and **Immunotherapy**~~Biotherapy Guidelines, Fourth Edition~~.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**CHEMOTHERAPY- PATIENT INTAKE ~~TO THE NURSING UNITS (DIRECT ADMIT, OUTPATIENT OR FORENSIC)~~**
Purpose:	To outline the responsibility of the physicians' offices and the Tri City **Healthcare District** ~~Medical Center's (TCMC)~~ **departments** ~~relief charge nurse, Assistant Nurse Manager on 2 Pavilion/Forensic unit for in~~ taking ~~all~~ direct admissions, outpatients and **justice involved** ~~Forensic~~ patients for chemotherapy administration and monitoring.

A. **PROCEDURE:** ~~**DIRECT ADMIT AND OUTPATIENT CHEMOTHERAPY**~~

1. The physician's office/**correctional facility** will notify **the appropriate department** ~~2 Pavilion~~ of the direct admits or outpatient chemotherapy that will receive care on Tri City Medical **Healthcare District** ~~Center's telemetry or medical surgical units~~.

~~2. The correctional facility will notify the forensic unit of the direct admit or outpatient chemotherapy that will receive care on the forensic unit.~~

~~3.~~2. The **department** ~~Assistant Nurse Manager (ANM) or Charge Nurse (Forensic or 2 Pavilion)~~ will complete the **intake per department process** ~~**Outpatient Chemotherapy Information Intake Form** (see attachment A)~~ when notified ~~by the physician's office or correctional facility~~ of a pending direct admit or outpatient chemotherapy.

~~4.~~3. The **department** ~~ANM or Charge Nurse~~ will **contact** ~~fax the following to~~ registration **to ensure the patient is registered prior to treatment** ~~immediately after the information is obtained to ext. 4016:~~.

~~a. Outpatient Chemo Patients:~~
- ~~i. Outpatient Chemotherapy Information Intake Form~~
- ~~ii. Chemotherapy Orders~~
- ~~iii. Insurance information~~
- ~~iv. Authorization for chemotherapy treatment~~

~~b. Direct Admit Chemo Patients:~~
- ~~i. Outpatient Chemotherapy Information Intake Form~~
- ~~ii. Chemotherapy Orders~~
- ~~iii. Insurance information~~
- ~~iv. Authorization for chemotherapy treatment and admission~~

~~c. Outpatient Chemo Forensic Patients:~~
- ~~i. Outpatient Chemotherapy Information Intake Form~~
- ~~ii. Health Care Services Physicians Request for Services Form (provided by the correctional facility)~~
- ~~iii. Chemotherapy Orders~~

~~5.~~4. The **department providing care** ~~ANM or Charge Nurse (2 Pavilion and Forensics)~~ will scan the chemotherapy orders to pharmacy and make a follow-up call to pharmacy to verify that the orders were received.

~~6.~~a. All direct admissions, outpatient or **justice involved** ~~Forensic~~ chemotherapy orders must be scanned prior to 1300 if chemotherapy is to begin the same day the intake information is obtained so pharmacy has ample time to order and prepare the chemotherapy.

~~7.~~5. The **department providing care** ~~ANM or Charge Nurse (2 Pavilion and Forensic)~~ will ensure there is proper coverage of chemotherapy competent nurses for the pending chemotherapy patient. The **schedule** ~~calendar~~ will be reviewed by ~~the~~ **Nursing Leadership/designee** ~~ANM or the Charge Nurse~~ every shift to evaluate that there will be chemotherapy nurse coverage for the pending chemotherapy patient 24 hours prior to the patient arriving. ~~The following information will be placed on the chemotherapy calendar under the day patient is to arrive.~~

~~a. Patients Initials~~

~~b. What time patient is to arrive~~

Department Review	Clinical Policies & Procedures	Nursinge Leadership Executive Council	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/12, 12/19, 03/20	9/12, 06/20	9/12, 07/20	n/a	09/20	10/12, 11/20	12/20	11/12, n/a	12/12

~~c. Chemotherapy drug to be administered~~
~~8. Patient Type: Direct Admit or Outpatient Chemotherapy.~~

~~9.~~6. The **department providing care**~~ANM or Charge Nurse~~ will contact pharmacy prior to the out coming shift that is expecting the chemotherapy patient to ensure that the chemotherapy has been ordered and is ready for preparation before patient arrives on the unit for that day. They will also assign a chemotherapy nurse to that patient prior to the shift that the patient is to arrive for treatment.

~~10.~~7. When patient arrives on the unit for their chemotherapy the primary care nurse should verify that the patient has **completed**~~gone to~~ the registration **process**~~department in the main lobby~~ prior to receiving any treatment~~ (does not apply to forensic patients)~~.

~~11.~~a. Contact registration at extension 3151 when forensic outpatient chemotherapy patients arrive on the unit~~ and administration~~.

8. The primary nurse will contact pharmacy to coordinate time of ~~when~~ chemotherapy preparation at the beginning of the shift or as soon as the patient arrives to the unit.

~~12.~~

~~B. OUTPATIENT CHEMOTHERAPY PROCESS~~

~~1. The primary nurse will complete or revise the Patients **Outpatient Summary List** upon arrival to the unit. The nurse shall make a copy of the new or revised Outpatient Summary List and place the copy in the **Outpatient Chemotherapy Binder**, filed alphabetically by patient's last name and send the original to medical records.~~

~~2. The primary nurse will complete an **Outpatient Oncology Flow sheet** (Tri-Fold). Start and stop times for any chemotherapy administration and/or IV fluid administration must be documented. Send completed forms to medical records.~~

~~3.~~9. The primary nurse/**Charge Nurse will forward any charges for chemotherpy to the appropriate department**~~must complete the **Oncology Services Charge Slip** for the~~ **(including but not limited to** outpatient chemotherapy and any other IV's or medications that were administered during the chemotherapy treatment**)**.

~~4. After the outpatient chemo has been administered the primary nurse will notify the ANM or Charge Nurse then staple and place the following in the Outpatient Chemotherapy Binder:~~
~~a. Copy of the Chemotherapy Orders~~
~~b. Outpatient Chemotherapy Information Intake Form~~
~~c. Health Care Services Physician Request for Services Form (forensic patient only)~~
~~d. Oncology Services Charge Slip~~

~~5. The ANM or Charge Nurse will enter the charges from the Oncology Services Charge Slip into Cerner and make a note in red pen at the bottom of the charge slip that the charges have been placed in Cerner as soon as possible.~~

~~C.~~B. **RELATED DOCUMENT(S)~~ATTACHMENT~~:**

1. Chemotherapy Information Intake Form

Chemotherapy Information Intake Form

This information must to be obtained when the physician or physician's office calls the Oncology Unit to schedule Direct Admits or Outpatient Chemotherapy

□ Direct Admit □ Outpatient ~~□ Forensic~~

Today's date	
Name of person requesting bed (Tell them to have patient check in at registration before they come to the unit on the day of treatment- This does not apply to forensic patients)	
Phone #	
Date bed needed	
Physician requesting bed	
Patient's name/Diagnosis	
Phone # to contact patient (non-forensic)	
Age and DOB of patient	
--Hx of MRSA? C-diff?	
Direct/ Outpatient Chemotherapy Patients (non-forensic) MD office to fax to 2P: 1. Insurance information 2. Chemotherapy Orders 3. Authorization for Chemo/ Admission *Fax these to registration at x4016 1. Put Pt arrival Date on Chemo Calendar 2. Call Bed Coordinator with Pt Arrival Date	Time/Date Faxed-: _____ Call x 3151 to confirm fax was received Name of pharmacy personnel confirming fax p: _____
~~Outpatient Chemotherapy- Forensic Patients~~ ~~Correctional Facility to fax to Forensic Unit:~~ ~~1. Healthcare Services Physician Request for Services Form~~ ~~Physician's Office to Fax:~~ ~~1. Chemotherapy Orders~~ ~~*Fax these to registration at x4016~~	~~Time/Date Faxed-~~ ~~Call x3151 to confirm fax was received~~ ~~Name of pharmacy personnel confirming fax:~~ _____
2P ~~ANM or~~ Charge Nurse to scan this form and orders to Pharmacy, -Verify they received Scan	Time/Date Scanned-: _____ Name of pharmacy personnel verifying : _____
Comments	
~~ANM or n~~Nurse completing intake form	

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/89	**SUBJECT:** HIV Testing: in an Occupational Exposure
REVISION DATE: 3/97; 3/00; 5/03; 11/06; 9/10, 06/15	~~POLICY NUMBER: 8610-385~~

Patient Care Services Content Expert Approval:	05/20
Clinical Policies & Procedures Committee Approval:	~~01/15~~07/20
Nurse Executive Committee Approval:	~~02/15~~08/20
Infection Control Committee Approval:	~~04/15~~08/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/15~~11/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~06/15~~ n/a
Board of Directors Approval:	06/15

A. **PURPOSE:**

1. To provide a mechanism for **human immunodeficiency virus** (HIV) testing in the event of an occupational exposure.

B. **DEFINITIONS:**

1. Disclosure - includes all releases, transmissions, disseminations or communications whether they are made orally, in writing or by electronic transmission [Health & Safety Code Sections 120980(k)].
2. Exposed individual - any individual health care provider, first responder, or any other person (including any employee, volunteer, or contracted agent of any provider) who is exposed, within the scope of his or her employment, to the blood or other potentially infectious materials of a source patient.
3. First responder - police, firefighters, rescue personnel, and any other person who provides emergency response, first aid care, or other medically related assistance, either in the course of the person's occupational duties or as a volunteer.
4. Health care provider - include the following persons and entities:
   a. Licensed and certified health personnel, including physicians, nurses and other health personnel who work in hospitals, clinics, health dispensaries and facilities. Employees, volunteers or contracted agents of Knox-Keene Health Care Service plans. Professional students of any of the above.
5. HIV test - any clinical test, laboratory or otherwise, used to identify HIV, a component of HIV, or antibodies or antigens to HIV [Health & Safety Code Section 120775].
6. Informed Consent - nature of the procedure; the risk, complications and expected benefits or effects of the procedure; any alternatives to the treatment their risks and benefits.
7. Significant exposure - direct contact with the blood or other potentially infectious materials in a manner that according to the **California Division Occupational Health & Safey** (CAL-OSHA) guidelines is capable of transmitting HIV.
8. Attending physician of the source patient - any physician who provides health care services to the source patient and includes any of the following:
   a. The private physician of the source patient.
   b. The physician primarily responsible for the patient who is undergoing inpatient treatment in a hospital.
9. Attending physician's designee - a registered nurse or **Allied Health Professional (AHP)**~~licensed nurse practitioner~~ that has been designated by the attending physician of the source patient.
10. Available blood or patient sample - blood or other tissue or material that was legally obtained in

the course of providing health care services and is in the possession of the physician or other health care provider of the source patient prior to the exposure incident.

11. Certifying physician - any physician consulted by the exposed individual for the exposure incident. A certifying physician must have demonstrated competency and understanding of the applicable guidelines or standards of the ~~Division of Occupational Safety and Health~~ (CAL-OSHA). The law does not specify how this competency may be demonstrated.

C. **POLICY:**

1. California law [Health and Safety Code Sections 120260-120263] provides a narrow exposure notification and information mechanism to permit health care personnel and other first responders who have experienced a significant exposure to a patient's blood or other potentially infectious materials, to learn of the patient's HIV status. The exposed individual may have a source patient's blood, tissue or other material tested for HIV even though the patient refuses to be tested. The testing may be done provided the blood, tissue or other material was obtained prior to the exposure. [See Administrative Policy #~~-~~**Notification to Pre-Hospital Personnel Exposure to Infectious Disease** 530~~ regarding Emergency Response Employees.~~]
2. A person who has experienced an exposure to potentially infectious materials while rendering occupational or health care related services must request, in writing, evaluation by a physician within 72 hours of the exposure to determine if the exposure was significant.
3. The physician must evaluate and certify the significant exposure, including the nature and extent, in writing within 72 hours of the request. Exposed individuals, including physicians may not certify their own exposures as significant.
4. Regardless of the HIV status of the source person, the exposed individual will be given counseling regarding the transmission of HIV, the limitations of HIV testing, need for follow-up testing, and precautionary procedures to be followed. Tri-City Medical Center Employee Health Department will be responsible for the counseling of the exposed individual.
5. To establish baseline information, the exposed individual must be tested for HIV and the results of that test must be confirmed as negative before testing the source patient for HIV without the source patient's consent.
6. The certifying physician must provide certification that an exposure is significant to the source patient's attending physician. The certification must be in writing within 72 hours of certifying the exposure. The certifying physician must also request information on the HIV status of the source patient and the availability of blood or other patient sample.
7. The source patient's attending physician must respond to the certifying physician's request for the information within three working days.
8. If the source patient is known to be HIV positive, the attending physician must attempt to obtain the source patient's consent to release this information to the exposed individuals.
   a. If the source patient refuses or cannot be contacted, an attending physician of the source patient may advise the exposed individual of the source patients HIV status as soon as possible after certification.
   b. Consent for release of information is not required where the exposed individual is a treating health care provider.
   c. The hospital will attempt to obtain consent from a legal representative of an incompetent or deceased patient, however if the legal representative refuses or cannot be contacted or if there is no legal representative, this law may authorize the hospital to disclose the HIV status if known. Where authorization to disclose HIV status is unclear, hospital legal counsel should be consulted.
9. If the source patient's HIV status is not known, and blood or other patient samples are available, and if the exposed individual has tested negative on a baseline HIV test, the source patient is given the opportunity to consent to HIV test. Within 72 hours after receiving written certification of a significant exposure, the attending physician of the source patient must do all of the following:
   a. The attending physician must make a good faith effort to notify the source patient, or the patient's authorized legal representative, of the significant exposure. This effort includes, but is not limited to, an effort to locate the patient by telephone or certified

first class mail. The efforts to contact the source patient must be documented in the source patient's medical record.

b. If the source patient or legal representative is contacted, the attending physician must attempt to get the voluntary written informed consent to the HIV test.

c. The exposed individual is prohibited from directly seeking consent to HIV testing from the source patient.

d. If the source patient or the legal representative cannot be contacted after a good faith effort, it may be treated as if the source patient has refused to be tested.

10. If the source patient or authorized legal representative refuses consent for an HIV test, available blood may be tested and the exposed individual informed of the test results.
    a. An inability of the source patient to provide informed consent constitutes a refusal of consent provided all of the following conditions are met:
        i. The source patient has no legal representative authorized to consent on his behalf.
        ii. The source patient is incapable of giving consent.
        iii. In the opinion of the attending physician, it is likely that the source patient will be unable to grant informed consent within the 72-hour period during which the physician is required to act pursuant to Section 3.8 herein.
11. If the source patient is deceased, consent for HIV testing is deemed granted.
12. The exposed individual's employer will pay for the cost of HIV testing and counseling. Exposed individuals who are not employees of the health facility or health care providers are financially responsible for the cost of their own post-exposure evaluation, follow-up counseling and the cost of testing and counseling of the source patient. (Health & Safety Code Section 121135(f)).
13. The source patient or authorized legal representative must be given the option as to whether or not he or she is advised of the HIV results.
    a. If the source patient refuses to consent to HIV test and refused to learn of the results of the test, the patient must sign a form documenting the refusal.
    b. HIV test results may be placed in the source patient's medical record only if the patient has given written consent to be informed of the test results.
    c. If the source patient or legal representative refuses to be informed of the test results, the HIV test results may be provided to the exposed individual only in accordance with the then applicable CAL-OSHA regulations.
    d. The source patient's identity must be "encoded" in the HIV test result record.
14. If the exposed individual is informed of the source patient's HIV test results pursuant to the law, the exposed individual must be counseled regarding confidentiality laws protecting HIV test results, protecting the identity of the source patient and the penalties for violating the law.

D. **RELATED DOCUMENTS:**

1. Administrative Policy: ~~# Emergency Response Employees, Notification~~ **Notification to Pre-Hospital Personnel; Exposure to Infectious Disease** 530

E. **REFERENCE:**

1. Current California Hospital Association Consent Manual
2. **California Code of Regulations, Title 8, Section 5193. Bloodborne Pathogens. https://www.dir.ca.gov/title8/5193.html**
~~1.~~3. **California Code, Health & Safety Codes: H&SC 120260-120263, 120775, 120980, & 121135**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 6/02 **SUBJECT:** Medical Equipment Brought into the Facility

REVISION DATE: 7/05, 7/07, 3/10, 8/12, 11/16 ~~**POLICY NUMBER: XI.E**~~

Patient Care Service Content Expert~~Department~~ Approval ~~Date(s)~~:	**~~02/16~~06/20**
Clinical Policies & Procedures Committee Approval:	**~~08/16~~07/20**
Nurse Executive Committee Approval:	**~~09/16~~08/20**
Pharmacy & Therapeutics Committee Approval:	**~~09/16~~09/20**
Medical Executive Committee Approval:	**~~09/16~~10/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~10/16~~ n/a**
Board of Directors Approval:	**11/16**

A. **POLICY:**
1. To provide guidelines for patient owned/supplied equipment that is brought into ~~the~~ **Tri-City Medical** eCenter.

B. **DEFINITION:**
1. Patient-Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.).

C. **POLICY:**
1. Tri-City Healthcare District's (TCHD) standard of care is to use hospital-owned equipment whenever possible.
   a. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.
   b. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):
      i. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States.
   c. Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals.
   d. Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:
      i. If the equipment requires audible alarms that cannot be provided.
      ii. If the equipment has alarms that can be defeated without clinical staff intervention.
      iii. If the patient should become incapacitated or is otherwise unable to maintain their equipment, the hospital may provide substitute equipment.
      iv. Any reason that TCMC deems reasonable that may place the patient's safety at risk.

2. Upon the patient's request to use PSE, the nurse caring for the patient should explain to the patient that TCHD's standard of care is to use hospital owned equipment whenever possible.
   a. If patient is agreeable to the use of hospital equipment, change the PSE to hospital equipment and send PSE home with family member (if family member available).
   b. If the patient refuses hospital equipment and requests use of PSE, the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.
      i. If the equipment is deemed medically appropriate, the physician will authorize use with an order.
3. Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will:
   a. Verify a physician's order has been obtained and entered in Cerner approving the use of the patient's equipment.
   b. Ensure the patient or legal representative signs a liability waiver (See Patient-Supplied Equipment Waiver) for use of PSE.
      i. The signed waiver shall be placed in the patient's chart.
      ii. If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital.
   c. Visually inspect the PSE (assessing for damage to the device, infestation with insects, excessively soiled.)
   d. Wipe down the PSE with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at extension ~~7410 or~~ 5696.
   e. Notify Bio-Med as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (Monday-Friday).
      i. If the device is brought in during the weekend, the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.
      ii. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center, (off hours and weekends contact the Administration Supervisor to notify Bio-Med).
   f. Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.
   g. If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well-being (example: pulse oximeter).
4. For any concerns or questions, please contact:
   a. The Director of Risk Management for risk issues.
   b. The Chief Nurse Executive for patient care issues.
   c. The Management of Clinical Engineering for medical equipment issues.

D. **SPECIAL CONSIDERATIONS:**

1. Insulin Pumps:
   a. See Patient Care Services (PCS) Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient.
2. Wearable Defibrillator:
   a. See PCS Policy: Wearable Defibrillator (LifeVest).
3. Implanted Pain Pumps:

a. The admitting physician will be notified immediately the patient has an implantable pain pump.
b. The admitting physician will attempt to contact the original prescribing physician of the pain pump for information on continuing, stopping or disconnecting.
c. The admitting physician will enter orders regarding the status of the pain pump.
    i. If the medication will continue during hospitalization, the medication that is being infused by the pain pump must be entered into the electronic health record.
        1) This will include the drug, dose, total volume, rate and volume infused.
        2) The order must specify that the drug is infusing through pain pump.
        3) The nurses will document on the electronic medication **administration** record (eMAR) daily.

4. Ambulatory Infusion Pump (AIP):
    a. The admitting physician will be notified immediately that the patient is wearing an AIP.
    b. Admitting physician will attempt to contact the original prescribing physician of the AIP for information on continuing, stopping or disconnecting.
        i. Admitting physician may also call the number located on the AIP for other information.
        ii. If the medication is a chemotherapeutic agent, the medication must be administered/discontinued by TCHD Chemotherapy Competent Registered Nurse (see PCS Procedure: Chemotherapy Administration).
    c. The admitting physician will enter orders regarding the status of the AIP.
        i. If the medication will continue during hospitalization, the medication that is being infused by the AIP must be entered into the electronic health record.
            1) This will include the drug, dose, total volume, rate and volume infused.
            2) The order must specify that the drug is infusing through AIP.
            3) If the AIP is continued, nurses will document on the eMAR daily.

E. **FORMS:**
1. **7010-1037** Patient-Supplied Equipment Waiver Sample

F. **RELATED DOCUMENTS:**
1. Outpatient Infusion Center Procedure: Ambulatory Infusion Pumps
2. PCS Policy: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient
3. PCS Policy: Wearable Defibrillator (LifeVest)
4. PCS Procedure: Chemotherapy Administration

PATIENT SUPPLIED EQUIPMENT WAIVER

This Patient Supplied Medical Device or Equipment Waiver between Tri-City Healthcare District (Tri-City) and _____ (Patient requesting to utilize patient supplied medical device or equipment or his/her legal representative) is entered into on _____, 20 _____. Patient or legal representative must initial each statement in order to use Patient Supplied Medical Device or Equipment in a Tri-City Healthcare District facility. The conditions set forth herein will expire upon my discharge from the facility in which the agreement is entered into.

Type of Medical Device or Equipment to be used: _____

(Do not use for Insulin Pump, refer to Insulin Pump Policy).

_____ I understand that I have voluntarily brought my medical device/equipment into a Tri-City facility for my use during my stay at a Tri-City facility.

_____ I certify that I have been trained on how to use and repair this medical device/equipment, and that I am fully capable of using and repairing the medical device/equipment.

_____ I understand that Tri-City performed an inspection of my medical device/equipment. This inspection is not a warranty that the medical device/equipment is safe or free from defects. I am not relying on Tri-City's inspection of the medical device/equipment to ensure its safety or my proper use.

_____ I understand that Tri-City may unilaterally determine without warning to me that I may no longer use my medical device/equipment. Tri-City may replace my medical device/equipment with its own medical device/equipment.

_____ I understand that by signing this document, I hereby waive any claim or right of action against Tri-City related to my use of my medical device/equipment. I release Tri-City and its employees, agents, and assigns from any and all liability resulting from the use, operation, damage to, and repair of my medical device/ equipment by myself, Tri-City, and any of its employees.

By agreeing to the above terms and conditions, I expressly assume the risks that may result from bringing a medical device or personal medical equipment to be utilized, into a Tri-City facility. I release Tri-City from any damages, and agree to indemnify, hold harmless, and defend Tri-City, its employees, affiliates, directors, officers, subsidiaries, and agents against any and all liability arising out of the negligent operation or use of the medical device/equipment by me or my family or visitors. I acknowledge and agree that in no event shall Tri-City be liable for any indirect, special, consequential, incidental, or punitive damages, injury, loss, or expense associated with the use of a personal medical device/equipment by me or my family and/or visitors. This agreement shall be legally binding on me and my designated family member(s) and/or visitors operating my personal medical equipment. My signature below indicates I have read this agreement, understand it, and agree to be bound by its terms.

Patient or Legal Representative _____ Date / Time (a.m./p.m.) _____

Witness _____ Date / Time _____

Affix Patient Label

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

7010-1037

PATIENT SUPPLIED EQUIPMENT WAIVER

White - Hospital Canary - Patient

PATIENT SUPPLIED EQUIPMENT WAIVER SAMPLE

This Patient Supplied Equipment Waiver between Tri-City Healthcare District (Tri-City) and _____ (Patient) is entered into on _____, 20__. Patient or legal representative must initial each statement in order to use Patient Supplied Equipment in Tri-City Healthcare District facility.

Type of Device used: _____ (Do not use for Insulin Pump, refer to Insulin Pump Policy)

_____ I understand that I have voluntarily brought my equipment into a Tri-City facility for my use during my stay at a Tri-City facility.

_____ I certify that I have been trained on how to use and repair this equipment, and that I am fully capable of using and repairing the equipment.

_____ I understand that Tri-City performed an inspection of my equipment. This inspection is not a warranty that the device is safe or free from defects. I am not relying on Tri-City's inspection of the equipment to ensure its safety or my proper use.

_____ I understand that Tri-City may unilaterally determine without warning to me that I may no longer use my equipment. Tri-City may replace my equipment with its own equipment.

_____ I understand that by signing this document, I hereby waive any claim or right of action against Tri-City related to my use of my equipment. I release Tri-City and its employees, agents, and assigns from any and all liability resulting from the use, operation, damage to, and repair of my equipment by myself, Tri-City, and any of its employees.

By agreeing to the above terms and conditions, I expressly assume the risks that may result from bringing personal medical equipment into a Tri-City facility. I release Tri-City from any damages, and agree to indemnify, hold harmless, and defend Tri-City, its employees, affiliates, directors, officers, subsidiaries, and agents against any and all liability arising out of the negligent operation of use of the medical equipment by me or my family or visitors. I acknowledge and agree that in no event shall Tri-City be liable for any indirect, special, consequential, incidental, or punitive damages, loss, or expense associated with the use of personal medical equipment by me or my family and/or visitors. This agreement shall be legally binding on me and my designated family member(s) and/or visitors operating my personal medical equipment. My signature below indicates I have read this agreement, understand it, and agree to be bound by its terms.

_____ _____
Patient or Legal Surrogate Date

_____ _____
Family Member if Operating Equipment Date

_____ _____
Tri-City District Hospital Representative Date

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**NEPHROSTOMY DRAIN, CARE OF**
Purpose:	To outline the nursing responsibilities in the care of nephrostomy drains.
Supportive Data:	A nephrostomy drain is a percutaneous tube inserted into the renal pelvis for temporary diversion of urine associated with urinary obstruction, to allow healing fistula or leaks secondary to injury, malignances or inflammatory fistula or hemorrhagic aptitis.
Equipment:	1. Gloves 2. Face Shield or Mask or Goggles 3. Collection Container 4. Biohazard disposal bag available 5. Tegaderm dressing 6. Chlorhexadine swab 7. Fenestrated gauze

A. **POLICY:**

1. Ensure locking mechanism of drainage tube in locked position to maintain proper and secure placement of the nephrostomy catheter or as ordered by the physician.
2. Maintain the drainage bag at a lower level than the kidney at all times.
3. Ensure the nephrostomy tube does not kink or otherwise become compressed.
4. Secure drainage bag, **via a safety pin connection or leg strap,** to prevent tension, accidental dislodgement or contact with the floor.
5. When bathing a patient with a nephrostomy tube in place, ensure insertion site remains dry.
6. Nephrostomy drain may only be removed by Interventional Radiology (IR) provider or physician

B. **PROCEDURE:**

1. Assess nephrostomy output as ordered or at least every four (4) hours and as needed
   a. Notify physician if output changes from baseline output.
2. Empty the drainage bag when it becomes half full or every shift
   a. Don clean gloves. If splashing is anticipated, wear mask, eye protection, and/or gown.
   b. Empty the drainage bag into a measuring container and carefully avoid touching the spout to the drainage container.
   c. Dispose of the drainage in the toilet, taking care not to splash contents.
   d. Document the amount and type of fluid drained in the electronic health record (EHR) on appropriate Intake and Output form.
3. Change the dressing every other day and PRN or as ordered.
   a. Perform hand hygiene.
   b. Don clean gloves., change gloves or perform hand hygiene as necessary throughout the procedure..
   c. Place the following supplies on a clean surface:
      i. Tegaderm dressing
      ii. Chlorhexadine swab
      iii. Fenestrated gauze
   d. Remove the soiled dressing.
   e. Assess insertion site for redness and oozing of fluid. Notify the primary care or Interventional Radiology (IR) provider if these signs are noted.
   f. Scrub the exit site with chlorhexadine swabs (or povidone iodine swabs if the patient is allergic to chlorhexadine) for 30 seconds. Allow to dry for 60 seconds.
   g. Place fenestrated gauze around the insertion site.
   h. Apply Tegaderm dressing on top of the gauze and over the tube, and apply additional tape to secure tube as needed to prevent dislodgement.

Patient Care Services Content~~Department~~ Review	Clinical Policies & Procedures	Nursing Executive Council	Department of Radiology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/09; 10/10;7/14, 12/19	03/11; 8/14, 01/20	03/11; 8/14, 02/20	08/15, 09/20	04/11, 01/16, 10/20	12/20	05/11, 02/16, n/a	08/09, 05/11, 02/16

i. Document date and time of dressing change and your initials on the dressing
j. Document in the EHR.

4. Monitor dressing after removal of drain by IR provider or physician
   a. Maintain dressing over drain site until site is healed. Secure gauze dressing with tape and change PRN.
5. If drain removed accidentally:
   a. Cover drain site with gauze dressing.
   b. Visually inspect the drain to ensure it is intact. If the drain is not intact collect drain, tubing and other associated products to send with patient to IR.
   c. Notify IR provider or physician
   d. Notify Risk Management regarding accidental withdrawal.
      i. If drain not intact, obtain instructions on where to send the product for further evaluation.
   e. Document incident in EHR.

C. **REFERENCES:**

1. Gottrup, F., Nix, D. P. & Bryant, R. A. *The multidisciplinary team approach to wound management*. In R. A. Bryant & D. P. Nix (Eds.), Acute & chronic wounds: Current management concepts (3rd ed., pp. 23-38). St. Louis, MO: Mosby.
2. Mosby's Nursing Skills Procedure: Nephrostomy Tube Care and Flushing. Retrieved June 9, 2014 from TCMC Intranet.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**PASSY-MUIR SPEAKING VALVE (PMV)**
Purpose:	Establish a standard for setting up and use of a PMV. To evaluate/assist the tracheostomized patient in possible vocalization, or as part of decannulation.
Supportive Data:	A. Passy-Muir Inc. Instructional Booklet B. Benefits: 1. Allows patients to use own voice to speak 2. Technique is more sterile than finger occlusion 3. Secretion reduction 4. Increased sense of well being 5. Assists in restoration of sense of smell 6. Improves potential to swallow 7. Demonstrated to expedite weaning from the ventilator and tracheostomy tube
Equipment:	PMV, suction set-up and device, pulse oximeter, Personal Protective Equipment (PPE). (PMVs are stored in Sterile Processing Department [SPD].)

A. **POLICY:**

1. Only licensed **Tri-City Healthcare District (TCDH)**~~TCMC~~ Respiratory Care Practitioners (RCP), Registered Nurses (RNs), and Speech **Language** Pathologists **(SLP)** are authorized to perform the following procedure. RCP must be present for initial use with ventilator-dependent patients, and must be available for follow-up treatments.
2. Patient selection criteria:
   a. Tracheostomy
      i. Tracheostomy tube can be:
         1) Cuffed – cuff must be deflated for use
         2) Cuffless
         3) Fenestrated
         ~~4) Metal – Jackson type requires a 15 mm adapter (~~
      ii. Do not use PMV with Bivona cuffed tracheostomy tubes.
      iii. Tracheostomy must be in place at least 48 hours before evaluation can be completed
   b. Awake and responsive patients or as ordered by physician.
   c. Stable cardiopulmonary status
3. Indications may include the following:
   a. Ventilator dependency
   b. Neuromuscular disease
   c. Quadriplegia
   d. Tracheomalacia
   e. Bilateral or unilateral vocal cord paralysis
   ~~f. Sleep apnea patients who are tracheostomized when awake~~
4. Contraindications may include the following:
   a. Unresponsive, unconscious, and/or comatose patients
   b. Patients who are unable to tolerate cuff deflation
   c. Inflated tracheostomy tube cuff
   d. Foam filled cuffed tracheostomy tube
   e. Severe airway obstruction which may prevent sufficient exhalation
   f. Thick and copious secretions
   g. Severely reduced lung elasticity that may cause air trapping
   h. Patients with endotracheal tubes
   i. Severe tracheal and/or laryngeal stenosis

~~Department~~ Review	Clinical Policies & Procedures	~~Nursing Leadership Executive Council~~	Division of Pulmonary	Pharmacy & Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/97, 04/08, 01/11; 09/14, 04/15, 02/20	02/11; 09/14, 06/15, 05/20	03/11;10/14, 07/15, 06/20	04/17, 09/20	n/a	04/11, 05/17, 10/20	12/20	05/11, 06/17, n/a	05/97,07/03, 03/04; 02/06, 08/08, 05/11, 06/17

j. Laryngectomized patients

5. Physician orders must contain an order for PMV and Speech Pathology consult

B. **PROCEDURE:**

1. NOTE: The first time the PMV is used on the patient the presence of both an RCP and Speech pathologist is required.
2. Verify order and assess patient for indicators or contraindications in the use of PMV.
3. Assess communicative potential and possible benefit of PMV by Speech Therapy.
4. Verify patient using two identifiers.
5. Perform hand hygiene, don gloves, identify patient, and explain procedure to the patient, family and RN, as indicated.
6. Suction patient's oral cavity and trachea to remove accumulated secretions.
7. Reposition patient for optimal breathing mechanics.
8. Ensure the inner cannula is in place and adaptable to the PMV.
9. Place patient on pulse oximeter, as indicated. Apply supplemental O_2 to maintain adequate saturation.
10. Deflate the cuff slowly, if patient is using a cuffed tracheostomy tube. Additional suctioning may be required once cuff is fully deflated. For patients with increased secretions, consider suctioning while deflating the cuff.
11. Place PMV on tracheostomy tube with a ¼ turn twist. If forced on too hard, it may occlude the valve.
12. Evaluate the patient for at least 15 minutes (if tolerated), once the valve is in place, for the following:
    a. Respirations, heart rate
    b. Respiratory distress/adequate airflow/obstructed airway
    c. Vocal quality, quantity, volume
    d. Oxygen saturation
    e. Breath sounds
    f. Overall comfort. May need to coach and re-educate patients to breathe through their upper airway.

~~13. Discontinue use of the PMV after 3 days if trial period fails or for patient decompensation, and await new order.~~

~~14. Discontinue speech therapy if tolerated consistently and no other communicative, cognitive, or swallowing deficits are identified.~~

C. **SPECIAL CONSIDERATIONS:**

~~1. PMV may be trialed 48 – 72 hours after insertion of a tracheostomy tube providing surgical secretions are minimal.~~

~~2.~~1. Valve can be used in some patients up to 18 – 20 hours. Do not use valve when the patient is sleeping.

~~3.~~2. Humidification and oxygen can be supplied through a mask or trach collar.

~~4.~~3. Take valve off before aerosolization of medication.

~~5.~~4. With proper training, patients and family members can apply and remove the valve independently.

~~6.~~5. Cleaning:
    a. The PMV is designed for single patient use. It is recommended that the valve be replaced after two months.
    b. The valve should be cleaned daily after the last usage.
        i. Swish PMV in soapy, warm water (not hot water)
        ii. Rinse thoroughly with warm water (do not use hot water)
        iii. Place on clean paper towel and air dry overnight. Place in storage container.
    c. Do not clean with the following:
        i. Hot water
        ii. Peroxide
        iii. Bleach

iv. Alcohol
v. Ethylene oxide/gas sterilization
vi. Autoclave
vii. Radiation sterilization

D. **REQUIRED DOCUMENTATION AND OBSERVATIONS:**

1. Date and time
2. PMV use, patient's tolerance, and communicative performance including duration
3. Vital signs (i.e., respiratory rate, heart rate)
4. SpO_2 levels
5. Adverse reactions
6. RCP shall record observations in the medical record
7. Speech pathologist shall document the PMV evaluation or Speech Therapy daily note in the medical record

E. **REFERENCES:**

~~1. Passy-Muir Inc. (2003). Passy-muir tracheostomy and ventilator speaking valve resource guide. Retrieved from http://www.passy-muir.com/sites/default/files/pdf/resource_guide.pdf~~

~~2.~~1. Passy-Muir Inc. (201~~9~~5). Policies and procedures for passy-muir use. Retrieved from http://www.passy-muir.com/policiesandprocedures

Tri-City Medical Center
Oceanside, California

DELETE - follow Patient Care Services Policy: Medical Equipment Brought into the Facility Policy

PATIENT CARE SERVICES POLICY

ISSUE DATE: 6/02

SUBJECT: Patient Owned/Supplied Equipment Brought into the Facility

REVISION DATE: 7/05, 7/07, 3/10, 6/12

POLICY NUMBER: XI.E

Patient Care Services Content Expert Approval:	08/20
Clinical Policies & Procedures Committee Approval	~~06/12~~08/20
Nursing Leadership Approval:	10/20
~~Patient Care Quality Committee Approval:~~	~~07/12~~
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	10/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~08/12~~ n/a
Board of Directors Approval:	08/12

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

~~1. To provide guidelines for patient owned/supplied equipment that is brought into the center.~~

~~B. **DEFINITION:**~~

~~1. Patient Supplied Equipment (PSE) relates to medical equipment supplied by the patient or family that is brought into the hospital for use during the patient's stay. (examples may include: patient owned medical equipment, medical equipment that is being rented loaned/leased, loaner equipment from other hospitals, doctor owned, or vendor supplied equipment for use by the patient, etc.)~~

~~C. **STANDARD OF PRACTICE:**~~

~~1. It shall be the standard practice at Tri-City Medical Center (TCMC) to not allow patients to bring in their own equipment for use during their hospital stay. Equipment that is not the property of the medical center or under a rental agreement may not be used in the care of patients unless there is no comparable equipment available. However, there may be instances in which the patient must bring in their own equipment. When these situations arise, this policy will describe how TCMC employees and physicians should respond. This policy will apply to limited types of patient supplied equipment.~~

~~2. Patients with continuous home parenteral therapy should not have therapy interrupted until pharmacy services can assess, provide, and continue the medication safely.~~

~~3. Prohibited PSE (Prohibited List): The following types of PSE are NOT allowed to be used in the hospital under any circumstances (the examples are illustrative only and are not all inclusive):~~

~~a. Equipment that is not approved by the Food and Drug Administration for sale/distribution or use under the Investigation Device Exemption (IDE) regulation within the United States;~~

~~b. High risk equipment e.g.,~~

- ~~Defibrillators~~
- ~~Automated External Defibrillator (AED)~~
- ~~Patient controlled analgesia (PCA) pumps~~
- ~~Anesthesia machines~~
- ~~External Medication pumps~~
- ~~Home Dialysis equipment~~

c. Any equipment that does not meet the electrical safety standards required for medical equipment or use in the hospitals.

D. **PROCEDURE:**

1. Patient and/or family request's the use of PSE. The nurse caring for the patient should explain to the patient that TCMC's standard of care is to use hospital-owned equipment whenever possible and that exceptions are made only when TCMC is unable to provide similar equipment.
2. Upon the patient's request to use PSE, the patient's physician and clinical staff will determine whether the equipment is medically appropriate for the patient's condition. The patient or family members must have the capacity, adequate training, and experience, to operate the equipment safely.
3. If the equipment is deemed medically appropriate, and the clinical staff deems that the patient or family members can safely and adequately use the equipment on his/her own, the physician will authorize use with an order.
4. Once the physician's order is obtained, the clinical staff in the department where the patient is being treated will complete a basic check of the device following the steps in Section 8 and a visual inspection of the device prior to use. Clean as needed.
5. Bio-Med must be contacted to perform an operation and safety check on the device.
6. Prior to use of the PSE while in the facility, the patient or legal representative must sign a liability waiver for use of PSE. The signed waiver shall be placed in the patient's chart. If the waiver is declined, or if the device does not meet clinical or electrical safety standards, the equipment will not be allowed to be used in the hospital. (See Patient-Supplied Equipment Waiver)
7. Even if the device is mechanically and electrically sound, there may still be reasons to prohibit its use. These reasons may include, but are not limited to the following:
   a. If the equipment requires audible alarms that cannot be provided;
   b. If the equipment has alarms that can be defeated without clinical staff intervention;
   c. If the patient should become incapacitated or is otherwise unable to maintain their, equipment the hospital may provide substitute equipment.
   d. Any reason that TCMC deems reasonable that may place the patient's safety at risk.
8. Prior to allowing patients to utilize their own equipment, a nurse/designee in the clinical department where the patient is being treated, will verify/complete the following for patient supplied equipment (PSE).
   a. A physician order has been entered in Cerner approving the use of the patient's equipment.
   b. Clinical nursing staff has completed a visual inspection (assessing for damage to the device, infestation with insects, excessively soiled.)
   c. The exterior shall be thoroughly wiped down with germicidal disinfectant (example: Sani-Wipe), being careful around any electrical portions. If there are any concerns related to infection control, the Infection Preventionist shall be contacted at Ext. 3007.
   d. Bio-Med shall be notified as soon as possible that a PSE device has been brought into the facility and the required inspection and safety checks must be completed. The safety check must be completed within 24 hours of the device being brought into the facility (M-F). If the device is brought in during the weekend, then the nurse should complete a thorough visual inspection for any frayed wires and plug, and Bio-Med shall be notified first thing Monday morning that a safety inspection is needed.

i. The exception to this rule is any use of life-support devices such as a ventilator, which must be inspected by Bio-Med prior to any use within the medical center. (Off hours and weekends contact the Administration Supervisor to notify Bio-Med).

e. Bio-Med shall label the device as Non-Hospital Owned Equipment with the date of their inspection.

f. If the medical device does not have alarms and failure of the device could lead to potential harm to the patient, then the clinical staff members must use adequate oversight or alternate means to monitor the patient's well being (example: pulse oximeter).

g. The patient or legal surrogate has signed a liability release for patient supplied medical equipment and this has been placed in the patient's chart.

i. Note: Any concerns or questions, please contact:

1) The Director of Risk Management for risk issues

2) The Chief Nurse Executive for patient care issues

3) The Management of Clinical Engineering for medical equipment issues.

E. **Forms Located on Intranet:**

1. Patient Supplied Equipment Waiver

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 05/06 **SUBJECT:** Pet Therapy

REVISION DATE: 07/06, 08/08, 07/11, 02/15, 12/17 ~~**POLICY NUMBER: II.C**~~

Patient Care Services Content Expert~~Department~~ Approval:	~~09/17~~08/20
Clinical Policies & Procedures Committee Approval:	~~09/17~~08/20
Nursing Leadership~~Executive Council~~ Approval:	~~09/17~~10/20
Infection Control Committee Approval:	~~10/17~~10/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/17~~11/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~11/17~~ n/a
Board of Directors Approval:	12/17

A. **PURPOSE:**

1. Pet Therapy is utilized to make hospitalization a less threatening experience and promote therapeutic patient goals. It is used to augment healing and to provide incentives to patients who are debilitated and/or uncommunicative.

B. **POLICY:**

1. All patients of Tri-City Healthcare District (TCHD) are eligible, **but must be authorized,** for participation in the program in order to promote cognitive skills, physical functioning and improve patient psycho-social well-being.
2. Patients of TCHD may request specific visitation on Acute Rehabilitation, Inpatient/Out Patient Behavioral Health, Cardiac Wellness, 4 Pavilion, 2 Pavilion, 1 North, Telemetry, and Emergency Services.
    a. Therapy dogs may not visit unauthorized areas or patients with the following:
        i. Shared rooms, unless both patients agree.
        ii. Patients with spleen removed or immuno compromised (neutropenic)
        iii. If an immuno compromised patient would like a pet therapy visit this is determined at the discretion of the patient's physician.
            1) Infection Control must be consulted before permitting pet visits for patients in various immune deficiency states.
        iv. Patients in isolation (Airborne, Droplet and Contact) including patients with:
            1) Tuberculosis (dogs and handlers can acquire tuberculosis).
            2) Patients with positive test for methicillin-resistant Staphylococcus aures (MRSA); dogs and their handlers can acquire MRSA.
            3) Patients colonized or infected with vancomycin-resistant enterococci (VRE), Salmonella, Campylobacter, Shigella, Strep A, Ringworm, Giardia, or Amebiasis.
        v. Food preparation area or carts.
        vi. Medication preparation or storage area or carts.
        vii. High risk areas; Intensive Care Unit, Operating rooms and Neonatal Intensive Care Unit and patients on dialysis.
3. Personal pets are not permitted in the hospital unless they are a service animal or an approved Pet Therapy dog:
    a. Exceptions shall be made through hospital administration with consultation from Infection Control.

b. Strict guidelines and criteria for approved Pet Therapy handlers and their dogs are outlined in the reference listed below.

4. Only Active members of Tender Loving Canines (TLC) Program are authorized to perform service with dogs and handlers who are registered with Pet Partners, Independent Therapy Dogs, Inc., or other therapy dog certifying agencies approved by TCHD.
5. Pet Therapy dogs must be wearing visible blue vests and TCHD identification name badges with their name and "Pet Therapy." Small Dogs that cannot be fitted with a vest should wear the TCHD bandana only.
6. Any problems identified with Pet Therapy pets or their handlers shall be directed to the **Nursing Leadership**~~Manager/Assistant Nurse Manager (ANM)~~**Charge Nurse** or designee.
   a. These concerns shall be directed to the Therapeutic Recreation Specialist/Pet Therapy Coordinator at extension 7387 for follow-up and resolution.
7. Patients shall be provided with hand hygiene product to wash their hands after a visit.
8. Any handler who does not follow proper procedures or a dog that appears to be out of control will be asked to leave the hospital premises immediately with notification to the Therapeutic Recreation Specialist/Pet Therapy Coordinator at extension 7387.
9. Dog's Equipment:
   a. Well-fitted buckle, quick-release connection, or snap closure blue collar and harness made of leather or fabric
      i. All metal/chain or slip collars may not be used.
      ii. Special training collars such as pinch, spike, electric or spray may not be used.
   b. Collars may be flat collars or Martingales (i.e. limited slip collar).
   c. Halters may be Gentle Leader, Promise, Snoot Loop or Halti and may only be used at the discretion of the animal behaviorist.
      i. Metal chain and retractable leashes may not be used (i.e. Flexi-Leash).
   d. Metal buckles, slip rings, and D-rings are acceptable.
   e. All leashes to be no more than 6' in length.
10. Handler's Attire:
    a. Clothing:
       i. Clothes are to be neat and tidy and may not include shorts, blue jeans, short skirts or tight-fitting clothing.
       ii. Shoes must be closed-toed.
       iii. No accessories or jewelry that may have sharp edges or corners.
    b. TLC Uniforms:
       i. TLC approved attire is to be worn by handler at all times when present in the facility on a visit with their dog.
       ii. TCHD identification (ID) badge and Pet Therapy ID badge from approved TCHD Pet Therapy certification/registration agency, both to be worn at all times.

C. **PROCEDURE:**

1. General Guidelines:
   a. All handlers must be at least eighteen (18) years of age.
   b. TLC is the only group sponsoring pets in the hospital that is supported by the medical staff. Dogs that have not been screened are not sponsored by TLC in the hospital. Dogs must be at least one year of age to start in the program and have been with the handler for at least six (6) months.
   c. Handler is required to become a member of the TCHD Auxiliary, which includes the following:
      i. Yearly membership dues
      ii. Background check
      iii. Influenza Vaccination
      iv. Tuberculosis (TB) screening
      v. Hospital Orientation
      vi. Annual auxiliary refresher course

d. Admittance to the TLC program requires a TCHD- approval and supervision by Therapeutic Recreation Specialist/Pet Therapy Coordinator.
e. Health tests are required for the handler, per TCHD volunteer policy for health screening and dog, signed off by veterinarian, per attached form and submitted to Therapeutic Recreation Specialist/Pet Therapy Coordinator.
f. The Handler will complete a TCHD Pet Therapy application form and submit to the Therapeutic Recreation Specialist/Pet Therapy Coordinator, pending approved trainee status. Certification/registration documents from Pet Partners, Independent Therapy Dogs, Inc., Love on a Leash or other therapy dog certifying agency approved by TCHD must be included with the application.
g. All trainee members (handlers and dogs) will attend an orientation meeting prior to beginning hospital work conducted by Therapeutic Recreation Specialist/Pet Therapy Coordinator:
h. Trainee handlers and their dogs should be accompanied by a certified handler and Therapeutic Recreation Specialist/Pet Therapy Coordinator for a minimum of three (3) consecutive visits within 3 months of being accepted into the TLC program. Appropriateness of their behavior and awareness of TCHD policies will be assessed before being scheduled to make visits on their own to units. The visits will include one visit to the unit on which they will be volunteering. .
i. On a yearly basis, the dog must pass the above-mentioned physical exam for membership renewal.

2. Scheduling by the TCHD Therapeutic Recreation Specialist/Pet Therapy Coordinator:
   a. Handlers will coordinate and schedule visits with Therapeutic Recreation Specialist/Pet Therapy Coordinator.
   b. Any aggressive behavior will be grounds for suspension. All dogs involved may be suspended by the Therapeutic Recreation Specialist/Pet Therapy Coordinator for up to three months pending investigation. Investigation of the incident will be conducted by the Therapeutic Recreation Specialist/Pet Therapy Coordinator, Risk Management Officer and Security Staff as needed. Upon investigation, the Committee will determine necessary steps for further training or dismissal of the involved team from the Pet Therapy Program,
   c. Return of the team to the TLC program, will be based on assessment and training by a nationally certified dog trainer, approved by TCHD Pet Therapy Coordinator.

D. **REFERENCE(S):**

1. Centers for Disease Control and Prevention Guidelines for Environmental Infection Control in Health-Care Facilities. *Recommendations of CDC and the Healthcare Infection Control Practice Advisory Committee (HICPAC).* MMWR 2003; 52 (No.RR-10); 1-48.
2. Lafebre et al. (2008). *Guidelines for animal assisted intervention in health care facilities.* AJIC, 36(2). P 78-85.
3. Medical Evaluation Form for Dogs and Cats. Development, Implementation, and Evaluation of Animal-Facilitated Therapy Programs, Delta Society Conference, Oct. 4-6, 1988.
4. Pet Therapy Certification Criteria 2016
~~5. Prescription Pet Program, the Children's Hospital, Denver, Colorado. Veterinary Health Protocol, Initial Behavioral Evaluation, Assn. of Volunteers for Children's Hospital and the Denver Area Veterinary Medical Society, Sept. 1987.~~
~~6.~~5. Proposal for Health Examination/Screening of Dogs - Pilot Pet Therapy Program. Barbara Deep, D.V.M., School of Animal Medicine, University of Washington, Oct. 1 1987.
~~7. Proposal to Provide Animal Assisted Therapy Services to Canyon Springs Hospital. Delta Society, California Desert Chapter, April 1989.~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE:	**064/13**
REVISION DATE(S):	**06/13**
SUBJECT:	**Radiation Safety**
	~~POLICY NUMBER: NEW~~

Patient Care Services Content Expert Approval:	**11/17**
Clinical Policies & Procedures Committee Approval:	**~~01/13~~02/~~18~~03/20**
Nurse Executive Committee Approval:	**~~05/13~~04/20**
~~Medical Staff~~ Department of Radiology/~~Division~~ Approval:	**~~n/a~~09/20**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**10/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~06/13~~ n/a**
Board of Directors Approval:	**06/13**

A. **PATIENT SAFETY:**

1. **A radiation warning sign will be placed outside the doors of any patients receiving radiation therapy or where there is a radiation exposure risk.**
2. ~~1.~~ ~~No more than two (2) radioactive implant therapy patients will be assigned to any one (1) Nurse (RN) per shift.~~ **Only a ~~registered nurse~~RN ~~can~~may ~~routine~~ provide routine care for ~~an~~ ~~in~~patients receiving ~~radiation~~radioactive ~~treatment~~therapy.**
3. ~~2.~~ **Admitted p~~P~~**atients ~~with~~ **receiving** radioactive ~~implants~~ **therapy** will be ~~cared for~~**assigned a room** on the 2 Pavilion ~~and~~**or Progressive Care Unit (PCU)**, unless the patient requires cardiac monitoring.
4. ~~3.~~ The Radiation Safety Officer (RSO) must be contacted for any **radiation therapy**~~implant~~ patient movement throughout the facility including an expired patient.
5. ~~4.~~ Gonadal protection will be used especially on children and adults of childbearing and producing ages during radiographic examinations whenever possible.
6. All radiographic and fluoroscopic systems will be maintained in accordance with the recommendations contained in the California Department of Public Health (CDPH) Title 22 and Title 17 regulations.
7. **Patients receiving Y-90- Radioembolization see Patient Care Services Procedure: Y-90 Micropsphere Brachytherapy Patient Management.**
8. ~~5.~~ **Patients receiving Iodine$_{131}$ see Patient Care Services Procedure: Therapeutic Use of Radiopharmaceuticals for Inpatients.**

B. **VISITOR SAFETY:**

1. Visitors will not spend more than thirty **(30)** minutes in any twenty-four **(24)** hour period in a radiation implant patient room.
2. Pregnant women will be restricted from radiation **therapy** ~~implant~~ rooms.
3. Persons under eighteen **(18)** years of age will be restricted from radiation ~~implant~~ **therapy** rooms.
4. All doors will be closed during radiographic and fluoroscopic examinations.

C. **PERSONNEL SAFETY:**

1. **A radiation warning sign will be placed outside the doors of any patients receiving radiation therapy or where there is a radiation exposure risk.**
   ~~Detailed instructions on how to care for patients receiving specific radiation therapy refer to the TCMC Radiation Therapy Manual.~~

2. **No more than two (2) radioactive therapy patients will be assigned to any one (1) Registered Nurse (RN) per shift.**

~~1.~~3. All ~~occupationally exposed personnel~~**designated radiation workers that** engaged in fluoroscopic or radiographic work will wear exposure-monitoring badges.
   a. Badges are to be worn outside the lead apron at collar level and should be put on upon arrival for duty.
   b. Badges are not to leave the facility.

~~2.~~4. Occupationally exposed personnel engaged in fluoroscopic or radiographic work should notify either their director or the RSO of a suspected or confirmed pregnancy in writing.

~~3.~~5. **Department of Human Services** (DHS) regulations do not allow technologists to hold patients during radiation exposures except during rare or emergent type situations. If a technologist is in a room during an exposure, lead aprons will be worn.

~~4.~~6. All personnel will stand behind lead barriers during exposures when appropriate. If personnel must be in the room during radiation exposures, lead aprons shall be worn.

~~5.~~7. All doors will be closed during radiographic and fluoroscopic examinations.

~~6.~~8. Personnel will not enter a radiographic or fluoroscopic room when the door is closed.

9. All lead aprons and gloves will be checked annually for leakage and replaced when needed.

~~7.~~10. **All personnel involved in the care of patients receiving ~~radiation treatment~~radioactive therapy or are involved with handling or exposure to radiation will receive yearly education on radiation safety.**

D. **AS LOW AS REASONABLY ACHIEVABLE (ALARA) GUIDELINES:**

1. Purpose:

~~1.~~a. The functional control of occupational radiation exposure for personnel employed in situations of exposure to ionizing radiation from radioactive materials under the authorization of the radioactive materials license will be the responsibility of the RSO and the Radiation Safety Committee (RSC). The goal will be to maintain personnel radiation dose ALARA and, in keeping with that goal, the following Action Levels (below the Maximum Permissible Dose [MPD] for occupational radiation have been established).

Dose Category	Action - Level I	Action - Level II
Whole Body	675 mrem/qtr	1275 mrem/qtr
Skin	750 mrem/qtr	2250 mrem/qtr
Extremities	1875 mrem/qtr	5625 mrem/qtr

2. Process:

~~2.~~a. When the monthly occupational dose reports are received, the RSO ~~as well as the Medical and Administrative Director of Diagnostic Imaging~~ will review them. **The Medical and Administrative Director of Diagnostic Imaging will review the report during the quarterly Radiation Safety Committee meetings.** ~~The RSO (or his designee) shall report on the status of the ALARA and on personnel exposures in general at each meeting of the RSC.~~

3. The RSO will make an annual written report to management on the Radiation Safety Program.

4. In the event an occupationally exposed person exceeds Level I doses, the RSO shall review the circumstances of the exposure in an informal manner and if determined advisable, will discuss the situation with accepted persons and, if necessary, counsel the individual exposed. Since the average monthly acceptable dose of Level I is only 40 mrem per month/ minor variations above this average acceptable dose are not to be considered alarming (since this is the allowable limit for the non-occupationally exposed general public as well as persons in the status of "Declared Pregnancy"), but rather the object is to monitor trends to prevent personnel doses from reaching or exceeding Level II or the MPD.

5. It must be remembered that when an occupationally exposed person becomes pregnant and it is known by responsible persons (a Declared Pregnancy), their maximum permissible dose is

reduced to 10% of the MPD for adults. In essence, when an individual is known to be pregnant, the Level I dose is the MPD.

6. In the event an occupationally exposed person exceeds the maximum occupational dose specified in the California Control of Radiation Hazard Regulations the Office of Radiation Control will be contacted immediately.
7. If a full year of dosimetry records indicate no exposure for an individual, that person will no longer need to wear personal dosimetry and will no longer be issued a badge.
8. These guidelines apply to those persons occupationally exposed as a result of activities related to this radioactive materials license.

E. RELATED DOCUMENT(S):

1. **Patient Care Services Procedure: Therapeutic Use of Radiopharmaceuticals for Inpatients**
2. **Patient Care Services Procedure: Y-90 Micropsphere Brachytherapy Patient Management Procedure**
3. **Principles of Radiation Safety**

F. REFERENCE(S):

~~9.~~1. **California Code of Regulations, Titles 17 and 22 California Department of Public Health**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/98 **SUBJECT:** Service Animals

REVISION DATE: 3/00, 6/01, 6/03, 8/07, 5/10; ~~10/13~~30/14

Patient Care Services Content Expert Approval:	08/20
Clinical Policies & Procedures Committee Approval:	~~10/13~~09/20
Nursinge Leaderhip~~Executive Committee~~ Approval:	~~10/13~~10/20
Medical Executive Committee Approval:	~~11/13~~10/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~01/14~~ n/a
Board of Directors Approval:	01/14

A. **POLICY:**

1. The Americans with Disabilities Act (ADA) of 1990 ~~(42 U.S.C.12181)~~ gives civil rights protection to individuals with disabilities. A disability is defined as a physical or mental impairment that substantially limits one or more of the major life activities of an individual.
2. The ADA guarantees equal opportunities and access in the areas of employment, state and local government services and programs, places of public accommodation and telecommunications. **Tri-City Medical Center and its respective health entities are considered places of public accommodation.**
   ~~a. Place of public accommodation refers to a facility, operated by a private entity, whose operations affect commerce. This includes Tri-City Healthcare District (TCHD).~~
3. ~~Section 36.302(c)(1)~~**ADA law** requires **that** a place of public accommodation modify its policies, practices, or procedures to permit the ~~use~~**owner** of a ~~service animal~~**Service Dog to be accompanied** by ~~an individual with a disability~~**his dog** unless making ~~the modifications~~**such accommodations** would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations ~~(Section 36.302(a)).~~**of the entity.**
4. As of 2008, patients and visitors with disabilities are entitled to be accompanied by their ~~service animal~~**Service Dog** when they are either admitted **to,** or visit hospitals, outpatient areas, or clinics. ~~That~~**This** includes areas where patients and visitors are normally allowed except~~:~~ areas that require a protected environment~~, when~~ **where** the ~~service animal~~**Service Dog** directly threatens the health and safety of patients, visitors or staff or the animal would fundamentally alter the provision of essential services including but not limited to infectious **or other** risk ~~or allergic risk posted~~**posed** by the animal.
   a. Service animals are **not** allowed in ~~but not limited to: admission and discharge offices, emergency rooms, inpatient rooms, rehab therapy, cafeteria, and restrooms.~~**the following areas of the hospital:**
   ~~b. Restricted areas include, but are not limited to, those requiring special garb or personal protective equipment. For example: isolation rooms, operating rooms, recovery areas, labor and delivery suites, neonatal intensive care unit, sterile processing areas, and medical center kitchens.~~
      i. **Operating Room (OR)**
      ii. **Post Anesthesia Care Unit (PACU)**
      iii. **Pre-Operative Hold**
      iv. **Intensive Care Unit (ICU)**
      v. **Neonatal Intensive Care Unit (NICU)**
      vi. **Interventional Radiology (IR)**
      vii. **Computerized Tomography (CT)**

viii. **Magnetic Resonance Imaging (MRI)**
ix. **Sterile Processing**
x. **Kitchens on any unit or the central hospital kitchen**
xi. **Rooms where droplet or airborne isolation is in effect**

5. A service animal is defined as ~~any domestic animal~~ **a dog that has been** individually trained to ~~provide assistance to~~ **do work or perform tasks for** an individual with a ~~physical, cognitive, or mental~~ disability. ~~The ADA definition of service animal does not limit the species of service animals.~~
   ~~a. Service animals tasks performed include, but are not limited to the following:~~
      ~~i. Guiding individuals for blind, deaf or hearing impaired.~~
      ~~ii. Providing minimal protection or rescue work.~~
      ~~iii. Pulling wheelchairs.~~
      ~~iv. Carrying and picking up things for persons with mobility impairments.~~
      ~~v. Retrieving medications~~
      ~~vi. Assisting during a seizure~~
      ~~vii. Providing physical support for balance or stability~~
      ~~viii. Assisting with navigation~~
~~b.~~**6.** ~~Psychiatric t~~Tasks performed ~~include, but are not limited to the following:~~**by the dog must be directly related to the person's disability.**
      ~~i. Providing safety checks or room searches~~
      ~~ii. Turning lights on for patients~~
      ~~iii. Interrupting self-mutilation~~
      ~~iv. Reminding to take medications~~
      ~~v. Keeping disoriented individuals from danger~~
7. ~~As of 2011, n~~**No animal other than a dog is recognized as a Service Animal under ADA law.**
~~6.~~**8.** A companion animal or emotional support animal ~~that~~**typically** assists persons with psychological disabilities. **They are not considered a service animal under ADA law and will not be permitted inside the hospital or clinical areas**~~Emotional support animals can help alleviate symptoms if depression, anxiety, stress, and difficulties regarding social interactions, allowing tenants to live independently and fully use and enjoy their living environment~~.
   ~~a. Therapy and comfort animal tasks performed include, but are not limited to the following:~~
      ~~i. Providing supervised, goal directed interventions to individuals in hospitals~~
      ~~ii. Providing emotional support, comfort therapy, companionship, therapeutic benefits or promote emotional well being~~
~~7. Staff may determine whether an animal is a service animal by: Asking if the animal is required because of a disability or asking what work or task the animal has been trained to perform, but you cannot require special ID cards for the animal. Staff may NOT ask about the nature or extent of a disability, require proof of disability, require animal to wear identification that it is a service animal, or charge a fee for allowing the animal~~
   ~~Personal animals such as pets are generally under ADA law and will not be permitted in inside the hospital. or any clinical area.~~
   a. Exceptions ~~shall~~**may** be made ~~through Hospital Administration with consultation from~~ **by the Clinical Risk Manager with the agreement of the department Director and the** Infection ~~Control~~**Preventionist** ~~RN~~.
   b. **No physician order for animal visitation is valid without agreement of the Clinical Risk Manager, the Infection Preventionist** ~~RN~~**, and the department Director.**
   c. **Pet Therapy dogs are thoroughly vetted by the volunteer department and are considered employees of the hospital. These dogs are permitted in areas of the hospital outlined in Patient Care Services Policy: "Pet Therapy**~~" policy # II.C~~**.**
9. **Staff may ask** ~~two, and~~ **only two**~~,~~ **questions of a dog owner claiming that their dog is a service animal:**
   a. **"Is this a service animal required because of a disability?"**
      i. **Staff~~We~~ are not permitted to ask what that disability is.**

b. **"What work or task has the dog been trained to perform?"**
   i. **Staff~~We~~ cannot require a demonstration of the dog's task(s)**
   ii. **If one or more of the dog's tasks is obvious i.e., pulling a person in a wheelchair or leading a blind person, this question should not be asked.**

c. **Absolutely no other questions are permitted to be asked by hospital workforce members at any level of the organization. Additional inquiries may subject the organization to large fines.**

10. **A service animal can be asked to leave or be denied entrance if any of the following apply, but not limited to:**
   a. **The dog is unruly or disruptive (e.g., barking, running around, sniffing persons nearby, unable to remain still, etc.…).**
   b. **The dog's behavior poses a direct threat to the health or safety of others (e.g., displays aggressive behavior toward any person or other Service Dog).**
   c. **The dog appears overtly ill (e.g., bizarre behavior, vomiting, repeated indoor toileting "accidents", excessive drooling or foaming at the mouth etc.…) .**
   d. **The dog is clearly unclean, smells bad, has apparent infestation, or is shedding excessively.**

11. **There is no special ID card or certification documentation for the dog. Wearing a vest or other indicator with the words "Service Dog" does not automatically qualify the animal as a service dog.**

~~8.~~12. Service animals may enter all areas of the medical center that are generally accessible to the public such as lobbies, cafeterias, and nursing units.

~~a. The animal shall not be allowed into the medical center if it~~ **If the patient** ~~is unhealthy, feverish, or suffering from gastroenteritis, fleas, or skin lesions. Employees shall visually evaluate cleanliness, health, in a double room~~ and behavior of the service ~~animal~~**second patient is either opposed** ~~to determine the safety of the animal.~~

~~b. Animals shall not be permitted to enter a room if the patient's roommate has a severe allergy or phobia to the animal.~~

~~i.~~a. **If the patient is in a double room and the second patient is either opposed** ~~If the service animal belongs to a frequent visitor and the roommate is~~ **or** allergic ~~or afraid, consider moving either~~**to the dog,** the patient ~~or~~**without** the ~~roommate~~**dog must be moved** to another room.

~~9. If a disabled patient requires an assistive animal, rather than a service animal to perform activities of daily living while hospitalized, the following shall be taken into account.~~

~~a. Situations involving restricted areas shall be addressed on a case by case basis. Contact the Infection Control Practitioner, Administrative Supervisor or Risk Management for assistance.~~

b. The hospital is not required to supervise or care for any ~~service animal (Section 36.302 C(2)).~~ **Service Dog while its owner receives medical care.** All obligations to feed, groom, exercise, ~~or in other ways care for~~**and toilet** the ~~animal~~**dog** must be arranged and paid for by the patient or patient's representative.
   i. **In the event the owner cannot care for the dog and has no representative to do so, the workplace member shall contact the local Humane Society during regular business hours. After hours, Oceanside Animal Control should be contacted. Both entities can provide assistance in the form of temporary care/housing for the animal for a nominal fee.**

c. In the case of a bladder and/or bowel accident in the patient care area by the service animal, ~~please notify Environmental Services immediately to~~**the owner or owner's representative is responsible for** clean~~ and disinfect the area.~~**up.**

~~10.~~13. Requirements of Service ~~Animals and their partners/handlers~~**Dog owners** include but are not limited to ~~the following~~:

~~a. Vaccination: The animal must be immunized against diseases common to that type of animal. Dogs must have had the general maintenance vaccine series, which include~~

~~vaccinations against rabies, distemper, and parvovirus. Other animals must have the appropriate vaccination series for the type of animal. All vaccinations must be current.~~

~~b. Dogs must wear a rabies vaccination tag.~~

~~c. Licensing: The animal must comply with local licensing requirements.~~

~~d.~~**a.** ~~Health:~~ The animal must be in good health.

~~e.~~**b.** ~~Leash:~~ The animal must be on a leash at all times.

~~f.~~**c.** ~~Under Control of Partner/Handler: The partner/handler~~**The owner or their representative** must be in full control of the animal at all times. The care and supervision of a service animal is ~~solely~~ the **sole** responsibility of its ~~partner/handler~~**owner**.

d. ~~Cleanup Rule:~~ The ~~partner~~**owner** must ~~1) Always~~ carry equipment sufficient to clean up the ~~animal's~~**dog's** feces whenever the animal ~~and the partner are~~ **is in or** on Hospital's property~~; 2) Properly dispose of the feces by flushing or discarding via a plastic bag into a trash receptacle. As a courtesy to patients, visitors and staff, the service animal~~**.**

~~g.~~**e.** **The Service Dog** will be taken outdoors for toileting by the ~~partner or designated friend or family member,~~**owner's representative** and all solid waste will be picked up ~~by the handler in a plastic bag~~ and disposed of in **an** outdoor trash ~~bins. Partners with disabilities who physically cannot clean up after their own service animal may not be required to pick up and dispose of feces. However, these individuals should use marked service animal toileting area when such areas are provided.~~**receptacle.**

~~11. If a disabled visitor with a service animal would like to leave the service animal outside a patient room, notify Security. Security shall:~~

~~a. Provide for the safety of the animal~~

~~b. Reunite the service animal with the owner when appropriate~~

14. If a ~~patient with~~ a Service Dog cannot remain with the patient~~have the dog with them~~ because of either a procedure, operation, or restricted unit location, the owner is responsible to have a representative care for the dog until such time the dog may again accompany the patient.

~~12.~~**15.** Immediate hand hygiene ~~shall~~**will** be ~~emphasized~~**required** for all persons who make physical contact with **a** ~~s~~Service **Dog**~~animal~~.

~~13. If medical justification shows that the presence or use of a service animal would pose a significant health risk or disruption to the disabled patient, surrounding patients, and/or employees of the medical center, the service animal may be restricted or excluded from the premises.~~

~~14. A service animal can be asked to leave if any of the following apply, but not limited to:~~

~~a. Disruption: The partner of an animal that is unruly or disruptive (e.g., barking, running around, bringing attention to itself) may be asked to remove the animal from the Hospital facilities. If the improper behavior happens repeatedly, the partner may be told not to bring the animal into any Hospital facility until the partner takes significant steps to mitigate the behavior. Mitigation can include muzzling a barking animal or refresher training for both the animal and the partner.~~

~~b. Poor Behavior: A service animal may be excluded form the Hospital when the animal's behavior poses a direct threat to the health or safety of others. For example, any service animal that displays vicious behavior towards other guests or customers may be excluded from certain areas due to concerns for health and safety.~~

~~c. Health: Service animals that are ill should not be taken into public areas. A partner with an ill animal may be asked to leave Hospital facilities.~~

~~d. Uncleanliness: Partners with animals that are unclean, odiferous, and/or bedraggled may be asked to leave Hospital facilities. An animal that becomes wet from walking in the rain or mud or from being splashed on by a passing automobile, but is otherwise clean, should be considered a clean animal. Animals that shed in the spring sometimes look bedraggled. If the animal in question usually is well groomed, consider the animal tidy even though its spring coat is uneven and messy appearing or it has become wet from weather related incidents.~~

~~e. Emergency situations: In the event of an emergency, the staff should recognize that the service animal may be trying to communicate the need for help. The animal may become disoriented from the smell or smoke in a fire or laboratory emergency, from sirens or wind noise, or from shaking or moving of the ground. The partner and/or family may be confused from the stressful situation. The staff should be aware that the animal is trying to be protective and, in its confusion, is not to be considered harmful. The staff should make every effort to keep the animal with its partner. However, the staff's first effort should be towards the partner; this may necessitate leaving an animal behind in certain emergency evacuation situations.~~

~~If a service animal must be separated from an individual, it is the responsibility of the individual with disability to arrange for the care and supervision of the animal during the period of separation.~~

B. REFERENCES:

1. **The Americans with Disabilities Act (ADA) of 1990 (42 U.S.C.12181)**
2. **28 C.F.R. §36.302**
3. **Patient Care Services Policy: "Pet Therapy"** ~~**policy # II.C**~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/11

SUBJECT: ~~Patient Skin Preparation~~**Antisepsis, Surgical/Procedural, Patient**

REVISION DATE: 03/14

POLICY NUMBER: IV.V

Patient Care Services Content Expert~~Department~~ Approval:	**~~03/17~~05/20**
Clinical Policies and Procedures Approval:	**~~03/17~~06/20**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~03/17~~07/20**
Operating Room Committee Approval:	**~~04/17~~08/20**
Infection Control Committee Approval:	**09/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/17~~11/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~09/17~~ n/a**
Board of Directors Approval:	**09/17**

A. **PURPOSE:**

1. To provide guidelines for surgical/procedural site skin antisepsis.

B. **POLICY:**

1. The surgical/procedural site and the surrounding area shall be free of dirt, debris, **alcohol-based hair or skin products, lotions, deodorant,** emollients, and cosmetics before surgical/**procedural** preparation.

~~1.~~a. For surgery on the hand or foot, the nails on the operative extremity should be clean and natural, without artificial nail surfaces (i.e., acrylics, nail extensions).

2. The surgical/procedural site shall be assessed before skin preparation.
   a. Presence of lesions, rashes, warts or other skin conditions at the surgical/procedural site shall be documented and the surgeon shall be notified.
   b. Jewelry or body piercings should be removed before skin preparation.
3. Hair at the surgical/**procedural** site should be left in place whenever possible. If the presence of hair will interfere with the surgical procedure/**procedure** and removal is necessary, the following precautions shall be taken:
   a. Hair removal shall be performed as close to the time of surgery/**procedure** as possible.
   b. Hair removal at the surgical/procedural site shall be performed according to physician orders.
   c. Hair removal shall be done in a manner that preserves skin integrity.
      i. Clip hair at the surgical/procedural site in a manner that minimizes injury to the skin.
      ii. Whenever possible, remove hair in a location outside the operating room.
      iii. If removing hair outside the operating room is contraindicated or not feasible, remove hair in the operating room/procedure room in a manner that prevents dispersal of hair into the environment, such as by wet clipping or by closely gathering hair with a hair collection device (i.e., suction or adhesive device).
      ~~i.~~iv. Electric or battery-powered clippers with a disposable or reusable head that can be disinfected between patients is preferred.
      ~~ii.~~v. Razor use is strongly discouraged, but if used wet shaving is preferable to dry shaving.

~~iii.~~**vi.** A sterile razor may be used by the surgeon to remove hair from the scrotum for scrotal procedures and implant cases involving the scrotum. The surgeon shall be provided a sterile razor and supplies to complete a wet shave.

4. The surgical/procedural site and surrounding area shall be prepared with a Food & Drug Administration (FDA) approved antimicrobial agent in accordance with manufacturer's written instructions **for use (IFU)**.
   a. Selection of antimicrobial agents shall be based on patient allergy or sensitivity, incision location, **procedure type,** skin condition, and physician preference.
   b. Skin antiseptics shall be **packaged in single-use containers and shall be** used in the full concentration as packaged by the manufacturer; do not dilute skin antiseptics prior to use.
   c. The surgical/procedural site shall be prepared by personnel who are knowledgeable about the patient and have demonstrated competency in skin preparation techniques.
      i. Preps shall be performed by a Registered Nurse (RN) or Physician/Allied Health Professional (AHP).
         1) Advanced Care Technicians (ACTs), Nursing Assistants, Anesthesia Technicians or Surgical Technicians may prep under the direct supervision of an RN or Physician/AHP.
   d. Confirm the surgical/procedural site before performing preoperative skin antisepsis.
      i. The surgical/procedure site mark should remain visible after prep application.
   ~~d. Personnel performing surgical skin antisepsis shall wear sterile gloves and use sterile supplies to apply antiseptic agents.~~
   e. **Preoperative skin** Aantiseptic agents shall be applied using ~~aseptic~~ **sterile** technique, ~~and~~ proceeding from the incision site to the periphery**, and according to manufacturer's IFU**.
      i. Perform hand hygiene before applying preoperative skin antiseptic.
      ii. Wear sterile gloves and use sterile supplies when performing preoperative patient skin antisepsis.
      iii. Arms may be covered during performance of preoperative skin antisepsis.
      iv. Items that touch the patient's skin after preoperative skin antisepsis should be sterile to prevent introduction of microorganisms at the surgical/procedural site.
      v. Apply the skin antiseptic to an area large enough to accommodate potential shifting of the surgical/procedural drapes, extension of the incision, potential additional incisions, and potential drain sites.
      vi. Discard the prep applicator after contact with a peripheral or contaminated area.
      ~~i.~~**vii.** Highly contaminated areas (e.g., anus, colostomy) near the surgical/**procedural** site should be isolated with a sterile barrier drape.
      ~~ii.~~**viii.** If a highly contaminated area is part of the procedure, the area with a lower bacterial count is prepped first, followed by the area of higher contamination.
      ~~iii.~~**ix.** An intestinal or urinary stoma within the surgical/**procedural** field should be cleansed gently and separately from the rest of the prepped area.
      ~~iv.~~**x.** When prepping the anus, vagina, or a stoma, sinus, ulcer, or open wound, the sponge should be applied once to the area and then discarded.
      ~~v.~~**xi.** Vaginal preps for procedures that include the abdomen should be performed in a manner to prevent splashing of antiseptic agent expelled from the vagina onto the prepped abdomen.
         1) Vaginal preps, inclusive or exclusive of Foley catheter insertion, are started and finished by the same RN. The vaginal prep sponges are removed from the vagina prior to disposal of prep supplies/Foley catheter supplies, to prevent unintentional retention of the vaginal prep sponges.

5. **Patient** ~~S~~skin ~~preparation~~**antisepsis** shall be done in a manner that preserves skin integrity and prevents injury.
   a. Antimicrobial agents shall not be allowed to pool beneath the patient, tourniquets, electrocardiography (ECG) electrodes, positioning equipment, or electrosurgical dispersive pad. **Remove any material near the patient that is in contact with the skin antiseptic solution and replace as necessary.**
   b. **Place a fluid-resistant pad under the patient's buttocks during preoperative skin antisepsis for patients in the lithotomy position. Remove the pad after the antiseptic is dry and before sterile drapes are applied.**
   ~~a.~~c. **Apply the antiseptic with care (i.e., gentle friction) on fragile tissue, burns, open wounds, or malignant areas.**
6. Skin antiseptics shall be stored in the original, single-use container, **according to manufacturer's IFU**.
7. Special ~~C~~considerations for **flammable (i.e.,** ~~A~~alcohol ~~B~~**b**ased) ~~Prep~~ **antiseptic** solutions **include**:
   a. **Prevent the flammable skin antiseptic solution from pooling or soaking into linens or the patient's hair by:**
      i. **Use sterile towels to absorb drips and excess solution during application.**
      ii. **Remove materials that are saturated with the skin antiseptic before the patient is draped.**
      iii. **Wick excess solution with a sterile towel to help dry the surgical/procedural prep area completely.**
   ~~a.~~b. **Allow** ~~S~~sufficient time ~~must be allowed~~ for the **flammable skin antiseptic** solution to dry **completely** and vapors to dissipate before the surgical**/procedural** drapes are applied and any heat**/ignition** source is used.
      i. Heat**/ignition** sources include: ~~E~~**e**lectrosurgery, cautery, laser, burrs, drills, defibrillators, and light cords.
      ii. Verify in a "time out" before starting the procedure **that a flammable skin antiseptic was used to prep and confirm dry time**~~to assure the above condition is~~ **was** met.
8. Skin preparation agents shall not be warmed prior to application.
9. **Assess the patient's skin for injury after surgery.**
~~9.~~10. Patient skin preparation**, hair removal,** and skin condition shall be documented in the Perioperative/Procedural record.

C. **RELATED DOCUMENT(S):**
1. Patient Care Services **Policy**: Sterile Technique

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

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SURGICAL HAND ANTISEPSIS**
Purpose:	To outline the steps to effectively perform surgical hand antisepsis
Supportive Data:	**The goal of surgical hand antisepsis is to remove soil and transient microorganisms from the hands of perioperative team members and suppress the growth of resident microorganisms for the duration of the surgical procedure to reduce the risk that the patient will develop a surgical site infection (SSI).** Surgical hand antisepsis is the primary line of defense to protect the patient from pathogens on the hands of scrubbed team members, whereas sterile surgical gloves are the secondary line of defense. **Safe and effective surgical hand antisepsis rapidly and persistently removes transient microorganisms and suppress the growth of resident microorganisms with minimal skin and tissue irritation.** ~~Surgical hand antisepsis is performed by personnel who will be scrubbed for the surgical procedure to remove dirt, skin oil and microbes from the hands and forearms to reduce the microbial count to as near zero as possible and to leave an antimicrobial residue on the skin to prevent growth of microbes for several hours. All personnel who perform surgical hand antisepsis shall maintain healthy condition of their fingernails and skin of their hands/arms. Unhealthy skin or fingernails may impede removal of microorganisms during hand antisepsis.~~

A. **DEFINITIONS:**

1. **Surgical Hand Antisepsis: Hand wash or hand rub using a surgical hand antiseptic, performed preoperatively by the surgical team to remove transient flora and reduce resident skin flora.**
2. **Surgical Hand Antiseptic: A product that is a broad-spectrum, fast-acting, and nonirritating preparation containing an antimicrobial ingredient designed to significantly reduce the number of microorganisms on intact skin. Surgical hand antiseptic agents demonstrate both persistent and cumulative activity.**

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

1. Surgical hand antisepsis shall be performed prior to donning sterile gowns and gloves for operative or other invasive procedures.
2. **All personnel who perform surgical hand antisepsis shall maintain healthy fingernail and hand skin condition.**
3. **Take measures to prevent hand dermatitis, including:**
   a. **Use moisturizing skin care products approved by Tri-City Medical Center (TCMC).**
   b. **Completely dry hands before donning gloves.**
   c. **In the absence of visible soil, disinfect hands with an alcohol-based hand rub rather than washing with soap and water.**
   d. **If necessary, sterile cotton glove liners may be worn under sterile gloves. Single-use cotton glove liners shall be discarded after each use.**
4. **Personnel with breaks in skin integrity shall not scrub.**

~~B.~~C. **PREPARING TO SCRUB:**

1. Personnel shall don surgical attire prior to beginning surgical hand antisepsis (see Patient Care Services [PCS] Policy Surgical Attire).
   a. The scrub shirt should be tucked into pants or fit snugly to the body.
   b. All jewelry must be removed or confined within the surgical attire. Hand and wrist jewelry may not be worn.
2. Don fresh surgical mask and adjust snugly over nose and mouth.

Patient Care Services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/12, 07/18, 04/20	07/18, 06/20	12/12, 08/18, 09/20	09/18, 10/20	10/18, 10/20	n/a	01/13, 10/18, 11/18, 11/20	01/19, 12/20	02/13, n/a	02/13, 01/19

3. Don protective eyewear, unless eye protection is integrated into mask or user will be wearing an orthopedic hood.
4. Inspect hands and forearms:
   a. **Fingernails shall be maintained short and natural.**
   ~~a. Cuticles, hands and forearms should be free of cuts, open lesions or breaks in skin integrity.~~
      ~~i. Persons with breaks in skin integrity shall not scrub.~~
      ~~b.~~i. In addition to Administrative Policy: Dress and Appearance Philosophy - 415, fingernails should be short (less than 2mm or 0.08") and in good repair. Nail jewelry, artificial nails, nail extenders, nail wraps or any other nail treatments are not allowed. If nail polish is worn, it must be free of chips or peeling.

~~C.~~D. SURGICAL HAND ANTISEPSIS WITH APPROVED SURGICAL HAND SCRUB:

1. Surgical hand antisepsis using a surgical hand ~~scrub~~ **antiseptic scrub** should be performed according to manufacturer's instructions for use **(IFU)**.
2. If hands are visibly soiled, wash hands with soap and water.
3. Remove debris from underneath fingernails using a disposable nail cleaner under running water.
4. Apply the amount of surgical hand scrub product recommended by the manufacturer to the hands and forearms using a soft, nonabrasive sponge. A commercially prepared, pre-moistened surgical scrub ~~brush~~ **sponge** with approved surgical scrub agent may be used.
   ~~4.~~a. **Do not perform the surgical hand scrub using a brush, which may damage skin and increase the amount of bacteria shedding from the hands.**
5. Visualize each finger, hand, and arm as having four sides. Wash all four sides effectively, keeping the hands elevated.
6. Scrub for length of time recommended by the manufacturer. The scrub should be timed to allow adequate product contact with the skin.
7. **For water conservation, turn off water when it is not in use, if possible.**
8. Avoid splashing surgical attire.
9. Discard sponge, if used.
10. Rinse hands and arms under running water in one direction from fingertips to elbows.
11. Hold hands higher than elbows and away from surgical attire.
12. In the OR or procedure room, dry hands and arms with a sterile towel (drying from fingertips to elbow, while bending forward at the waist) using sterile technique before donning a surgical gown and gloves.

~~D.~~E. SURGICAL HAND ANTISEPSIS USING APPROVED SURGICAL HAND RUB:

1. Perform surgical hand antisepsis using a surgical hand **antiseptic** rub according to the manufacturer's **IFU**~~instructions for use~~.
2. If hands are visibly soiled, wash hands with soap and water.
3. Remove debris from underneath fingernails using a disposable nail cleaner under running water.
4. Rinse hands and forearms under running water and dry hands and forearms thoroughly with a disposable paper towel.
5. Apply the surgical hand rub product to the hands and arms according to the manufacturer's ~~instructions for use~~**IFU**, including amount of product to be dispensed for each use, method of application, and time.
6. Allow hands and arms to dry completely before donning gown and gloves, per manufacturer's ~~instructions for use~~**IFU**. Do not dry with a towel.

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

1. Administrative Human Resources Policy: Dress and Appearance Philosophy 8610-415
2. Tri-City Healthcare District Approved Surgical Scrub Products

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

1. ~~Conner, R. (2018). Guidelines for Perioperative Practice, 2018 Edition. Denver, CO: Association of PeriOperative Registered Nurses.~~ **AORN, Inc. (2020). *Guidelines for Perioperative Practice*. Denver.**

Tri-City Healthcare District
Approved Surgical Scrub Products

- Ecolab Scrub Stat (2% CHG) "multi-dose dispenser"
- Avagard "multi-dose dispenser"
- Betadine (individually packaged brushes)
- BD E-Z Scrub 116 (3% PCMX – individually packaged brushes)

Note: Approval for all surgical scrub products must be obtained through the Infection Control Committee prior to use.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTIK USING MCKESSON CONSULT 120 URINE ANALYZER**
Purpose:	To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regarding the status of carbohydrate metabolism, kidney and liver function, acid-base balance, and urinary tract infection.
Supportive Data:	Mckesson Consult 120 Urine Analyzer is a CLIA waived test
Equipment/ Supplies:	Mckesson Consult 120 Urine Analyzer Mckesson Urine Reagent Strips 2 levels of Quality Control

A. **PRINCIPLE:**

1. The McKesson Consult® 120 Urine Analyzer is intended for use in conjunction with the McKesson Consult® Urinalysis Reagent Strips for the semi-quantitative detection of the following analytes in urine: Glucose, Bilirubin, Ketone (Acetoacetic acid), Specific Gravity, pH, Blood, Protein, Urobilinogen, Leukocytes, Ascorbic Acid, as well as the qualitative detection of Nitrite. The instrument is intended for professional, in vitro diagnostic use only. The measurement can be used in general evaluation of health, and aids in the diagnosis and monitoring of metabolic or systemic diseases that affect kidney function, endocrine disorders and diseases or disorders of the urinary tract.

B. **SPECIMEN:**

1. A urine specimen must be collected in a clean and dry container and tested as soon as possible. Do not centrifuge. The use of urine preservatives is not recommended. If testing cannot be done within an hour after voiding, refrigerate the specimen immediately and let it return to room temperature before testing.
2. Prolonged storage of unpreserved urine at room temperature may result in microbial proliferation with resultant changes in pH. A shift to alkaline pH may cause false positive results with the protein test area.
3. Urine containing glucose may decrease in pH as organisms metabolize the glucose.
4. Contamination of the urine specimen with skin cleansers containing chlorhexidine may affect protein (and to a lesser extent, specific gravity and bilirubin) test results.

C. **REAGENTS / SUPPLIES:**

1. McKesson Consult® 120 Urine Analyzer – operating temperature is 0-40°C (32-104°F)
2. McKesson Consult® Urinalysis Reagent Strips should be stored at Room Temp or Refrigerated (2-30°C or 36-86°F)
   a. Unopened bottles: stable until expiration on the bottle
   b. Opened bottles: stable for 3 months
2. Consult® Diagnostics Liquid Urine Control – stored @ 2-8°C (36-46°F)
   a. Unopened bottles: stable until expiration on the bottle
   b. Opened bottles: stable for 30 days

B. **CALIBRATION:**

1. An automatic calibration is done before each test.

C. **QUALITY CONTROL:**

1. Performance of reagent strips should be confirmed by running 2 levels of controls in the following conditions:
   a. Run control on each day of use before performing patient tests
   b. Run control on new lot and/or new shipment of reagent strips

Department Review	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Department of Pathology	Pharmacy and Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
NEW 05/20	06/20	07/20	09/20	n/a	10/20	12/20	n/a	

c. Run control when you open a new bottle of reagent strips
d. Run control to ensure reagent storage integrity; train new users; confirm test performance; and when patients' clinical conditions or symptoms do not match the results obtained on the test strips

2. If the QC tests do not provide expected results, perform the following checks:
   a. Ensure the strips used are not past their expiration date.
   b. Ensure strips are fresh from a new canister.
   c. Ensure the controls are not past their expiration date.
   d. Repeat the test to ensure no errors were made during the test.

D. **PROCEDURE**:

1. Quality Control:
   a. Ensure the operating Mode is set to QC. All test numbers in QC mode will begin with 2. This allows results to be searched for and found easily.
   b. Allow the strip and urine controls to reach room temperature at 15-30°C (59-86°F) prior to testing.
   c. The urine control test procedures are the same as Normal Operation. Refer to the procedure below.
2. Patient Test:
   a. Allow the strip, urine specimen, and/or controls to reach room temperature at 15-30°C (59-86°F) prior to testing.
   b. Remove the strips from the closed canister. Use them as soon as possible. Tightly close the canister after removing the strips.
   c. Press START for the strip prompt. Wait for the audible triple beep to immerse the strip.
   d. The countdown clock is displayed on the bottom right. The clock will start to count down from 65. The operator has 3 seconds before the triple beep sounds to immerse the strip into the urine.
   e. Upon hearing the triple beep and/or seeing the countdown clock reach 62, completely immerse the reagent areas of the strip in fresh, well-mixed urine. Immediately remove the strip to avoid dissolving the reagents.
   f. Run the edge of the strip against the rim of the urine specimen container to remove excess urine. Hold the strip in a horizontal position. Bring the edge of the strip into contact with an absorbent material (e.g. a paper towel). This prevents mixing chemicals from adjacent reagent areas.
   g. Place the strip with the reagent area facing up, onto the Strip Holder Channel. Make sure the strip end touches the Strip Holder Backstop.
   h. When the countdown clock on the display reaches 1, the Strip Holder will carry the strip inside and begin testing.
   i. The results will be displayed on the screen and stored in memory after each test. Any abnormal results will be highlighted on the screen and flagged on the print out.
   j. If Auto-print is set to on the results will be printed. If Auto-print is set to off, press Print to print the results.
   k. Remove the used strip from the Strip Holder when the strip carrier moves out. Discard the used strip

E. **MAINTENANCE**:

1. Refer to the Maintenance Section of the Mckesson Consult® 120 Operators Manual for cleaning and disinfecting of the analyzer and strip holder.

F. **TROUBLESHOOTING**:

1. Refer to the Troubleshooting section of Mckesson Consult® 120 Operators Manual for possible problem and corresponding solutions.

G. **AMR, CRR, REFERENCE RANGES, AND CRITICAL VALUES**:

The following are the reference ranges for qualitative urinalysis:

1. Specific Gravity: 1.016 - 1.022 (normal fluid intake)
2. pH: 5.0 – 8.0.
3. Protein: Negative
4. Glucose: Negative
5. Ketone: Negative (NOTE: Detectable levels of ketones can be found in the urine during physiological stress such as exercise and dieting)
6. Bilirubin: Negative
7. Blood: Negative
8. Leukocyte Esterase: Negative
9. Nitrite: Negative
10. Urobilinogen: <2.0 mg/dL

H. **REPORTING RESULTS:**

1. Results are recorded on the electronic medical record of the clinic

I. **TECHNICAL NOTES:**

1. Refer to the Mckesson Consult 120 Operators Manual for Performance Characteristics of Urinalysis Reagent Strips

J. **LIMITATIONS:**

1. Refer to Limitations section and Interference Studies of the Consult Diagnostics 10SG Urine Reagent Strips Package Insert
2.

K. **FORMS:**

1. Point of Care Quality Control Log – Urine Consult

L. **RELATED DOCUMENTS: N/A**

M. **EXTERNAL LINKS:**

1. Mckesson Consult® 120 Urine Analyzer Operators Manual https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/121-120_manual_2016-03.pdf
2. Consult Diagnostics 10SG Urine Reagent Strips Package Inserts: https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/liquid_urine_control_insert_2017-05.pdf
3. Consult Diagnostics Liquid Controls: https://imgcdn.mckesson.com/CumulusWeb/Click_and_learn/IFU_163-89116_2017-05.pdf

N. **REFERENCES:**

1. Mckesson Consult® 120 Urine Analyzer Operators Manual
2. Mckesson Consult Diagnostics 10SG Urine Reagent Strips Package Inserts. Rev. 00 03/15
3. Mckesson Consult Diagnostics Premium Liquid Controls Package Inserts Rev. 2 5/17

Tri-City Medical Center	Patient Care Services ~~Nuclear Medicine Procedure Manual~~
PROCEDURE:	**Y-90 MICROPSPHERE BRACHYTHERAPY PATIENT MANAGEMENT**
Purpose:	**Provide guidelines for the care of patients receiving Y-90 therapy.**
Supportive Data:	NRC 10 CFR 35.75
Equipment:	TheraSpheres or SIR-Spheres
~~Issue Date:~~	~~NEW~~

A. **DEFINITIONS:**

1. Selective Internal Radiation Therapy (SIRT) utilizes Radioembolization to selectively target a very high radiation dose to all tumors within the liver while maintaining a low radiation dose to the normal tissue. Tiny glass (TheraSpheres) or resin (SIR-Spheres) beads called microspheres filled with radioactive isotope Yttrium 90 (Y-90) are placed inside blood vessels that feed a tumor. This blocks blood supply of the cancer cells and delivers a high dose of radiation to the tumor while sparing normal tissue. Radioembolization with Y-90 microspheres is a palliative treatment, it will not provide a cure but will help slow down the growth of the disease and alleviate symptoms.

B. **POLICY**

1. Y-90 patients are administered an amount of radioactive material that is below regulatory limits and therefore may be immediately released in accordance with the NRC criteria under 10 CFR 35.75. For certain reasons or as a special medical precaution some patients may be hospitalized for observation with private bathroom facilities.

C. **PROCEUDRE:**

1. The delivery of the Y-90 microspheres is **performed**~~done~~ in the Interventional Radiology department in conjunction with Nuclear Medicine utilizing a procedure called Radioembolization.
2. Once the procedure is complete the patient is taken to Nuclear Medicine for a scan to ensure the proper placement of the microspheres and then to a recovery room.
3. Post administration Nursing care includes the following:
   a. Non-pregnant staff only
   b. Pregnant visitors and children should not visit
   c. Nursing care should be delivered from the LEFT side of the patient if possible
   d. Collection of bed linen, rubbish or clothing is NOT necessary
   e. Universal precautions should be stressed
4. Notify Radiation Safety Officer immediately if there is a medical emergency (including death)

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Committee	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/19	01/20	02/20	09/20	n/a	10/20	12/20	n/a	

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 05/91 **SUBJECT: Code Gray: Hostage Response Plan**

REVISION DATE: 12/03; 9/05; 9/10; 02/14; 03/17 **POLICY NUMBER:** 8610-283

Administrative Content Expert~~Department~~ Approval:	**~~02/17~~09/20**
Administrative Policies & Procedures Committee Approval:	**~~02/17~~10/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~03/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **PURPOSE:**

1. To provide a rapid, organized and thorough response at Tri-City Healthcare District (TCHD) to an incident where there is an individual being held against their will or in a hostage situation while in the facility or in the immediate surrounding parking areas.

B. **POLICY:**

1. It is the policy of TCHD while responding to a hostage or barricaded suspect situation that the primary aim of personnel is to ensure the safety of all people on the premises, as well as, preserve life and protect property.

C. **PROCEDURES:**

1. The TCHD personnel who witnesses or comes upon a hostage situation shall:
   a. Warn others of the situation by calling out for everyone to "take cover" and also take cover as well.
   b. ~~If a landline is available d~~Dial "66" **via the telephone** and report "Code Gray" to the PBX Operator, and advise of the incident location, and any other pertinent information, such as the number of hostages, a complete description of the hostage taker(s), and the description of any weapons.
      i. The PBX/Operator will announce "Code Gray" three (3) times overhead, followed by the unit, department or location.
      ii. The PBX/Operator will immediately notify the Security Department of the Code Gray and the location of the incident.
      iii. The PBX/Operator will also notify Oceanside Police Department via "911" and advise of the current situation.
   c. TCHD Security Personnel will respond to the incident location and it will be the responsibility of the Security Supervisor or designee to assume the primary Officer designation.
      i. The Security Supervisor shall remain in this capacity until such time that they are relieved of command by Oceanside Police Department personnel..
      ii. The Security Supervisor will be responsible to brief Oceanside Police Department personnel of the hostage situation and will supply any requested support or additional personnel.
      iii. The Security Supervisor will also advise for the facility to be placed into a security lockdown mode until further orders.
   d. The PBX/Operator will initiate the following call-out process.
      i. The on-duty Administrator / Administrative Supervisor.
      ii. The Environment of Care/Safety Officer.
      iii. The on-call Administrator if after hours.

1) The Chief Executive Officer (CEO) will notify;
   a) Board of Directors
   b) Chief of Medical Staff

iv. The Public Information Officer.

v. The Director of Risk Management.

e. Security Department personnel will proceed to the incident location and begin to safely remove all patients, visitors, and staff members to a safe location and properly ensure that all approaches into and exits out of the immediate situation area are secured.

f. The Emergency Department and Surgery staff shall be advised of the hostage situation and prepare for possible trauma patients.

g. During or after the evacuation processes any capable witnesses will be interviewed by Security personnel for pertinent information regarding the hostage situation.

h. A secure area will be established for use as a command center and central location for the hostage negotiation team. A floor plan of the incident area will be obtained from the Facilities Department and a secured communications system will be established.

i. The Administrator or Designee along with Oceanside Police Department will obtain any pertinent information from the **Department Leader**~~unit Manager or Designee~~ of the affected area or department, regarding the hostage and hostage taker.

j. TCHD medical personnel will be reassigned as needed to this area in order to ensure proper staffing and continuance of the necessary medical services if possible.

k. At no time during the hostage situation will any TCHD personnel attempt to rescue a hostage or disarm a hostage taker. Open communications with the hostage taker can be attempted to deescalate the incident or obtain information, but at no time will any TCHD personnel offer any promises or concessions to the hostage taker.

l. It will be the responsibility of the primary Security Officer to document all pertinent circumstances related to the hostage situation. This documentation should include but not limited to the date, time, location, actions taken and personnel involved.

m. At the completion of the Hostage situation, all involved personnel will remain available for interviewing by local law enforcement personnel and will only return to normal operations after first receiving authorization to do so from the Security Supervisor or Designee.

D. **RELATED DOCUMENTS:**

1. Emergency Operations Procedure: Code Silver Person with Weapon or Active Shooter

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE: 07/76

SUBJECT: Lost and Found Articles

REVISION DATE: 04/89; 06/94; 10/99; 09/00; 09/02; 06/03; 02/06; 01/09; 02/11; 02/14 03/17

POLICY NUMBER: 8610-202

Administrative Content Expert~~Department~~ Approval:	**~~01/17~~09/20**
Administrative Policies & Procedures Committee Approval:	**~~01/17~~10/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~02/17~~ n/a**
Board of Directors Approval:	**03/17**

A. **PURPOSE:**

1. The Lost and Found service provided by Security and the ~~Patient Representative Office~~**Complaints and Grievances Coordinator** provides a method for returning lost or misplaced articles to their proper owners and/or reimbursement, if applicable.

B. **DEFINITIONS:**

1. Items of Value: Money, Credit Cards (to be destroyed after 90 days), jewelry, and watches.

C. **POLICY:**

1. Lost or misplaced items shall be promptly returned to their rightful owners.

D. **PROCESS:**

1. When an article is found, a reasonable effort is made to determine its ownership immediately, and, whenever possible, to return the article to its rightful owner. If this is not possible, the person who found the article must attach a Tri-City Healthcare District (TCHD) "Found Property Slip" and take directly to the Lost and Found or Security. ~~Call Security and someone will meet you to receive the item.~~ "Found Property Slips" may be obtained from Security. NOTE: The loss of hearing aids, dentures and glasses will be reported directly to the **Complaints and Grievances Coordinator**~~Patients' Representative~~.
2. If the owner is a patient who has been discharged, a representative from the Nursing Unit where the article was found will contact the patient or his/her family and ask him/her to claim the article in the Lost and Found section of Security. The time and date of the contact, the name of the person contacted, and the person making the call, is to be recorded and provided to Security. The **item**~~article~~ **must be brought to Security immediately and** may not be **kept**~~held~~ on the unit~~, but forwarded immediately to Security~~.
3. The article is to be forwarded by placing it in a container labeled with the name of the person who found the article, the patient's name, address, room number, contents of container, and recorded notes of contact with patient or family on the TCHD "Found Property Slip." A notation should also be made on the patient's medical record in Clinical Notes.
4. Items found in areas other than patient rooms, which cannot be returned to the owners (or ownership cannot be determined), are to be placed in a container and labeled with a TCHD "Found Property Slip", indicating where the item was found, the time and date of discovery, the name of the person who found the article, and the contents of the container and sent to Lost and Found.
5. Upon receipt of lost items Security will:
   a. Place all items deemed to be of value in the Security Office safe until claimed. If

unclaimed after 90 days, the item is to be donated to an approved charitable organization.

b. Give all other items an identification number and properly log into the Lost and Found Control Binder.

c. Attempt to identify ownership, then contact owner.

6. The **Complaints and Grievances Coordinator**~~Patient Representative~~ will mail identified articles to owners who are unable to come to the hospital. Mail certified, return receipt.
   a. After a period of 90 days all unclaimed items will be donated to a charity as determined by Administration and allowed by law.
7. Anyone who has lost articles may contact Security through the PBX operator..
8. Reports of lost articles that cannot be found are to be referred to the **Complaints and Grievances Coordinator**~~Patient Representative's Office~~ via **a report in RL**~~phone~~ **in order to properly track any investigation**~~, with follow-up in writing for investigational purposes and information with~~**. Security staff will also enter item** description and**/or owner** contact information ~~placed~~ in the Lost and Found Inquiry **Log**~~book~~.
9. If an investigation concludes **the**~~a~~ hospital **should replace the item claimed lost or damaged, the claimant will be instructed by the Complaints and Grievances Coordinator to purchase or repair the item in question after TCMC authorizes the reimbursement. The claimant will then notify the Complaints and Grievances Coordinator of the cost and submit a receipt to TCMC. The Complaints and Grievances Coordinator will then have the patient sign a General Release of All Claims form. The release form and the receipt(s) shall be uploaded into the online incident reporting system and forwarded to the Risk Manager**~~representative is responsible for a lost/damaged article, and reimbursement by the Organization is appropriate, a check request and a copy of the investigation General Release of All Claims Form (from the patient) will be submitted by the Patient Representative Office to the Director of Risk Management~~.
10. The ~~Director of~~ Risk Manager~~ment~~ **shall complete the check request form,** ~~will~~ obtain the signature of the proper **authority**~~administrator. The Patient Representative will obtain the cost center location for charging purposes. The check request will be~~ **and** forwarded **the request** to **finance**~~AP in Accounting~~.
11. When the check is issued Accounting emails the **Complaints and Grievances Coordinator**~~Patient Representative~~ the date, the check number and the amount. Accounting sends out the check to the patient/family member or the professional who is preparing the replacement articles (for example: new dentures or hearing aid).
12. The original forms will be filed along with the check information to the **Complaints and Grievances Coordinator**~~Patient Relations Specialist~~ and into the **respective RL**~~Complaint Resolution~~ file.

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

1. General Release of All Claims Form Sample

General Release of All Claims Form Sample

The undersigned, being over the age of eighteen, for the sole consideration for waiving events that occurred on or about **date:**_____ with a value in the amount of _____**($00.00)** by **TRI-CITY HEALTHCARE DISTRICT** (hereinafter referred to as the "**RELEASEE**") do/does hereby and for my/our/its heirs, executors, administrators, successors and assigns release, acquit and forever discharge the **RELEASEE**, their agents, servants, successors, heirs, executors, administrators and all other persons, firms, corporations, associations or partnerships of and from any and all claims, actions, causes of action, demands, rights, damages, costs, loss of service, expenses and compensation whatsoever, which the undersigned now has or which may hereafter accrue on account of or in any way growing out of any and all known and unknown, foreseen and unforeseen bodily and personal injuries and/or property damage or loss and the consequences thereof resulting.

It is understood and agreed that this settlement is the compromise of doubtful and disputed claims, and that the payment made is not to be construed as an admission of liability on the part of the **RELEASEE.** The **RELEASEE** specifically denies liability therefor and intends merely to avoid litigation and buy its peace. It is further understood and agreed that this Release in Full of All Claims and the write off herein acknowledged shall be held in confidence and that the undersigned and his/her attorneys will not publicize, publish, disclose, talk about, or promote the publication or disclosure of the facts or terms of this Release in Full of All Claims or the payment/write off here acknowledged to any person not a party to this Release of All Claims.

It is further understood and agreed that all rights under Section 1542 of the *Civil Code of California* and any similar law of any state or territory of the United States are hereby expressly waived. Section 1542 reads as follows:

> "Section 1542. [Certain claims not affected by general **RELEASE**.] ***A general release does not extend to a claim which the creditor does not know or suspect to exist in its favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."***

The Undersigned hereby declares and agrees that they rely only upon their own judgment, belief and knowledge of the nature, extent, effect and duration of said damages and liability. This **RELEASE** is made without reliance upon any statement or representation of the **RELEASEE** or its/their representatives or by any party or person employed by it/them.

The Undersigned further declares and represents that no promise, inducement or agreement not herein expressed has been made to the Undersigned, and that this **RELEASE** contains the entire agreement between the parties hereto and that the terms of this **RELEASE** are contractual and not a mere recital.

The Undersigned has been advised by the **RELEASEE** of the right to have this **RELEASE** reviewed by counsel and has either voluntarily chosen not to seek counsel or the Undersigned have been represented by counsel of their own choosing and have relied only upon the advice and counsel of their attorney.

The Undersigned has read the foregoing **RELEASE** and fully understands it.

CAUTION: READ BEFORE SIGNING BELOW

I declare under penalty of perjury according to the laws of the state of California that the forgoing is true and correct.

Signed this _____date. Print or Type Name: _____:___

Signature:_____

FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM:

ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Tri-City Medical Center	~~Distribution:~~ Cardiac Cath Lab
PROCEDURE: IMPLANT ~~PERMANENT PACEMAKER~~ TRAY SET UP	
Purpose:	To be performed ~~by all CCL~~ **by scrub** personnel for the setup of a permanent pacemaker, **Implantable cardioverter defibrillator, or Loop ~~tray~~recorder tray.**
Supportive Data:	None
Equipment	**Sterile ~~Permanent~~** pacemaker pack ~~,~~Retractor tray: **pacemaker or implantable cardioverter implant** ~~;~~ Suture ~~per(~~physician's preference); Pacing cables~~;~~ 1% Lidocaine 10mg/ml ~~with 5ml Sodium Bicarbonate;~~ ~~1~~Heparin**ized saline ~~solution~~ (2units/ml)** ~~1,000 units~~ in 0.9% sodium chloride, **500 ml bag;~~ Antibiotic solution (ordered by physician);~~** **1-250 ml bag of 0.9 % normal saline** ~~-~~Sheath introducer (physician preference)~~;~~ Disposable #10 or #15 with retractable blade cover (physician preference) **Sterile gloves** **Plasma or aqua mantis (generator changes, lead revisions)** **1-pack sterile towels** **~~Ioband~~ Surgical Incise Drape (physician preference)** **Dressing (physician preference)**
Issue Date:	**01/87**

A. **PROCEDURE:**

1. Table is wiped with ~~disinfectant~~ and allowed to dry for **per manufacturer's instructions for use~~2-3 minutes~~.**
2. **Will perform hand hygiene hospital policy**
3. **Scrub person will don sterile gown, gloves, hat and mask to organize table.**

~~A.~~**4. All bowels, syringes and containers will be labeled with medication concentration/strength**

~~B.~~**5.** Pacemaker pack is opened in sterile fashion and draped over the table.

~~C.~~**6.** Equipment is added in a sterile manner.

~~1. Scrub person will don sterile gown, gloves, hat and mask to organize table.~~

~~2. Circulator will:~~

~~a. Add 1 bag Heparinized solution (500ml) to labeled retractor tray.~~

~~b. One bag of antibiotic solution (250ml) to labeled Small Basin.~~

~~c. 1% Lidocaine with Bicarbonate added to labeled cup.~~

~~D.~~**7.** All sheaths, arterial needles and leads will be wiped down **and flushed, if appropriate,** with Heparin**ized saline** ~~-~~solution ~~from the retractor tray~~.

~~3. 10ml of Lidocaine is drawn up in a 10ml syringe with a 21 guage needle from the Lidocaine labeled cup. 10ml of Lidocaine is drawn up in a 10ml syringe with a 25 guage needle from the Lidocaine labeled cup. Syringes are labeled with medication.~~

~~4. Suture, xray detectable sponges and xray detectable lap sponges count will be preformed before procedure start and after procedure finished and documented on McKesson.~~

8. **Initial count to be performed by scrub person and any team member assigned to case, with documentation in McKesson.**
9. **Sharps, needles, x-ray detectable sponges to be counted per hospital policy**

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~1/87~~	~~6/97; 10/00; 3/03; 5/05; 1/09; 9/12~~	~~6/97; 10/00; 4/03; 6/05; 1/09; 9/12~~	~~1/87~~

Cardiac Catheterization Lab	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/97; 10/00; 4/03; 6/05; 1/09; 9/12, 02/20	07/20	09/20	10/20	12/20	n/a	02/11

Tri-City Medical Center	~~Distribution:~~ Cardiac Cath Lab
PROCEDURE: PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY SETUP	
Purpose	To ensure uniform setup for PTCA procedures in the Cath Lab
Supportive Data:	None
Equipment	Inflation device' 12" high pressure line; 6" ~~high pressure~~ **red stripe** line~~;~~ ~~Rotating~~ hemostatic valve; 35ml Luer lock syringe; ~~-~~PTC~~S~~**-A** guidewire **, (physician's preference)** **Guide catheter** (physician's preference); PTCA balloon catheter (physician's preference) **Drug eluting stent or Bare metal stent (physician's preference);** Wire torque device~~; 60/40 contrast solution~~ ~~ConRay~~ **contrast solution**; ~~O2 nasal cannula;~~ ~~Nitroglycerin 100mcg/ml; Nicardipine 100mcg/ml; ACLS meds available.~~
Issue Date:	**05/94**

A. **PROCEDURE:**

1. Setup table according to Policy titled "*Setup for Sterile Table*". ~~If the percutanious transluminal coronary angioplasty has not immediately followed a diagnostic catheterization, a timeout is performed~~.

~~2. Explain procedure to patient.~~

~~1. Patient prepped according to policy~~

~~2. 10ml Nitroglycerin 100mcg/ml in labeled cup on sterile field.~~

~~3. 10ml Nicardipine 100mcg/ml in labeled cup on sterile field.~~

2. **All syringes, bowls and cups to be labeled with medication name, concentration/strength**

~~B.~~**a.** 50ml of ~~60/40~~ contrast solution in labeled cup on sterile field.

~~C.~~**3.** Select guiding catheter, PTCA balloon catheter and PTCA guidewire of physician preference.

~~1. Have ACLS medications off of sterile field to be given upon physician's order, if needed.~~

~~D.~~**4.** Attach 12" high pressure line and stopcock to inflation device. Fill inflation device with contrast solution according to manufacturer's instructions. ~~You may u~~**U**se the 35ml syringe to perform this step.

~~E.~~**5.** Attach 6" ~~high pressure~~ **red stripe** line to ~~rotation~~ hemostatic valve**, then attach the red stripe line to the** ~~and connect female end of pressure line to the rotating part of the~~ manifold assembly**, flush the hemostatic valve, once flushed connect the guide catheter**.

~~F.~~**6.** Prepare PTCA balloon according to manufacturer's recommendations.

7. Insert

a. **For over the wire (OTW) insert** PTCA guidewire into **straight** port ~~marked "distal"~~ on the PTCA balloon catheter. Attach wire torque device to proximal end of guidewire.

b. **For ~~the monorail (MR) or~~ rapid exchange insert the PTCA guidewire into the vessel via the guide catheter, then the PTCA balloon is inserted over the wire**

~~G.~~**8.** **Maintain wire control at all times.**

~~H.~~**9.** Attach inflation device to balloon port on PTCA balloon catheter. Prep balloon by drawing back twice on on 35ml syringe, turn stopcock off to syringe and pull negative on inflation device.

~~I.~~**10.** Be ready to follow all instructions given by physicians.

~~1.~~**11.** Upon completion of procedure, attach arterial sheath to continuous pressure flush with transducer unless closure device is used.

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~5/94~~	~~6/97; 10/00; 3/03; 5/05; 1/09~~	~~6/97; 10/00; 4/03; 6/05; 1/09~~	~~5/94~~

Cardiac Cath Lab	Division of Cardiology .	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/97; 10/00; 4/03; 6/05; 1/09, 02/20	07/20	09/20	10/20	12/20	n/a	02/11

Tri-City Medical Center	~~Distribution:~~ Cardiac Cath Lab
PROCEDURE:	**SET-UP AND INSERTION OF IAB CATHETER**
Purpose:	To assist the physician with the insertion of **the Intra Aortic Balloon (IAB).** ~~Personnel to follow the procedure set forth for proper insertion of IAB with a patient consent obtained prior.~~
Supportive Data:	~~None~~**Arrow Balloon Pump equipment tray instruction insert**
Equipment:	Arterial pressure tubing **x2** ; ~~Electric razor~~; ~~IAB cath tray.~~ **30 or 40 cc Intra Aortic Ballon** **Pressure Bag** **Balloon Pump** **8 6 FR sheath** **Statlock or suture (physician preference)** **3-large tegaderm**
Issue Date:	**01/87**

A. **PROCEDURE:**

1. **Choose correct size of IAB, based on patients height**

~~A.~~2. ~~Set up arterial pressure tubing according to existing procedure~~. **Prepare an arterial transducer line x2 for monitoring according to hospital procedure**

~~1. Remove body hair at the insertion site and from 2-3 inches above inguinal crease to above knee with electric razor from above groin to knee.~~

~~2. Scrub site with antimicrobial solution from above the groin to the knee. Allow to dry for 3 minutes.~~

~~3. Drape patient using sterile technique.~~

~~B.~~3. ***Scrub Tech:***

~~C.~~a. Following manufacturer's instructions for preparation of balloon equipment and pump, assist physician with insertion. ~~Maintain sterile field while passing off IABP connections and line to circulating RN~~.

~~D.~~b. Wipe down the ~~sheath,~~ wire and balloon with ~~sterile~~ Heparinized saline, **flush the sheath.**

~~E.~~4. ***Physician:***

~~F.~~a. Localize the site.

~~G.~~b. Insert the balloon under fluoroscopy.

~~H.~~c. Verify the position of balloon under fluoroscopy and verify complete expansion.

~~I.~~d. Suture balloon and sheath at insertion site.

~~J.~~5. ***Circulating RN:***

~~K.~~a. Prepare IAB pump according to manufacturer's instructions.

~~L.~~b. ~~Prepare an arterial transducer line for monitoring according to hospital procedure~~.

~~M.~~c. Maintain sterile field when accepting connecting lines, **plug in the fiber optic key, cal key, ensure zeroed prior to insertion and connect pressure tubing after insertion.**

~~N.~~d. ~~Suture balloon and sheath, if used, with 2.0 silk~~.

~~O.~~e. Verify ~~with physician~~ pump settings **with physician**.

~~P.~~f. Begin pumping sequence on physician order.

~~Q.~~g. Verify proper timing of balloon inflation and deflation.

~~R.~~h. ~~Communicate with physician and staff systolic, diastolic and augmented pressures~~.

~~S.~~i. Adjust timing according to **patient hemodynamic needs using** manufacturer's instructions.

~~T.~~6. ***Monitoring Tech:***

~~1. Monitor patient's rhythm according to department standards.~~

~~U.~~a. Record insertion **time,** ~~and pressure on McKesson protocol~~ **serial number and expiration date and balloon pump timing.**

Cardiac Cath Lath	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/97; 04/03; 06/05; 07/09; 9/12, 02/20	07/20	09/20	11/20	12/20	n/a	02/11

~~2. Assist circulating RN and physician with insertion and pump set-up.~~

~~Issued:~~	~~Reviewed~~	~~Revised:~~	~~Approved:~~
~~01/87~~	~~06/97; 10/00; 03/03; 05/05; 07/09; 9/12~~	~~06/97; 04/03; 06/05; 07/09; 9/12~~	~~01/87~~

Tri-City Medical Center	~~Distribution:~~Cardiac Catheterization Lab
PROCEDURE:	**STENTING PROCEDURE**
Purpose:	~~Designated cath lab personnel will be trained in the u~~**Use of ~~the~~ equipment used for stenting ~~placement~~ during an ~~in an acute and/or threatened closure~~ intervention~~of a coronary artery during coronary angioplasty procedures, or for primary prevention of restenosis by the cardiologist.~~**
Supportive Data:	None
Equipment	**Sterile heart ~~C~~cath tray setup for PTCA ~~; Large lumen guide catheter (internal diameter~~ physician preference~~0.084 or greater); 0.014 extra support exchange length wire (300 cm) or comparable wire (e.g., sport, platinum plus); ACT machine; Stent delivery system; Selected balloon for pre-dilatation; High pressure PTCA balloon for post dilatation.~~ Interventional wire (Physician preference) Balloon and Stent (s) (Physician preference)**
Issue Date:	**09/95**

A. **PROCEDURE:**

1. **Preparation:**
   a. Patient to be prepped and draped according to policy~~for PTCA patients~~.
   b. Lesions are redilated with a PTCA balloon to allow passage of stent delivery system. Direct stenting may apply.
2. **After Placing Stent on Table, Perform the Following Steps:**
   a. Remove protective stylet from balloon tip.
   b. Flush balloon central lumen with Heparinized saline solution.
   c. Flush delivery sheath with Heparinized saline solution.
   d. **DO NOT PREP BALLOON** until stent has crossed the lesion.
   e. If there is any doubt regarding balloon integrity, ease of movement or stent placement on the system, it is best to remove the system from the field and begin with a new system.
   f. When position of the stent is optimal, inflate the balloon to expand the stent. Increase inflation pressure to the recommended stent expansion pressure shown on the label. The proximal and distal ends of the balloon will expand first (**do not exceed** the rate burst pressure).
   g. If the stent cannot be deployed, **do not** try to pull it back in the guide. This may embolize the stent. Remove the guide, stent and guiding catheters as a single unit.
3. **Balloon Withdrawal:**
   a. Completely deflate the balloon, using the inflation device or a syringe.
   b. Allow adequate time for the balloon to fully deflate. Adequate deflation requires 15-30 seconds.
   c. Intra coronary nitroglycerin may help with balloon withdrawal.
   d. Maintain suction on the balloon while withdrawing slowly. Allow the motion of the myocardium to gently dislodge the balloon from the stent.
   e. Maintain the position of the guiding catheter to prevent it from **being** drawn into the vessel. It may be necessary to pull back on the guiding catheter.
   f. Administer nitroglycerin via the coronary artery to reduce spasm, which may occur after coronary stenting per physician order.
4. **Placing Multiple Stents in Tandem:**
   a. Stent the most distal area first.

~~Issued:~~	~~Reviewed:~~		~~Revised:~~	~~Approved~~
~~09/95~~	~~07/97; 10/00; 03/03; 05/05; 9/12~~		~~07/97; 10/00; 04/03; 06/05; 08/09~~	~~: 09/95~~

~~Cardiac Catheterization Lab Review~~	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
~~07/97; 10/00; 04/03; 06/05; 08/09, 09/12, 09/18, 02/20~~	07/20	09/20	11/20	12/20	n/a	09/95

b. Use larger diameter proximal stent if necessary, or use higher inflation pressures
c. The stents should touch or overlap slightly. Better to overlap than leave a gap.

5. **Placing Multiple Stents in Multiple Vessels**:
   a. It is occasionally necessary to stent lesions in more than one vessel during the same procedure. Patient management is no more difficult in a patient with stents in multiple vessels than in a patient with a single stented vessel.
6. **Removing an ~~Accordioned~~Accordion Stent**:
   a. Keep balloon inflated to 1 ATM. This will prevent the stent from slipping off the balloon.
   b. Pull stent back until proximal marker nears distal tip of guiding catheter.
   c. Withdraw guiding catheter and stent catheter and sheath if necessary "as one unit", leaving wire in place.
   d. Discard removed stent.
7. **Stent Delivery and Implantation**:
   a. Once proper positioning of the stent has been established, the physician inflates the balloon to plant the stent. AT THIS TIME A NEGATIVE PREP should be performed on the balloon.
   b. Nominal pressure varies from stent to stent depending on manufacturer diameter of the stent.
   c. After stent expansion the balloon is deflated and the entire SDS is removed, leaving guidewire across the lesion.
   d. Further stent expansion may be performed with a high-pressure balloon.
   e. Post stent placement patient will be prepared for transport according to existing PTCA protocol

Tri-City Medical Center	Cardiology
PROCEDURE:	**EXERCISE STRESS ECHOCARDIOGRAM**
Purpose:	Cardiovascular technologists (CVT) shall be knowledgeable in performing An **exercise** Stress Echocardiogram. The CVT performs the echocardiogram. A Cardiologist or a physician extender under the supervision of a Cardiologist, and an EKG tech performs the treadmill exercise test.
Supportive Data:	Current American Society of Echocardiography (ASE) and American Registry of Diagnostic Medical Sonography (ARDMS) accepted guidelines
Equipment:	Mortara X-Scribe Stress System, Philips IE33 Ultrasound machine, Horizon Cardiology digital workstation

A. **POLICY:**

1. An **exercise** stress echocardiography is a procedure that determines how well the heart and blood vessels are working.
2. A patient is expected to exercise on a treadmill or stationary bike while a Cardiologist or physician extender monitors the blood pressure and heart rhythm.
3. Physician written order is mandatory.
4. A Cardiologist or physician extender must be present during the exercise portion of the exam.
5. The echocardiogram should contain the images, Doppler, and measurements. Modified views may be necessary as some views and measurements may not be available. Attempts must be documented.
6. Images will be captured digitally in a quad format and stored on the Horizon Cardiology digital workstation.
7. Machine settings, transducer selection and patient position will be adjusted as needed to optimize all captured images, including Doppler display.
8. Check the ECG signal for a well-defined R wave on both the ultrasound machine and the exercise stress system before beginning the examination.
9. If necessary, ECG electrodes can be repositioned to ensure "window" access.
10. The resting echo window positions can be marked on the patient's chest for post stress references; however, remember that the window can change after exercise.
11. Perform a pre exercise echo to help determine that a contraindication to stress testing does not exist.
12. Maintain a uniform depth setting throughout the exam. Generally, the depth should be no more than 16cm.
13. Be certain to position the apical views correctly within the quad screen so that the apex of the heart is visible.
14. After acquiring resting images, a reference mark can be placed on the exam table so the patient can return to the best place and position on the exam table after exercise.
15. Apply gel to the transducer during patient exercise to save valuable seconds after exercise.
16. Introduce yourself and use (2) identifiers to verify correct patient.
17. CVT will explain the test to patient.
18. Perform "Standard Precautions" at all times.
19. Maintain patient privacy.
20. **Relative** Contraindications:
    a. Severe aortic stenosis
    b. Severe left atrial enlargement
    c. Severe mitral regurgitation
    d. Moderate to severe left ventricular systolic dysfunction
    e. Not a contraindication, however significant mitral annular calcification, sclerosis, diastolic dysfunction should be commented on in the Summary of the report.

Department Review	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/18, 10/20	12/18, 11/20	n/a	n/a	01/19, 12/20	n/a	02/19

f. In certain instances or contraindications, a Cardiologist may override a contraindication but must be present for the procedure.

21. Reason For Termination Of The Treadmill Exercise:
    a. Target heart rate achieved
    b. Wall motion abnormalities that correspond to two or more coronary territories
    c. Wall motion abnormalities associated with ventricular dilation and/or global reduction of systolic function
    d. Significant chest pain and/or ECG changes consistent with an ischemic response
    e. A decline in blood pressure
    f. Patient is unable to continue due to fatigue or excessive shortness of breath
    g. Significant arrhythmia

B. **PROCEDURE:**

1. Daily Preparation:
    a. Check for prior exam for each patient. Print previous report and add to patient folder.
    b. Connect dedicated black cable from back of treadmill system to the front of the ultrasound machine
2. Patient Preparation:
    a. Establish indication for exam. Obtain brief cardiac history from patient.
    b. Enter patient data into ultrasound machine and select appropriate settings.
    c. Enter patient data into the exercise treadmill system and select appropriate settings
    d. Obtain signed consent form for treadmill exercise exam
    e. Prepare the skin area and connect the ECG leads to patient in appropriate modified positions.
    f. Place blood pressure cuff on patient's arm, preferably the right arm
    g. Obtain resting blood pressure and print a resting ECG.
3. Performing the Procedure:
    a. Use ultrasound gel as appropriate
    b. Perform pre-exercise echo to assist in evaluating for any contraindications; attending Cardiologist or physician extender's determination. Transfer exam to CPACS and prepare preliminary report for attending Cardiologist or physician extender's review, analysis and signature.
    c. If baseline ECHO windows are poor, consider using Definity contrast for rest and exercise images.
    d. Preset/Protocol
    e. Select "Stress Echo" - Begin with trim know turned to AP4CH
    f. Begin with "Resting" Stress Echo
        i. "Acquire" loops: 4Ch, 2CH, Apical LAX (if needed), PLAX, SAX and select image for the (4) quad views
        ii. Observe the view icon and stage to ensure correct labeling (look at monitor screen trim knob)
        iii. May have to acquire additional "off axis" and "foreshortened" views to have available to correlate w/ impost images
        iv. Select "Accept Stage"
        v. To show a Cardiologist or physician extender the images select resting images - "Review", "Shuffle View", then "Shuffle Stage"
    g. Ready for "Impost" Stress Echo
        i. Put gel on transducer
        ii. Press "Review" to turn review off and to show ROI box
        iii. Patient is instructed on how to walk on the treadmill and the need to safely and quickly return to the bed and assume the same left decubitus position post exercise.
        iv. Patient performs exercise according to conventional exercise protocol
        v. Press "Timer" when treadmill belt stops

vi. "Acquire" loops: 4CH, 2CH, Apical LAX (if needed), PLAX, PSAX
vii. Acquire images within 60 - 90 seconds
viii. May push "Enter" on keyboard or turn "trim knob" when changing from one view to another - will label view automatically
ix. Push "Acquire" on keyboard when you want to stop acquiring images
x. Select "End Acquisition" on screen - all "impost" images will appear
xi. Select image for the (4) quad views (cardiologist may select final impost images at this time)
xii. Select "Accept Selected" (each view)
xiii. Select "Accept Stage"
xiv. Select "Shuffle View", then "Shuffle Stage" - Cardiologist analyzes and reviews side-by-side images (Resting images side-by-side with Impost images)

h. Serial blood pressures, pulse and ECG recordings are obtained in the recovery period according to the Cardiologist or physician extender. Patient monitoring is terminated and patient is released from the echo lab upon the attending Cardiologist or physician extender.

4. At the conclusion of the test:
   a. Patient is wiped clean of and supplies are re-stocked.
   b. Proper infection control measures are taken to clean room.
   c. Transfer images to CPACS digital workstation.
   d. Complete the CVT preliminary report for the pre-exercise echo and place patient folder in cardiologist's in-box.
   e. Stress echo exam is dictated by attending Cardiologist or physician extender.
   f. Record the exam information on the CVT log.
   g. CVT will process the appropriate billing charges through Compass.

Tri-City Medical Center	Cardiology
PROCEDURE:	**ECHOCARDIOGRAM STUDY ALERT**
Purpose:	At the completion of an echocardiography (ECHO) study, a patient who has been identified with values consistent with progressive or severe disease per the current AHA/ACC guidelines will be identified through an ECHO alert process triggering a sequence of correspondence directly with the ordering physician and primary care provider. This correspondence will confirm identification of the disease process with facilitation in establishing a clinical plan of care.

A. **DEFINITIONS:**

1. Heart Valve Coordinator: Clinical Care Coordinator
2. Multidisciplinary decision-making Heart Team: Heart valve team and experts in valvular heart disease (Cardiologist, Interventional Cardiologist, Cardiac Surgeon, and Heart Valve Coordinator).

B. **POLICY**

1. Echocardiography measurements that are consistent with valvular heart disease, as defined by the American College of Cardiology (ACC) and the American Heart Associations (AHA) and reinforced by the American Society of Echocardiography (ASE), will be considered critical values and will be reported to the interpreting cardiologist, admitting physician, and the patient's primary care physician to ensure collaborative and comprehensive evaluation of valvular heart disease.

C. **PROCEDURE:**

1. A copy of the current AHA/ACC guidelines for identification of patients with severe valve disease will be readily available and referenced during completion of ECHO studies.
2. Upon completing an echocardiogram, the technician will trigger an ECHO alert if there are findings consistent with progressive or severe heart valve disease
3. An ECHO alert with be the completion of a worksheet including all patient demographics, ordering physician information, and admitting diagnosis.
4. The ECHO technician notifies the:
   a. Reading Cardiologist and the Heart Valve Coordinator of the severe findings.
   b. The Heart Valve Coordinator of the Progressive findings
5. Upon finalization of the echocardiogram report, the Heart Valve Coordinator or designee will establish the patient within the Heart Valve Program quality database. A phone call correspondence to the ordering physician is completed including the finding and recommendation for evaluation based on the 2014 AHA/ACC Guidelines
6. The finalized ECHO report and copy is sent to the ordering physician and primary provider with accompanying cover letter describing findings and classification per current AHA/ACC guidelines.
7. Documentation of all correspondence is completed within the patient record.

D. **REFERENCES:**

1. Nishimura RA, Otto CM, Bonow RO, Carabello BA, Erwin JP III, Guyton RA, O'Gara PT, Ruiz CE, Skubas NJ, Sorajja P, Sundt TM III, Thomar JD, 2014 AHA/ACC Guideline for the Management of Patients With Valvular Heart Disease, Journal of the American college of Cardiology (2014), doi 10.1016/j.jacc.2014.02.536.

Cardiology Department	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
NEW 10/20	11/20	n/a	n/a	12/20	n/a	

Tri-City Medical Center
Oceanside, California

Emergency Department

ISSUE DATE: NEW

SUBJECT: Ketamine for the Management of Pain in the Emergency Department

REVISION DATE:

Emergency Department Approval:	**05/20**
Department of Emergency Medicine Approval:	**07/20**
Pharmacy and Therapeutics Committee Approval:	**09/20**
Medical Executive Committee Approval:	**11/20**
Administration Approval:	**12/20**
Professional Board Committee Approval	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To define guidelines for patient selection, administration, monitoring and recovery for use of **K**~~k~~etamine in the Emergency Department (ED).

B. **INDICATIONS FOR USE:**

1. Provide pain relief to patients with severe acute painful conditions who are likely opiate tolerant and/or would not respond to high doses of IV opiates (i.e. migraine headaches, undifferentiated abdominal pain, back/neck pain, renal colic, etc…); relief of intractable neuropathic pain, intractable chronic pain, intractable cancer pain, and moderate to severe acute post-traumatic pain.

C. **POLICY:**

1. ED Physician will assess the patient for etiology and severity of pain, as well as likelihood of response to alternative therapies
2. ED Physician will assess the patient for possible contraindications
3. ED physician will assess patient's vital signs, oximetry, and mental status
4. Exclusion criteria:
   a. Hypersensitivity to **K**~~k~~etamine or any component of the formulation
   b. Recent hospitalization for psychiatric disorder, or a suicide attempt
   c. History of Psychosis: schizophrenia
   d. History of seizures
   e. Hydrocephalus or acute head injury
   f. **History**~~x~~ of glaucoma or acute globe injury
   g. Known or possible CAD, CHF, and/or uncontrolled HTN
   h. History of COPD with hypercarbia, asthma, laryngospasm, or upper respiratory infection
   i. **History**~~x~~ of airway instability, tracheal surgery, tracheal stenosis, tracheomalacia, and laryngomalacia
   j. Procedures that will stimulate the posterior pharynx
   k. Acute alcohol or drug intoxication
   l. Thyroid disease
   m. Pregnancy
   n. ~~Age less than (<) 12 months~~ **ED RN must give IV; so should be weight based; not age.**
5. Discharge Criteria:
   a. Patient is able to ambulate (unless lower extremity injury)
   b. Patient's mental status has returned to baseline
   c. Patient has a ride home or is being admitted to the hospital (ED)
   d. Patient's vital signs have returned to baseline

e. At least two hours have passed since time to last dose of ketamine was given

D. **PROCEDURE:**

1. Administration Guidelines: Restricted to adult patients being evaluated by an Emergency Medicine Physician (in ED only)
2. Recommended Dosing:
   a. Consider 0.3mg/kg IV over 10 minutes x1. (Usual dose range= 0.1mg/kg-0.5mg/kg).
      i. Use IBW in obese patients (BMI ≥ 30)
         1) Males= 50 + (2.3 x inches over 5 ft)
         2) Females= 45 + (2.3 x inches over 5 ft)
      ii. More rapid administration may result in respiratory depression/apnea and enhanced pressor response.
      iii. Maximum total dose = 50mg, although up to 35mg is usually sufficient. In the event that less than the recommended dose is used, an additional dose not to exceed the maximum total recommended dose can be considered to achieve desired effect.
   b. To be used in conjunction with other analgesics as adjuvant therapy
3. Nursing Considerations:
   a. May be administered peripherally or centrally **under the supervision of MD**
   b. **Suction must be available at the bedside prior to administration.**
   c. Monitoring:
      i. HR, BP, RR, Temperature, SPO2, and Pain Level must be monitored every 15 minutes for 1st hour, then every 30 minutes times 1 hour,
      ii. Maintain quiet area with minimal physical stimulation if possible
4. Notify ED Physician for presence of any of the following signs or symptoms:
   a. Systolic blood pressure of less than (<) 90mmHg or greater than BP (>)180mmHg
   b. Heart rate of less than (<) 60 bpm or greater than (>) 110 bpm
   c. Respiratory rate of less than (<) 10 breaths/minute
   d. Oxygen saturation of less than (<) 93% if ordered
   e. Nausea or vomiting
   f. Excess salivation
   g. Excess sedation

E. **REFRENCES:**

1. Correll GE et al. Subanesthetic Ketamine Infusion Therapy: A Retrospective Analysis of a Novel Therapeutic Approach to Complex Regional Pain Syndrome. Pain Medicine. 2004; 5(3):263-75.
~~1.~~2. Goldberg ME et al. Multi-day low dose Ketamine infusion for the treatment of complex regional pain syndrome. Pain physician. 2005; 8(2):175-9.
3. Bell RF et al. Peri-operative Ketamine for acute post-operative pain: a quantititative and qualitative systematic review. (Cochrane review). Acta Anaesthesiol Scand. 2005; 49(10):1405-28.
~~2.~~4. DeKock M et al. "Balanced Analgesia" in the perioperative period. Is there any place for Ketamine? Pain. 2001; 92:373-80.
5. Farida A. Emergency Department Visits for Chest Pain and Abdominal Pain: United States, 1999-2008, NCHS Data Brief. 2010: 43.
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8. Laeben L et al. Low-dose Ketamine for Analgesia in the Emergency Department: A Retrospective Review. Western Journal of Emergency Medicine. 2008; 9(1):61.
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~~5.~~10. Loftus RW et al. Intraoperative Ketamine Reduces Perioperative Opiate Consumption in Opiate-dependent Patients with Chronic Back Pain Undergoing Back Surgery. Anesthesiology. 2010;

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11. Zempsky WT et al. Use of Low-dose Ketamine Infusion for Pediatric Patients With Sickle Cell Disease-related Pain: A Case Series. Clinical Journal Pain. 2010; 26(2):163- 7.

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13. Marnix JS et al. Ketamine produces effective and long-term pain relief in patients with Complex Regional Pain Syndrome Type 1. 2009; 145:304-11.

~~7.~~14. Finkel JC et al. Ketamine as an Adjuvant for Treatment of Cancer Pain in Children and Adolescents. J of Pain. 2007; 6:515-21.

~~8.~~15. Clinical Practice Guideline for Emergency Department Ketamine Dissociative Sedation: 2011 Update Steven M. Green, Mark G. Roback, Robert M. Kennedy, Baruch Krauss Annals of emergency medicine 1 May 2011;57(5):449-461.

Tri-City Health Care District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/01**	**SUBJECT:**	**Bloodborne Pathogen Exposure Control Plan**
REVISION DATE(S):	**09/02, 09/03, 09/04, 09/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/12, 10/15, 08/16, 10/17, 08/18, 12/19**		

Infection Control Department Approval:	**~~10/19~~10/20**
Infection Control Committee Approval:	**~~10/19~~10/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/19~~11/20**
Administration Approval:	**~~11/19~~12/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **DEFINITION(S):**

1. 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.

C. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

D. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

E. **AVAILABILITY TO HEALTHCARE WORKERS:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

F. **PROGRAM ADMINISTRATION:**

1. Employee Health Services (EHS) with the Infection Preventionist, will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures. Employee Health Services is responsible for the implementation, maintenance, and administration of the Injury Prevention Program.

2. The Management/Leadership Team will ensure each employee for their area/unit of responsibility is provided information and training on the potential for exposure to bloodborne pathogens.
   a. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   b. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
3. The Management/Leadership Team is responsible for compliance in their respective areas. They work directly with the Safety/Environment of Care (EOC) Officer, the Infection Control Department, Employee Health and our employees to ensure that proper exposure control procedures are followed.
   a. The Management/Leadership Team will support activities that encourage the active involvement of employees in education and safety programs. The Management/Leadership Team will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. The Management/Leadership Team will review quality review reports (RL Solutions) their employees complete to document any needlestick occurrence.
      i. The Management/Leadership Team will counsel employees who do not use safe practices, PPE, and/or safety devices.
4. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
5. The Product Steering Committee has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See Products Steering Committee Product Evaluation and User Product Evaluation.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environmental Health and Safety or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
6. Workforce Members who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
   a. If an employee exposure occurs:
      i. Employees are to notify their Director/Manager/Supervisor of any exposure immediately.
      ii. Director/Manager/Supervisor will refer employee for follow to:
         1) Employee Health during business hours.
         2) Emergency Room after hour and weekends.
            a) Employee to notify Employee Health within 24 hours of exposure.
   b. If a Workforce Member other than an employee exposure occurs:
      i. Workforce Members must notify Director/Manager/Supervisor of the area of any exposure immediately.
      ii. Director/Manager/Supervisor will refer Workforce member to the Emergency Room for follow up.

iii. The Workforce Member is to notify their employer/agency or workers compensation as appropriate.

c. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).

c. Our employees are expected to complete initial bloodborne pathogens training and annual review.

7. Employees will participate in the trial and selection of new safety devices.
   a. Safety rounds are conducted on an annual or as needed (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the Safety/Environment of Care (EOC) Officer or designee and reports the results to the Environmental Health and Safety Committee (EHSC),, the Infection Control Committee, and Products Standards Committee.
   c. Risk, Legal and Regulatory Services forwards information from Incident and Quality Review Reports (RL reports) to the Safety/EOC Officer, Infection Preventionist and or Materials Management as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
8. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Recommendations are made to the Materials Management- when a need for a safety device or alternative product is detected.
   e. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   f. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting annually (i.e. safety devices, work practice changes or engineering).

G. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which Workforce Members may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., Workforce Members are considered to be exposed even if they wear personal protective equipment).
2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some Workforce Members handle human blood and OPIM, which may result in possible exposure to bloodborne pathogens.

3. Since not all of the Workforce Members in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these Workforce Members to have occupational exposure are listed in Potential Blood Exposure by Job Category.

H. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize Workforce Member exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying Workforce Members with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   f. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily
      iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.
      iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.
   g. In addition to the engineering controls identified on these lists, the following engineering

controls are used throughout our facility.

i. Hand washing facilities and waterless hand cleansers are readily accessible to Workforce Members with potential for exposure.
ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

I. **WORK PRACTICE CONTROLS:**

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize Workforce Member exposure to bloodborne pathogens.
   a. Workforce Members follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
      i. Semen
      ii. Vaginal Secretions
      iii. Peritoneal fluid
      iv. Tissue and Organs
      v. Amniotic fluid
      vi. Synovial fluid
      vii. Pleural fluid
      viii. Saliva with visible blood
      ix. Pericardial fluid
      x. Cerebrospinal fluid
   b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
      i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
      ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
   c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
   d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
   e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
      i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
      ii. Information regarding the contamination is conveyed to all affected Workforce Members, the equipment manufacturer, and the equipment service representative.

J. **PERSONAL PROTECTIVE EQUIPMENT (PPE):**

1. PPE is the Workforce Member's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our Workforce Members) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:
   a. Gloves
   b. Fluid resistant gowns
   c. Glove liners

d. Laboratory coats
e. Face shield
f. Resuscitation bags
g. Masks
h. Hoods
i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to Workforce Members who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

K. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All Workforce Members are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
   c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
   d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.
4. All regulated waste is safely handled by staff according to TCHD policies and procedures.

Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual Section 6: Hazard Material Management: Waste Management Policy.

a. See TCMC Waste Disposal Guidelines.

5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides should hold the bags away from their bodies when removing waste. During removal, use heavy gloves to protect their hands from possible sharps injury, and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Workforce Members who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

L. **FORM(S):**

1. Potential Blood Exposure by Job Category
2. Products Steering Committee Product Evaluation
3. Safer Work Survey
4. Standard Precautions – Personal Protective Equipment
5. User Product Evaluation

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

1. Employee Health and Wellness Policy: Injury and Illness Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: Waste Management
5. Infection Control Procedure: Hand Hygiene
6. Infection Control Policy: Standard and Transmission Based Precautions
7. TCMC Waste Disposal Guidelines

N. **REFERENCE(S):**

1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. https://www.dir.ca.gov/title8/5193.html (accessed **10/13/2020~~9-11-2019~~**)
2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2017 https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf **(accessed 10/13/2020)**

3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc. Waste Management Chapter 113
4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf (accessed ~~9-11-2019~~**10/13/2020**)

Tri-City Health Care District
Oceanside, California

POTENTIAL BLOOD EXPOSURE BY JOB CATEGORY

'ALL' EMPLOYEES	'SOME' EMPLOYEES (TASKS PERFORMED WITH RISK)
Administrative Coordinator Advanced Care Technician	Case Managers/ Clinical Social Worker (during patient interviews or family conferences)
Biomedical Tech Mechanic I & II	Chaplain (during patient or family ministrations)
Cardiac Rehabilitation Coordinator	Food Service Worker (during tray delivery, pick-up, or cleaning)
Certified Nursing Assistant	Clinical Dietician
EEG Tech and EEG coordinator	Security Officer
EKG Tech	
Environmental Service Aide and Supervisor	
Emergency Medical Technician	
Employee Health Nurse Occupational Health Nurses & Manager	
Infection Control Specialist	
Laboratory Assistant/Phlebotomist Operations Manager Clinical Laboratory Scientist Histology Lab Tech	
Licensed Vocational Nurse	
Lift Team	
Nurse Practitioner Physicians Assistant	
Occupational Therapist and Rehab Aid	
OR Tech/Sterile Processing Tech/Perioperative Aide/Surgical Instrument Aide	
Perfusionist	
Phlebotomist	
Physical Therapist	
Physicians	
Pulmonary Services Operations Manager	
Radiology Operations Manager & Tech	
Registered Nurse	
Rehabilitation Services Manager	
Respiratory Care Practitioner I, II & III	
Security Officer	
Wound Care Nurses	

Tri-City Health Care District
Oceanside, California

Products Steering Committee Product Evaluation

1. Manufacturer of Product_____
2. Name of Product_____
3. Distributed by_____ Sales Rep_____
4. Description of Use_____
5. Will this device replace a high-risk device (hollow-core, blood-filled, or capable of deep injury)? ☐ Yes ☐ No
6. Product would be used? ☐ House-wide ☐ Lab ☐ OR ☐ Specialty Unit _____
7. What items would this replace?_____
8. Cost _____ Standard item cost_____
9. Has TCHD rejected the device in the past? ☐ Yes ☐ No _____
10. Does the device have a passive safety mechanism? ☐ Yes ☐ No
11. Can the safety mechanism be activated with one hand? ☐ Yes ☐ No
12. Can the user tell when the safety mechanism has been activated? ☐ Yes ☐ No
13. Are minimal changes in technique and use required? ☐ Yes ☐ No
14. Is this product dependent on other products or items? ☐ Yes ☐ No
    Identify:_____
15. Is the device compatible with products currently in use? ☐ Yes ☐ No
16. Does the system/device require a minimal number of parts? ☐ Yes ☐ No
17. Is the product available in typical size ranges? ☐ Yes ☐ No
18. Is the product on contract ☐ Yes ☐ No
19. Product rep available for 24hrs/day in-service? ☐ Yes ☐ No
20. Does the manufacturer supply free trial products? ☐ Yes ☐ No
21. Does the manufacturer have adequate supply capability? ☐ Yes ☐ No

APPROPRIATE FOR TRIALS ☐ **REJECTED** ☐

COMMENTS_____

Tri-City Health Care District
Oceanside, California

SAFER WORK SURVEY

The Centers for Disease Control and Prevention (CDC) estimates that between 100,000 and 1,000,000 sharps injuries occur each year. Various studies have estimated the risk of developing occupationally acquired bloodborne pathogen infections: HCV (3% - 10%), HBV (2% - 40%), and HIV (0.3%) following sharps exposure. The risk of transmission increases if a device visibly contaminated with blood causes the percutaneous injury, is used to puncture the vascular system, or causes deep injury.

1. Safety Devices

Do you have suggestions for sharp devices with built in protection that would make your job safer?
Comments: _____

_____

_____

_____

_____

_____

_____

2. Safe Work Practices

Do you have suggestions for adoption of safer user actions? (Examples: neutral or safe zone for sharps, second layer of gloves, and avoid handling dirty trays)
Comments: _____

_____

_____

_____

_____

_____

_____

3. Personal Protective Equipment

Do you have suggestions for use of personal protective equipment? (Examples: double gloving, heavy leather gloves for trash handling, effective eye and face protection)
Comments: _____

_____

_____

Tri-City Health Care District
Oceanside, California

Standard Precautions
Personal Protective Equipment Table

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
REMOVING, OPENING AND MANIPULATING OR ASSISTING WITH THE REMOVAL OF HOLLOW CORE BLOOD OR BODY FLUID FILLED TUBES, NEEDLES OR CATHETERS															
• Abdominal paracentesis catheter • Angiograph catheter • Bronchoscope (as above & to clean) • Central venous catheter • Chest tube/vent • Endoscope (as above & to clean) • Intravascular catheters • Thoracentesis • Urine catheter	*			*				*			*			*	
ASSISTING WITH PROCEDURES															
Angiography	*			*					*	*				*	
Bone marrow asp/bx	*				*			*			*				*
Bronchoscopy	*			N95				*			*				*
Bronchoscopy (R/O TB)	*			PAPR				*			*				*
Central venous catheter insertion	*				*			*			*				*
Chest tube/vent placement	*				*			*			*				*
Childbirth	*			*					*	*				*	
Endoscopy	*			*			*				*				*
Intubation	*			*				*			*				*
L.P. (holding R/O meningitis)	*			*				*			*				*
Morgue Release	*					*			*						*
Proctosigmodoscopy	*				*			*			*				*
Suture or stapling (within 3 ft. of wound)	*			*				*			*			*	
Assisting with Surgery														*	
Thoracentesis ass.	*				*			*			*				*
SPECIMEN COLLECTION															
ABG	*				*			*			*				*
Blood glucose test	*				*			*			*				*
Clean catch urine specimen	*				*			*			*				*
Dipstick urine test	*				*			*			*				*
Gastric occult. blood test	*			*				*			*				*
Nose/throat (R/O infection)	*			*				*			*				*
Sputum for AFB or TB culture	*			N95				*			*				*
Stool	*				*			*			*				*
Stool occult blood test	*				*			*			*				*
Urine	*				*			*			*				*
Urine specific gravity	*				*			*			*				*
Vaginal or urethral	*				*			*			*				*
Venipuncture for blood	*				*			*			*				*
Wound or wound drainage	*				*			*			*				*
SPECIMEN PROCESSING	*			per S.O			Lab coat								

Tri-City Health Care District
Oceanside, California

R = Required A = Available N/A = Not Applicable	Exposed Body Parts						Contamination of Clothing								
	Hands			Face			Soiling			Saturation			Dripping		
	Gloves			Face Shield or Mask & Goggles			Cloth Gown			Water-proof Gown			Shoe Covers		
	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A	R	A	N/A
CLINICAL TASKS															
Ambu bag: usage	*			*				*			*				*
Bladder irrigation	*			*				*			*				*
Blood or blood products administration	*				*			*			*				*
Blood warmer	*				*			*			*				*
Cleaning used instruments	*			*				*			*				*
Urine catheter: insert	*				*			*			*				*
Colostomy irrigation	*			*				*			*				*
Condom catheter application	*				*			*			*				*
Contact lense care	*				*				*			*			*
Dressing change	*				*			*			*				*
Emerson pump: use	*				*			*			*				*
Endoscope / Bronchoscopy cleaning	*			*			*				*				*
Enema administration	*			*				*			*				*
Enteral feeding tube (insert or manipulate)	*			*				*			*				*
Fecal disimpaction	*			*				*			*				*
Fecal or gastric occult blood test	*				*			*			*				*
Foley cath insertion	*				*			*			*				*
Gastric lavage	*			*					*	*					*
Hemovac drains-manipulate, empty / DC	*			*				*			*				*
Injections	*				*				*			*			*
Intravenous catheter insertion	*				*			*				*			*
J-P drain care	*				*			*			*				*
Nasogastric tube insertion and DC	*			*				*			*				*
Neonatal suck evaluations (latex-free)	*				*			*				*			*
1st. Newborn bath	*			*				*			*				*
Normal Saline or Heparin lock irrigation	*				*			*				*			*
O2 therapy w/ mucus membrane touch	*				*				*			*			*
Open suctioning of airway or airway tube	*			*				*			*				*
Oral care	*			*				*				*			*
Oral/nasal airway insertion or DC	*			*				*			*				*
Pleur-evac care	*				*			*			*				*
Postural drainage	*				*			*			*				*
Rectal tube insertion	*				*			*			*				*
Resp. Tx, cough inducing	*			*				*				*			*
Restraint placement		*			*			*				*			*
Seizing patient		*			*			*				*			*
Sputum Induction for AFB	*			N95				*				*			*
Sputum Induction for AFB R/O tuberculosis	*			PAPR				*				*			*
Total parenteral nutrition administration	*				*			*				*			*
Urine bag emptying	*			*				*				*			*
Vital signs and Weighing patients		*			*			*				*			*
Wound care (without irrigation)	*				*			*			*				*
Wound irrigation Pulsevac Tx	*			*				*			*				*

Tri-City Health Care District
Oceanside, California

User Product Evaluation

Name_____ Date_____

Dept/Unit_____

How would you rate this product compared to other similar products you have used?

CRITERIA	BETTER	SAME	WORSE
Easy to open package			
Ease of assembly			
Ease of use			
Comfortable feel for user			
Length of time required for use			
Activation of safety feature			
Safety feature can't be defeated			
Has minimum failure rate and functions as intended			
Good for use with different patients			
Safe for healthcare workers			
Safe for patients			
Patients complaints			
Doctors complaints			
Easy to dispose			
Compatible with other products			
Will reduce the risk of injury			
Reasonable number of parts			
Available in the sizes you need			

How many times did you use the product?_____

Would you recommend purchasing this device? ☐ Yes ☐ No

Is there another safety device you would rather use? ☐ Yes ☐ No

Specify:_____

Comments? _____

_____

_____

_____

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 08/17 **SUBJECT: Ebola Plan**

REVISION DATE(S):

Department Approval:	**07/2020~~06/17~~**
Infection Control Committee Approval:	**~~07/17~~08/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~11/20**
Administration Approval:	
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. To standardize the risk assessment, triage, transportation, and management of patients with possible/confirmed Ebola Virus Disease (EVD) throughout Tri-City Medical Center (TCMC) and its affiliated facilities.

B. **INTRODUCTION AND BACKGROUND:**

1. **Ebola virus (EV) was first discovered in 1976 near the Ebola River in the Democratic Republic of Congo. The virus has been infecting people from time to time since then leading to outbreaks in several African countries. Scientists believe that the virus is animal-borne, with bats or nonhuman primates being the most likely source. Infected animals carrying the virus can transmit it to other animals and humans. The virus spreads to people initially through direct contact with blood, body fluids and tissues of animals. EV then spreads to other people through direct contact with body fluids of an infected person or a person who has died from EVD.**
2. **Pregnant women with EV appear to be at an increased risk of fetal loss and pregnancy associated hemorrhage. Ebola virus can cross the placenta, and pregnant women infected with the virus will likely transmit it to the fetus. The risk of spontaneous fetal loss is high.**
3. **While the risk of importation of Ebola virus into California remains very low, infectious diseases can be introduced by returning California residents and global travelers visiting the state.~~It is the mission of TCMC to take care of those in need, regardless of their illness. With that in mind, safety always has been and will continue to be the number one priority. TCMC is committed to providing a safe environment for everyone, including patients, visitors and staff in its facilities.~~** The U.S. Centers for Disease Control and Prevention (CDC) recommends that all hospitals in the U.S. be prepared to care for patients who could have EVD.

C. **TCMC IS CONSIDERED A FRONTLINE HEALTHCARE FACILITY ACCORDING TO CDC, WHOSE ROLE IS TO:**

1. Rapidly identify and triage patients with relevant exposure history AND signs and symptoms compatible with EVD.
2. Immediately isolate any patient with relevant history and signs and symptoms of EVD and take appropriate steps to adequately don personal protective equipment (PPE) to protect staff triaging and caring for the patient.
3. Immediately notify hospital Infection Control, appropriate facility staff and local public health agency.

4. Frontline healthcare facilities, in accordance with the state's plan, should consider immediately transferring patients who have a higher probability of EVD or are more severely ill to an Ebola treatment center (University of California San Diego Medical Center; San Diego, California) that can provide Ebola testing and care for the higher risk patients until an EVD diagnosis is either confirmed or ruled out.

D. **ABOUT EBOLA:**

1. While Ebola is a dangerous virus that can be life-threatening, its spread can be contained.
   a. EVD is spread by contact with blood or any other body fluid from a person with symptoms of EVD infection. Infection is spread when infected body fluids come in contact with mucous membranes, breaks in the skin or by sharps injuries.
   b. EVD is not transmitted through the air unless there is exposure to body fluid droplets from an infected person (e.g., coughing, sneezing or spitting).
   c. EVD is not transmitted from persons who don't have symptoms of infection (see below for symptoms of EVD infection).
2. EVD usually starts with a sudden onset of fever along with symptoms, including chills, weakness, abdominal pain, joint muscle aches, headache, lack of appetite and body aches. Vomiting and diarrhea are common. In severe cases, internal and external bleeding may occur.
3. The illness begins an average of 8-10 days following exposure (although it could be from 2 to 21 days).
4. Some of the symptoms of EVD are similar to those of other infections that are common in West Africa, such as malaria and diarrheal illnesses.
5. There currently are no FDA-approved medications specific for treating Ebola virus infection. The main way we treat EVD is through supportive care. This means providing excellent medical and nursing care, including monitoring and replacing fluids and electrolytes, as well as transfusions as necessary. The goal is to provide this care to the patients until their bodies can control the virus.

E. **ASSUMPTIONS:**

1. Risk assessments will be done for patients entering our system through numerous routes, including:
   a. Emergency Department (ED)
   b. Labor and Delivery
   c. Walk in entrances as indicated by patient presentation
2. Procedures for risk assessments and screening at points of entry will include:
   a. Questioning about travel history within the past 21 days before illness onset, exposure risk, and history of febrile illness as provided below.
3. TCMC patients with suspect EVD will be triaged, isolated on site and transferred to the Ebola treatment center UCSD, under the direction of San Diego County Public Health. Single patients will remain in the ED room 26 for the duration of their hospitalization and necessary supplies and equipment will be provided in that location.
4. Obstetric patients over 20 weeks will be managed in ED room 26 with the support of the Labor and Delivery staff.
5. Patients will be transferred to University of California, San Diego Hospital in collaboration with the County of San Diego Public Health for definitive care.
6. General Incident Command Structure (HICS) will be activated during the period of time a patient with suspected EVD is within TCMC. The mission and direction will be provided by the Incident Commander with input from the Medical/Technical Specialists. The Incident Response Guide: Infectious Disease (HICS, 2014) will be utilized as a framework for general HEICS response.

F. **RISK ASSESSMENT:**

1. Because travel to high-risk areas is one of the risk factors for transmission, these guidelines address patients who are considered at high risk for EVD who meet travel criteria. In addition, exposure to a known EVD patient has also been included in the assessment. Upon initial arrival

to one of the entry points into the system, patients will be screened for a positive travel history and symptoms consistent with EVD.

2. High-risk of EVD (Refer to CDC Checklist for Patients being Evaluated for EVD in the U.S.)
   a. High-risk exposure (defined below) plus ANY symptoms suggestive of EVD (fever [subjective or > 38 degrees C, 100.4 degrees F] and/or other symptoms, including severe headache, muscle pain, vomiting, diarrhea, abdominal pain, bleeding). High-risk exposure is defined by the CDC as:
      i. Percutaneous (e.g., needle stick) or mucous membrane exposure to body fluids of confirmed or suspected EVD patient
      ii. Direct care of an EVD patient or exposure to body fluids from such a patient without appropriate personal protective equipment (PPE)
      iii. Processing body fluids of confirmed EVD patients without appropriate PPE or standard biosafety precautions
      iv. Direct contact with a dead body without appropriate PPE in a country where an EVD outbreak is occurring
   b. Low-risk exposure (defined below) plus high probability of infection based on clinical assessment.
      i. Low-risk exposure defined by the CDC as:
         1) Household contact with an EVD patient
         2) Other close contact with EVD patients in health care facilities or community settings. Close contact is defined as:
            a) Being within approximately 3 feet (1 meter) of an EVD patient or within the patient's room or care area for a prolonged period of time (e.g., health care personnel, household members) while not wearing recommended PPE (i.e., standard, droplet and contact precautions)
            b) Having direct brief contact (e.g., shaking hands) with an EVD patient while not wearing recommended PPE
         3) NOTE: Brief interactions, such as walking by a person or moving through a hospital, do not constitute close contact.

G. **DOCUMENTATION:**

1. Nursing documentation of EVD Risk Assessment will be documented in the Cerner Triage Form v2 for patients entering the ED. Patients arriving for Labor and Delivery care will have risk assessment documentation placed in the OB nursing intake assessment form in Cerner.
2. Initial Triage: (Refer to CDC Checklist for Patients being Evaluated for EVD in the U.S.)
   a. The following actions will be taken for patients who demonstrate the following:
      i. Identify Exposure History (needs to meet one of the two below):
         1) a travel history to an affected country within the last 21 days
         2) contact with an individual with Ebola within the last 21 days
      ii. And one of the signs and symptoms of Ebola below:
         1) Fever: ≥100.4 F or 38.0 C or the following Ebola compatible symptoms:
            a) Headache
            b) Fatigue
            c) Weakness
            d) Muscle Pain
            e) Vomiting
            f) Diarrhea
            g) Abdominal Pain
            h) or Hemorrhage (bleeding gums, blood in urine, nose bleeds, coffee ground emesis or melena).
   b. If both i. and ii. are met (exposure history and signs and symptoms consistent with Ebola Virus Disease), the following measures should be implemented immediately in accordance with CDC recommendations.

c. If only i. (the exposure/travel history) is met and not symptoms, continue with usual triage & notify public health for further guidance.

3. Initial Actions (if above is met):
   a. Mask patient immediately. Do not place in waiting room. Instruct patient to wait outside briefly in patio area away from other patients or visitors.
   b. Immediate triage staff don personal protective equipment (PPE), the minimum being a hooded Tychem suit, water resistant gown, double gloves, N95 mask*, goggles, face shield and knee high shoe covers.
      i. If patient is exhibiting bleeding, vomiting, diarrhea then a PAPR should be utilized.
         1) Additional full PPE will be donned by all direct care providers in the ante room adjacent to ED room 26 (See PPE Guidance Matrix by Job Positions and Job Checklists).
   c. Contact Security to assist with controlling the area. Security will also obtain the names of those are in the proximity of the patients.
   d. Prior to placement of patient in room C26: room must be prepared to accept patient
      i. See job role (Job Checklists).
   e. ED Charge to assign job roles. (Job Checklists)
   f. Contact the ED charge RN and instruct them to unlock the exterior door to room 26.
      i. See ED Charge Nurse Job Descriptions for further initial actions (see Job Checklists).
   g. Escort patient OUTSIDE to the exterior entrance to room 26.
   h. Place "CONTACT, AIRBORNE" isolation and STOP signs on interior door. All dirty linens and supplies are to remain in the room with the patient.
   i. Contact Eengineering to start monitoring the negative pressure room (C26) and to Contact ATI company to set up anteroom and Decon Room outside C26 (Diagram).
   j. Don all recommended PPE for direct care provider prior to entering the room for patient care.
   k. Post a designated assistant outside the room to monitor/assist PPE use and hand hygiene (see job description, Job Checklists)
   l. Post a designated observer outside of room to monitor staff who enter/exit room. Take vital signs of staff before Donning and after Doffing of PPE (see job descriptions- Job Checklists and Observer Tracking Form).
   m. Contact Administrative Supervisor, Infection Control, and Public Health (619-692-8499(Mon-Fri) or 858-565-5255 (after hours) as per posted advisement. Await direction from Public Health for ordering of labs, diagnostic studies, etc.
   n. Contact EVS STAT for any contamination to public areas and to restrict access to any potentially contaminated areas.
   o. Observer role: Document all staff who cared for patient and/or entered the room (see appendix for the form) Observer Tracking Form. Limit the amount of staff entering the room.

H. SPECIMEN MANAGEMENT FOR HIGH-RISK TESTING:

1. ~~Laboratory~~ Gguidelines for handling/testing specimens from suspected cases of Ebola virus disease:
   a. General Considerations:
      i. Initial testing of patients upon presentation shall be limited to the CDC-required PCR testing for confirmation of Ebola. All testing will be guided by the County of San Diego Public Health **(CDPH)** Epidemiology department (along with Infection Control and the Laboratory)
      ii. There will be **no** transport of specimens to the Laboratory.
      iii. Specimen processing should be performed in the patient's room or nearby in a contained testing area.
   b. Specimen Collection:

i. In order to limit the number of TCMC employees involved in the patient's care and to limit exposure, an RN already inside the patient's room will draw 2 tubes of blood and place each tube in separate biohazard bags that another RN within the room is holding.
ii. A minimum volume of 4 ml of whole blood preserved with EDTA or SPS (Sodium polyanethol sulfonate) in plastic vacutainer tubes should be drawn for EVD testing. Do not collect specimens in glass containers.
iii. The specimen, enclosed in a small cold pack, will then be transported to the ante-room for pick-up by the San Diego County Public Health **(SDPH)** Microbiologist.
iv. Immediately contact the San Diego County Public Health **(SDPH)** ~~Services~~ Epidemiology Program by phone at 619-692-8499 (Mon-Fri) or 858-565-5255 (after hours).
v. San Diego County Public Health **(SDPH)** ~~Services~~ Epidemiology will assess the request, and will, if warranted, contact **SDPH** ~~the San Diego County Public Health Services~~ Laboratory.
vi. **SDPH** ~~San Diego County Public Health Services~~ Laboratory will send a specifically trained Public Health Microbiologist, with packaging and shipping materials, to the specially designated TCMC patient care containment area.
vii. The trained Public Health Microbiologist will prepare documents, prepare and package specimens, and arrange for shipment to the CDC and Los Angeles County Public Health laboratory for PCR testing.
viii. Fill up the attached Primary Specimen Contact List to record all personnel who come into contact with the specimen, including contact with primary specimen container.

2. Laboratory procedures for consideration while waiting for PCR results:
   a. NOTE: Unless critically needed, do not perform any additional laboratory testing. ~~iSTAT~~**Rapid Point 500 instrument** should be ordered from the lab. If ~~iSTAT~~**Rapid Point 500 instrument** is used, it will need to be kept in containment area for later cleaning with other supplies.
   b. Chemistry, Hematology:
      i. Blood gases, electrolytes, hemoglobin, hematocrit
      ii. Testing should be limited to ~~iSTAT~~**Rapid Point 500** and should only be performed in the patient's room by the RN.
   c. Urinalysis:
      i. Available as a urine dipstick and performed in the patient's room.
      ~~d. Malaria testing:~~
      ~~i. Collect in a plastic lavender top (EDTA) vacutainer tube~~
      ~~ii. Preparation of thin blood smears should be done in the patient's room. Wipe the outside of the lavender top tube (EDTA) with Super Sani Cloth disinfectant.~~
      ~~iii. Remove stopper of lavender tube (EDTA) with Super Sani Cloth disinfectant wipes to prevent aerosol formation.~~
      ~~iv. Prepare a thin blood film, fix in methanol for 30 minutes, and then place in dry heat at 95°C for 1 hour to inactivate the specimen.~~
      ~~v. The smear can then be stained in the Hematology slide stainer.~~
      ~~vi.~~**ii.** ~~WBC and platelet count can be estimated from the stained blood film~~.
   ~~e.~~**d.** Blood Cultures:
      i. ~~Perform~~ **Contact SDPH if required.** ~~only if required and minimize blood draws for blood cultures~~.
      ~~ii. Once received in Microbiology, wipe the outside of the bottles with Super Sani Cloth. If the blood culture bottles are flagged as positive, unload the bottles from the instrument.~~
      ~~iii. Wear the appropriate PPE (impermeable gown, double gloves, eye protection, N-95 mask, shoe covers).~~

~~iv. Transfer the bottle to the biological safety hood and prepare slides for Gram stain examination and allow to dry.~~

~~v. Fix the blood smears in methanol for 30 minutes, followed by dry heat at 95°C for 1 hour to inactivate the specimen. Perform testing of the gram stain QC slide in the same manner.~~

~~vi. The smears can then be stained and read as usual.~~

~~3. Do not perform any plate subcultures on positive blood cultures until the results of PCR Ebola testing from the patient are available.~~

I. EVALUATING PATIENTS FOR EBOLA VIRUS AT L&D ENTRY

1. Initial Intake:
   a. DAYS: Secretary will have patients fill out the intake questionnaire at front desk, where (2) EBOLA specific questions have been added. If the patient answers "YES" to BOTH questions, the patient will be given a mask to wear and instructed to sit in wheel chair away from other patients. The charge nurse will be called and the patient immediately transported to Room #201 on 2S.
   b. NOCS: Before the patient is allowed access to the L&D Unit, the (2) EBOLA specific questions will be asked over the phone. If the patient answers "YES" to BOTH questions, will NOT be given access to the unit. Staff will bring the patient out a mask to wear, wheelchair, and escort to Room ~~#201 on 2S~~**LDR 3 with window open and door closed**.
2. Initial PPE Precautions for staff transporting the patient:
   a. The staff member shall follow Standard, Contact and Droplet precautions and wear:
      i. White bunny suit
      ii. Gloves (2) pairs if desired (double donned)
      iii. Surgical Mask with face shield/ eye protection OR Surgical Mask and goggles(KITS have been made and are located on top of the File Cabinet in the Managers hallway)
      iv. Before removing the PPE, another staff member must be present to ensure correct removal practice.
3. Main Goals:
   a. To contain spread of the virus (masking patient) and transport patient to secure location for containment (~~Room 201 on 2S~~**LDR 3**)~~Enter the BACK WAY EXIT or MOST direct way to the ROOM, need to deactivate the ALARM to do this~~.
   b. Once patient is secure in ~~201~~**LDR 3**, notify the ~~Emergency Department (ED) Charge Nurse: ext. 3509 (anytime day or night)~~**Administrative Supervisor (AS)** and also L&D Nursing Chain of Command, so staffing items can be discussed.
4. Ongoing Precautions:
   a. A more DETAILED, DOUBLED DONNED, PPE process will need to occur once the patient is moved to~~ room 201~~**LDR 3** by the staff member expected to assess and care for the patient. ~~The PPE Cart is located in the ED currently~~**Hang PPE supplies on door and place isolation sign on door**. Staff SHOULD NOT re-enter the room without this more detailed level of PPE protection.
   b. A BUDDY System to both APPLY and REMOVE PPE, will be required.
   c. All removed items from staff (PPE) and the patient's room (waste, etc.) will have specific disinfection needs and will be disposed of in an identified container.~~) our perioperative aides will be getting this training~~.
   d. If patient is admitted and in labor, she will labor and deliver in room ~~201~~**LDR 3 then remain in same room for post partum care**. ~~Designated equipment (portable fetal monitor) and use of disposable items will be considered. (Items for delivery will be moved to her location) Although not ideal,~~ LIMITED MOVEMENT of the infected person is what is BEST.

e. Staff entering the room will be restricted to essential personnel ONLY (RN/Provider/ OB Tech, etc.) Items needed for care (supplies, meds, etc.) will be BROUGHT to the ROOM by an outside source

f. A log of who enters the patient's room will be kept for any follow-up needs.

~~g.~~ If delivery does occur, MOM and BABY may be separated and isolated from each other, Baby will ~~remain in room next to mom, 200~~**be placed in an isolette. All caregivers must wear PPE while caring for baby.**~~and will have his/her own care team.~~

J. **EDUCATION:**

a. System-wide education for PPE use will be provided to all staff in high risk patient care areas (ED, RT, EVS) as well as any staff who are interested. Education will include hands on practice in donning and doffing minimum required PPE, according to CDC recommendations. Advanced PPE, including PAPR use will be provided to direct care providers in high risk areas (ED, RT).

b. Netlearning trainings are available on the doffing and donning of PPE.

i. Education for Donning and Doffing of PPE for all staff is located on the TCMC Intranet>Departments>Clinical>Clinical References>Ebola Virus Disease References: Donning and Doffing in Ebola Virus Disease.

c. Employee Health Services (see Employee Health Management EVD Protocol)

d. Employee Health Services (EHS) is charged with establishing medical evaluation, surveillance procedures and ongoing review of the health status of all personnel in the event of a potential Ebola Virus Exposure. Employee Health Services will follow guidance as directed by the County of San Diego Public Health Epidemiology, CDPH and CDC.

K. **FORM(S):**

1. Potential Exposure Contract List – Sample
2. Observer Tracking Form – Sample

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

~~2.~~**1. Online Skills: Isolation Precautions: Ebola Donning and Doffing Personal Protective Equipment**

~~L.~~**M. RELATED DOCUMENT(S):**

1. CDC: Checklist for Patients Being Evaluated for EVD in the United States
~~1.~~**2.** Direct Health Care Provider Symptom Questionnaire (EVD)
~~2.~~**3.** Employee Health Management EVD Protocol
~~3.~~**4.** Job Checklists
~~4.~~**5.** PPE and Cleaning Supply List
~~5.~~**6.** PPE Guidance Matrix by Job Positions
~~6.~~**7.** PPE Guidance Matrix for EVD
~~7. Putting on PPE Properly for Ebola (N95)~~
~~8. Removal of PPE Properly for Ebola (N95)~~
~~9.~~**8.** Room Diagram
~~10.~~**9.** Room Signage

N. **REFERENCES:**

1. **CDC General Information: https://www.cdc.gov/vhf/ebola/index.html**
2. **CDC For Clinicians: https://www.cdc.gov/vhf/ebola/clinicians/index.html**
3. **CDC for Pregnant Women: https://www.cdc.gov/vhf/ebola/clinicians/evd/pregnant-women.html**

4. CDPH Ebola Virus Disease: Information for Health Professionals: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx
5. San Diego County Health & Human Services: Ebola: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/dc/ebola.html

Potential Exposure Contract List – Sample

Tri-City Medical Center

Potential Exposure Contact list

Date:

Name	Location in Hospital	Approximate Arrival Time	Address	Phone number

Security Officer Name: _____

Observer Tracking Form – Sample

Tri-City Medical Center

Observer Tracking Form: Health Care Workers Entering Patient Care Room

Health Care Worker Name	Employee ID	Vital Signs prior to Donning (B/P, T, P, R)				Time Entered Room	Time Exited Room	Vital Signs after Doffing (B/P, T, P, R)			
		B/P	T	P	R			B/P	T	P	R

Date: _____ **Observer Name:** _____

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

Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States

Upon arrival to clinical setting/triage

- ❑ Assess the patient for a fever (subjective or ≥ 100.4°F / 38.0°C)
- ❑ Determine if the patient has symptoms compatible EVD such as headache, weakness, muscle pain, vomiting, diarrhea, abdominal pain or hemorrhage
- ❑ Assess if the patient has a potential exposure from traveling to a country with widespread Ebola transmission* or having contact with an Ebola patient in the 21 days before illness onset
  Suspect Ebola if fever or compatible Ebola symptoms and an exposure are present
  See next steps in this checklist and the Algorithm for Evaluation of the Returned Traveler for Ebola at http://www.cdc.gov/vhf/ebola/pdf/ebola-algorithm.pdf

Upon initial assessment

- ❑ Isolate patient in single room with a private bathroom and with the door to hallway closed
- ❑ Implement standard, contact, & droplet precautions
- ❑ Notify the hospital Infection Control Program at _____
- ❑ Report to the health department at _____

Conduct a risk assessment for:

High-risk exposures

- ❑ Percutaneous (e.g., needle stick) or mucous membrane exposure to blood or body fluids from an EVD patient
- ❑ Direct skin contact with skin, blood or body fluids from an EVD patient
- ❑ Processing blood or body fluids from an EVD patient without appropriate PPE
- ❑ Direct contact with a dead body in an Ebola-affected area without appropriate PPE

Low-risk exposures

- ❑ Household members of an EVD patient or others who had brief direct contact (e.g., shaking hands) with an EVD patient without appropriate PPE
- ❑ Healthcare personnel in facilities with EVD patients who have been in care areas of EVD patients without recommended PPE

Use of personal protective equipment (PPE)

- ❑ Use a buddy system to ensure that PPE is put on and removed safely

Before entering patient room, wear:

- ❑ Gown (fluid resistant or impermeable)
- ❑ Facemask
- ❑ Eye protection (goggles or face shield)
- ❑ Gloves

If likely to be exposed to blood or body fluids, additional PPE may include but isn't limited to:

- ❑ Double gloving
- ❑ Disposable shoe covers
- ❑ Leg coverings

Upon exiting patient room

- ❑ PPE should be carefully removed without contaminating one's eyes, mucous membranes, or clothing with potentially infectious materials
- ❑ Discard disposable PPE
- ❑ Re-useable PPE should be cleaned and disinfected per the manufacturer's reprocessing instructions
- ❑ Hand hygiene should be performed immediately after removal of PPE

During aerosol-generating procedures

- ❑ Limit number of personnel present
- ❑ Conduct in an airborne infection isolation room
- ❑ Don PPE as described above except use a NIOSH certified fit-tested N95 filtering facepiece respirator for respiratory protection or alternative (e.g., PAPR) instead of a facemask

Patient placement and care considerations

- ❑ Maintain log of all persons entering patient's room
- ❑ Use dedicated disposable medical equipment (if possible)
- ❑ Limit the use of needles and other sharps
- ❑ Limit phlebotomy and laboratory testing to those procedures essential for diagnostics and medical care
- ❑ Carefully dispose of all needles and sharps in puncture-proof sealed containers
- ❑ Avoid aerosol-generating procedures if possible
- ❑ Wear PPE (detailed in center box) during environmental cleaning and use an EPA-registered hospital disinfectant with a label claim for non-enveloped viruses**

Initial patient management

- ❑ Consult with health department about diagnostic EVD RT-PCR testing***
- ❑ Consider, test for, and treat (when appropriate) other possible infectious causes of symptoms (e.g., malaria, bacterial infections)
- ❑ Provide aggressive supportive care including aggressive IV fluid resuscitation if warranted
- ❑ Assess for electrolyte abnormalities and replete
- ❑ Evaluate for evidence of bleeding and assess hematologic and coagulation parameters
- ❑ Symptomatic management of fever, nausea, vomiting, diarrhea, and abdominal pain
- ❑ Consult health department regarding other treatment options

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

* See 2014 Ebola Outbreak in West Africa—Case Counts or http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/case-counts.html to determine if a country has widespread Ebola transmission

** See Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus or http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html

*** See Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Persons Under Investigation for Ebola Virus Disease in the United States or http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-specimen-collection-submission-patients-suspected-infection-ebola.html

Tri-City Medical Center

Direct Health Care Provider Symptom Questionnaire (EVD)

Direct Health Care Provider (including Lab Personnel and Anyone Managing the Waste Stream) Symptom Questionnaire (EVD)

Name_____

Employee ID #_____

Date_____

Time _____

Cell phone number (best contact #) _____

1.	Temperature:_____degrees C/F			If yes, onset and duration
2.	Nausea/Vomiting:	N_____	Y_____	_____
3.	Diarrhea:	N_____	Y_____	_____
4.	Headache:	N_____	Y_____	_____
5.	Joint or Muscle Aches, or both	N_____	Y_____	_____
6.	Stomach Pain:	N_____	Y_____	_____
7.	Lack of Appetite:	N_____	Y_____	_____
8.	Weakness:	N_____	Y_____	_____

1. All health care providers providing direct patient care (including lab personnel and anyone managing the waste stream) are **required** to complete this form at the beginning and at the end of their shift.
2. If you have a fever of ≥ 37.8 degrees C, 100 degrees F, or any of the symptoms listed above, please call Employee Health Services prior to leaving the Unit.
3. Complete an Employee Injury/Illness Form.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.
5. Any health care provider (including lab and anyone managing the waste stream) are required to monitor their temperature twice daily and monitor for any symptoms (listed above) on days not worked on the Unit. Report these symptoms immediately to Occupational Injury Management. You are required to report any fever of ≥ 37.8 degrees C, 100 degrees F or any of the following symptoms (chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain or lack of appetite) for 21 days from the last shift worked on the Unit.

Signature: _____

Tri-City Medical Center

EVD Response Plan: Protocol for employees providing direct patient care (including lab personnel and anyone managing the waste stream)

A. To provide guidelines for employees who are providing direct patient care to a patient with Ebola Virus Disease. This includes lab personnel and anyone managing the waste stream.

B. **PROCEDURE**

1. All health care providers, including lab personnel and anyone managing the waste stream are **required** to measure their temperature and complete the symptom questionnaire twice daily.
2. Employees are required to report:
   a. Fever of 100 degrees F or equal or greater than 37.8 degrees C
   b. Symptoms of chills, malaise, headache, joint/muscle aches, weakness, diarrhea, nausea/vomiting, stomach pain, or lack of appetite.
   c. If symptomatic, **do not** leave the Unit; notify EHS, department manager/ designee and you will be evaluated in the Emergency Department.
3. Employees, who have provided care to a patient with Ebola, are **required** to complete the questionnaire and take their temperature twice a day, for **21 days** from the last shift worked and report to EHS if temperature or symptoms develop.
4. If you are unable to work an assigned shift, notify the Unit Manager/designee as well as EHS as soon as possible.

C. **COMPLIANCE**

1. Compliance with this policy is mandatory. Employees who do not comply with this requirement may be subject to disciplinary actions.

Tri-City Medical Center

A. Job Descriptions Overview:
   1. Observer #1
   2. Observer #2
      a. Please Note: There are two observer positions:
         i. One posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window
         ii. the other posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
      b. In Room Observer (Optional Role)
      c. Assistants
         i. Ante Room Assistant
         ii. Decon Room Assistant
   3. Charge Nurse

Tri-City Medical Center

Observer #1:

A. Location: posted in the ED outside of room C25 and C26 to view health care actions within room through the glass window (Stationed at all times)
B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation
C. Perform the following activities:
    1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
    2. Limit anyone entering and exiting room
    3. If anyone tries to enter, direct them to the entrance outside C26 Ambulance Bay. (see Diagram in Rom Diagram).
    4. Do not allow visitors (unless approved by Public Health).
    5. Look through window outside of room C26 during patient care activities: Observe practice of worker within room to ensure that worker does not contaminate self (ie. Accidently remove PPE, compromise PPE, etc).
    6. Provide immediate corrective action if the worker does not follow recommended activities.
    7. Should know the exposure management plan in the event of the unintentional break in the procedure
    8. Helps to coordinate patient care rotation

Tri-City Medical Center

Observer #2:

A. Location: Posted outside of room C26 ambulance bay to assist with Donning and Doffing procedures.
B. Role: Observe and read aloud each step of the Donning and Doffing of the Worker entering/exiting the patient room. Ensure adherence to the donning and doffing process. Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The Observer does not participate in any Ebola patient care activities while conducting observation
C. Perform the following activities:
    1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
    2. Limit anyone entering and exiting room
    3. Document and record anyone entering and exiting room with corresponding time. (see Observer Tracking Form).
    4. Do not allow visitors (unless approved by Public Health).
    5. Obtain vital signs of worker prior to donning PPE.
    6. Read aloud each step of the donning and doffing procedure. Refer to PPE Guidance Matrix for EVD for each step.
    7. Provide immediate corrective action if the worker does not follow recommended step
    8. Should know the exposure management plan in the event of the unintentional break in the procedure
    9. Ensure the following after worker leave decon area. Ensure worker has at least a ½ break before resuming activities and rehydrates.

Tri-City Medical Center

In Room Observer (Optional Role):

A. Location: posted in the patient care room
B. Role: Observe for safe worker practice while in room (i.e. worker not contaminating self while in room). The In Room Observers primary role is not to perform patient care activities but to conduct observation (But may assist with patient care activities as needed).
C. Perform the following activities:
    1. Wear appropriate PPE (see PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD)
    2. Do not allow visitors (unless approved by Public Health).
    3. Observe practice of worker within room to ensure that worker does not contaminate self (ie. accidently remove PPE, compromise PPE, etc).
    4. Assist with patient care activities as needed.
    5. Provide immediate corrective action if the worker does not follow recommended activities.
    6. Should know the exposure management plan in the event of the unintentional break in the procedure
    7. Role will transition into primary patient care worker and be replaced by a new In room observer.

Assistants:

A. Ante Room Assistant
   1. Role: Assist the "Clean" worker in the Ante Room to don the PPE.
   2. Perform the following:
      a. Wear appropriate PPE. PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
      b. Assists the "Clean" Worker in donning the PPE under the guidance of the observer
      c. Confirm visually that all PPE is serviceable
      d. Confirm the integrity of the ensemble with no skin or hair visible

B. Decon Room Assistant
   1. Role: Assist the "Dirty" worker in Decon in removing the PPE.
   2. Perform the following:
      a. Wears the same level of PPE as the worker (caring for the patient). PPE Guidance Matrix by Job Position and PPE Guidance Matrix for EVD
      b. Assists the "Dirty" Worker in removing the PPE under the guidance of the observer
      c. Periodically clean the decon area and decon area floors when visibly soiled using EPA approved disinfectant: bleach

Tri-City Medical Center

Charge Nurse

A. Role: Oversee the management & coordination of the patient care.
B. Perform or assign the following initial steps:
    1. Contact Security
    2. Contact Administrative supervisor (who should contact Infection control)
    3. Contact Public Health (619-692-8499)
    4. Contact Engineering: to start monitoring room and they will call the company to set up decon room containment.
    5. Prepare the Room (C26)*
        a. Cover equipment in room with C-arm
        b. Place commode with red bags in the room
    6. Get the PPE cart from Disaster cage (basement)
C. Perform or assign the following continuing steps:
    1. Oversee additional PPE supply needs

Tri-City Medical Center

High Level PPE Direct Caregiver	Step Down PPE Indirect Care	Cleaning Supplies
Item Description	Item Description	Item Description
TYCHEM SUIT - LG	TYCHEM HOODED SUIT – LG	DISINFECTING DETERGENT 4X 1GAL
TYCHEM SUIT - XL	TYCHEM HOODED SUIT - XL	SANI-CLOTH WIPES -PURPLE TOP
TYCHEM SUIT - 2XL	TYCHEM HOODED SUIT – 2XL	SANI-CLOTH XLG 8X14 PURPLE TOP
LEVEL 4 SURGICAL GOWN – LG GO	N95 MASK – SM, MED, LG	BLEACH WIPES
KNEE HIGH SURGICAL BOOTS - LG	LEVEL 4 SURGICAL GOWN - LG	ABSORBENT 21GR
PLASTIC APRON	KNEE HIGH SURGICAL BOOTS - LG	
PLASTIC SAFETY GOGGLES	PLASTIC APRON	
FACE SHIELD	GLOVE NITRILE 6" - SM, MED, LG	
TYVEK SHROUDED PAPR HOOD	GLOVE NITRILE 8" – SM, MED, LG	
COVER BOOT – LG	FACE SHIELD	
GLOVE NITRILE 6" - SM, MED, LG	PLASTIC SAFETY GOGGLES	
GLOVE NITRILE 8" – SM, MED, LG	SURGICAL HEAD COVER	
DUCT TAPE		
BELT MOUNTED PAPR W CARTRIDGE (OBTAIN FROM SPD)		

Tri-City Medical Center

Role	Observer 1	Observer 2	In Room Observer	Anteroom Assistant	Decon Assistant	Direct Caregiver	EVS
Description of role	Posted outside room to view actions in the room through window. Redirects caregiver when needed to protect from contamination. Provide aide if needed. Link for communication outside room.	Posted outside to direct Donning and Doffing - Reads step by step the donning or doffing process and observes to make certain correctly completed. Observes for any signs of contamination during doffing.	Optional: depends on how sick patient is and how much care is required	Hands on assistance with doffing	Hands on Assistance with doffing	Anyone working inside the patient room	Cleaning outside patient room. (Cleaning inside room, handling linens or trash from inside the room is considered Direct care.
Level of PPE required	Tychem suit Knee high surgical boots Readily available if needed for assistance in room: PAPR with Cartridge Shrouded PAPR Hood Level 4 Surg. Gown Plastic Apron Cover boot 2 pr long nitrile gloves 1 pr. reg nitrile gloves. Duct tape	No PPE necessary	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	No PPE necessary	Same level of PPE as person assisting with doffing. (N95 or PAPR) Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	PAPR with Cartridge Tychem suit Level 4 Surg. Gown Knee high surgical boots Plastic Apron Shrouded PAPR Hood Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape	Correct size N95 mask. (If unable to be fit test N95, must wear PAPR) Tychem suit Level 4 Surg. gown Knee high surgical boots Plastic Apron Safety Goggles Face shield Cover boot 2 pr. long nitrile gloves 1 pr. reg. nitrile gloves Duct tape

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Direct Care Giver –PAPR)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O Long nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvek jumpsuit (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Put on PAPR hood
- O Attach PAPR and secure around waist.
- O Blue surgical gown over the jumpsuit and inside layer of PAPR hood. Tie.
- O Put outer layer of hood down over shoulders.
- O Long Nitrile gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

Tri-City Medical Center

Trained Observer Checklist
Doning PPE properly for Ebola
(Indirect Care Giver –N95 mask)

- O Change into Hospital scrubs
- O Hand Hygiene
- O Take and record vital signs
- O Hydrate
- O Assemble needed equipment and inspect for integrity.
- O 12" nitrile gloves
- O Blue surgical booties on over scrub pants.
- O Put on Tyvekjumpsuit with hood (over gloves and booties)
- O Zip the jumpsuit to the chin
- O Tape gloves to the jumpsuit with tab at end of tape.
- O Blue surgical gown over the jumpsuit. Tie.
- O 12" Nitra-gloves over the surgical gown.
- O Tape (and tab) gloves to gown at top of gloves
- O Bouffant cap if needed to contain hair
- O Proper size N95 mask
- O Goggles
- O Put hood on & zip the jumpsuit the rest of the way
- O Face shield over the hood and tape (with tab) to hood. (No exposed skin or hair)
- O Put black boots on over the jumpsuit.
- O Tape the boots to the jumpsuit at the top of the boot.
- O Apron
- O Gloves – no tape.

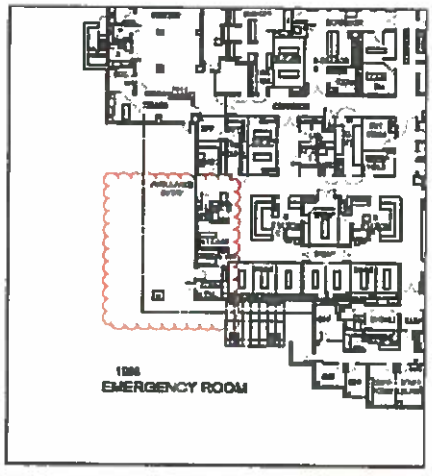
Tri-City Medical Center

A. C 26(Negative Pressure Room): Patient Care room
B. C25 (Inside of ED): Cordon off area. This is controlled area. Do not enter room from this side. This is where Observer #1 observes practice through window.
C. Outside of C26 (Ambulance Bay area): Doffing & Decon area- containment set up by ATI.

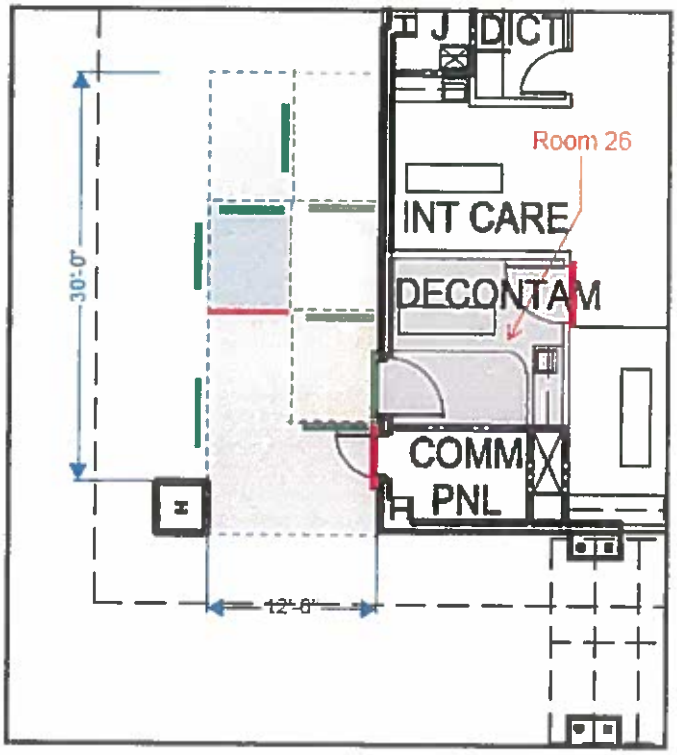
Tri-City Medical Center
Infectious Diseases
Barrier Layout







BARRIER LAYOUT



ADMIT PATHWAY & SUPPLY ROOM
EXIT ROOM
CLEAN ROOM
PPE ROOM
SHOWER ROOM
DIRTY ROOM
ROOM 26

PPE Storage and Donning Area

Patient Room

(Keep door Closed)

PPE Removal Area

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

SUBJECT: **Prion Diseases: Transmissible Spongiform Encephalopathies (TSE) such as: Creutzfeldt-Jakob disease (CJD) and Variant (vCJD), ~~Gerstmann-Sträussler-Scheinker Syndrome (GSS), Kuru, Fatal Insomnia, or Bovine Spongiform Encephalopathy (BSE or Mad Cow disease)~~**

ISSUE DATE: 01/03
REVISION DATE(S): 01/09, 02/12, 02/17

Department Approval:	**06/2020~~17~~**
Infection Control Committee Approval:	**~~07/17~~09/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~11/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **INTRODUCTION:**

1. Prion diseases or transmissible spongiform encephalopathies (TSE's) are a family of rare progressive neurodegenerative disorders that affect both humans and animals. They are distinguished by long incubation periods, characteristic spongiform changes associated with neuronal loss, and a failure to induce inflammatory response. The causative agents of TSE's are believed to be prions. The term "prions" refers to abnormal, pathogenic agents that are transmissible and are able to induce abnormal folding of specific normal cellular proteins called prion proteins that are found most abundantly in the brain. This abnormal folding of the prion proteins leads to progressive degenerative brain and nervous system damage. Prion diseases are usually rapid progressive and always fatal. Examples of Human Prion Diseases: Creutzfeldt-Jacob Disease (CJD), Variant Creutzfeldt-Jakob Disease (vCJD), Gerstmann-Straussler-Scheinher Syndrome, Fatal Familial Insomnia, and Kuru. Examples of Animal Prion Diseases: Bovine Spongiform Encephalopathy (BSE or Mad Cow Disease), Chronic Wasting Disease, and Scrapie.
2. Prion diseases are not known to spread by contact from person to person. In the healthcare setting, risk of transmission to patients has been associated with direct contact with infectious tissues (See B.7. Tissue Infectivity). Contaminated surgical equipment or implantation of electrodes deep in the brain can also transmit infectious prions from one patient to another. Transmission has occurred during invasive medical interventions (two confirmed and four unconfirmed cases) after contaminated medical equipment was not properly cleaned before use on another person.
3. The prions that cause TSE's exhibit an unusual resistance to conventional chemical and physical decontamination methods. The infectious agents that transmit prion diseases are resistant to inactivation by heat and chemicals, and therefore require special biosafety precautions. Incineration is the preferred method for all instruments exposed to high infectivity tissues.
4. Prion diseases are transmissible by inoculation or ingestion of infected tissues. A new variant CJD has been linked to eating contaminated beef, elk or deer meat.
5. Symptoms include an insidious onset of confusion, progressive dementia, variable ataxia, seizures, visual or sensory deficits, and rapid mental deterioration in patients' aged 16+, most frequently between 40 and 70 years old. Incubation period ranges from 15 months to more than 30 years, usually fatal within 1 year after diagnosis.
6. **The most common form of classic CJD is believed to occur sporadically at a rate of**

approx 1-1.5 cases per million population per year. ~~The most common form, sporadic Creutzfeldt-Jakob disease (CJD), has a worldwide death rate of about 1 case per million people each year~~.

B. **PATIENT CARE:**

1. Normal social and patient contact, and non-invasive procedures with TSE patients do not present a risk to healthcare workers, relatives, other patients or visitors.
2. Standard precautions should be used for all known or suspected cases.
3. It is very important that patients who are known or suspected to have prion disease be identified before any surgical procedure involving tissues that may be infectious.
4. Patients with TSEs must not donate organs, tissues, or blood components.
5. TSE is not known to be transmitted from mother to child during pregnancy or childbirth.
6. To prevent the transmission, it is important to consider: (1) the probability that an individual has or will develop TSE, (2) the level of infectivity in tissues or fluids, and (3) the nature or route of the exposure. Risk assessment and prevention of exposure through the use of personal protective equipment and disposable equipment are the best means to reduce any risk of transmission in the healthcare setting [Assignment of different organs and tissues to categories of high and low infectivity is chiefly based upon the frequency with which infectivity has been detectable, rather than upon quantitative assays of the level of infectivity, for which data are incomplete.]
7. Tissue infectivity:

a.	Highly infective tissues	Brain, spinal cord and eye
b.	Low infective tissues	Cerebral spinal fluid, lung, liver, kidney, spleen/lymph nodes, and placenta
c.	Not infective	Heart, skeletal muscle, peripheral nerve, adipose tissue, gingival tissue, intestine, adrenal gland, thyroid, prostate, testis) or in blood, bodily secretions or excretions (urine, feces, saliva, mucous, semen, milk, tears, sweat, serous exudates).

8. Route of exposure:

a.	Very serious risk	CNS exposures (i.e. inoculation of the eye or CNS)
b.	Greater potential risk	Transcutaneous exposures: cut or puncture by a contaminated sharp instrument or contact with the mucus membrane of the eye
c.	Negligible risk	Cutaneous exposure of intact skin or mucous membranes, except those of the eye

C. **DIAGNOSTIC AND SURGICAL PROCEDURES**

1. All non-emergent brain biopsy procedures and neurosurgical and neuroophthalmology procedures are screened by the schedulers in Surgery Services or Interventional Radiology (See Appendix A). If the brain biopsy is for any reason other than tumor, or if TSE is suspected, notify the departments listed on the screening tool so that planning can be made for instrument handling, storage, cleaning and decontamination or disposal.
   a. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details. Clinical Laboratory stores 1 Molar sodium hydroxide.
   b. All known cases and cases that meet the case definition of suspect Transmissible Spongiform Encephalopathies will be performed with disposable instruments whenever possible.
   c. Procedures that are normally carried out at the bedside (e.g. lumbar puncture) may be performed at the bedside. Use a chux at the site to contain a potential spill of infective material.
   d. Alert the laboratory and clearly label all specimens. Place specimens in formalin as

usual.

2. Dental Procedures: general infection control practices recommended by national dental associations are sufficient when treating TSE patients during procedures not involving neurovascular tissue. The following are precautions for major dental work:
   a. Use single-use items and equipment e.g. needles and anesthetic cartridges.
   b. Re-usable dental broaches and burrs that may have become contaminated with neurovascular tissue should be destroyed after use by incineration or decontaminated by a method listed on Controlling TSE Agent Transmission Table on pages 6, 7, 8, and 9 for details.
   c. Schedule procedures involving neurovascular tissue at end of day to permit more extensive cleaning and decontamination.
3. If reusable instrumentation must be used keep instruments and other devices moist between the time of exposure to infectious materials and subsequent decontamination and cleaning. See Appendix B for Instrument Handling algorithm and Controlling TSE Agent Transmission Table on pages 6,7, 8, and 9 for details.
   a. Remove bio-burden from reusable instruments while wearing a face shield or goggles and surgical mask and double glove. Instruments are then placed in a flash pan for processing as close as possible to the room where the procedure was performed. Autoclave for 18 minutes at 134°C.
   b. If the procedure was performed in another department (for example a brain biopsy in the CT scan) call Sterile Processing Department for assistance with autoclaving.
   c. After autoclaving place instruments in a robust, leak-proof container labeled "Incinerate Only". This box will be placed and remain in a designated locked area.
      i. If the laboratory result is negative, all items can be returned to the decontamination area and reprocesses as normal.
      ii. If the laboratory result confirms a Transmissible Spongiform Encephalopathy, the instruments will be sent out for incineration.
4. See unit specific policies for safety in the Clinical Laboratory.
5. Occupational exposure
   a. There have been no confirmed cases of occupational transmission of TSE to humans. Report any occupational exposure to blood, body fluids, or other potentially infectious materials to your supervisor and go to Emergency Room for assistance.

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

1. Controlling TSE Agent Transmission in the Hospital
2. Employee Health & Wellness: Injury Illness Prevention Program
3. Infection Control Policy: Standard and Transmission Based Precautions
4. Infection Control Policy: Bloodborne Exposure Control Plan
5. Instrument Handling Algorithm
6. Laboratory Microbiology Policy: Tissues Handling Protocol
7. Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

E. **REFERENCE(S):**

1. Brown, P., Wolff, A., Gajdusek, D.C. (1990) A simple and effective method for inactivating virus infectivity in formalin-fixed tissue samples from patients with CJD. Neurology, 40: 887-890
2. Karasin, M. (2014, October). Special Needs Populations: Perioperative Care of the Patient with Creutzfeldt-Jakob Disease. Vol 100, No 4.
3. Kavanagh, B. (2014) Creutzfeldt-Jakob disease and other Prion Diseases. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 73:1-14.
4. Rutula, W., and Weber, D. (2010, February). SHEA Guideline: Guideline for Disinfection and Sterilization of Prion-Contaminated Medical Instruments. *Infection Control and Hospital Epidemiology*, Vol 31, No.2, 107-117.

5. Steelman, V.M. (1994) Creutzfeld-Jakob Disease: recommendations for infection control. American Journal of Infection Control, 22(5): 312-318.
6. www.who.int/emc WHO Infection Control Guidelines for Transmissible Spongiform Encephalopathies. (1999)
~~6.~~7. **ANSI/AAMI ST79:2017 page 124 C.2**

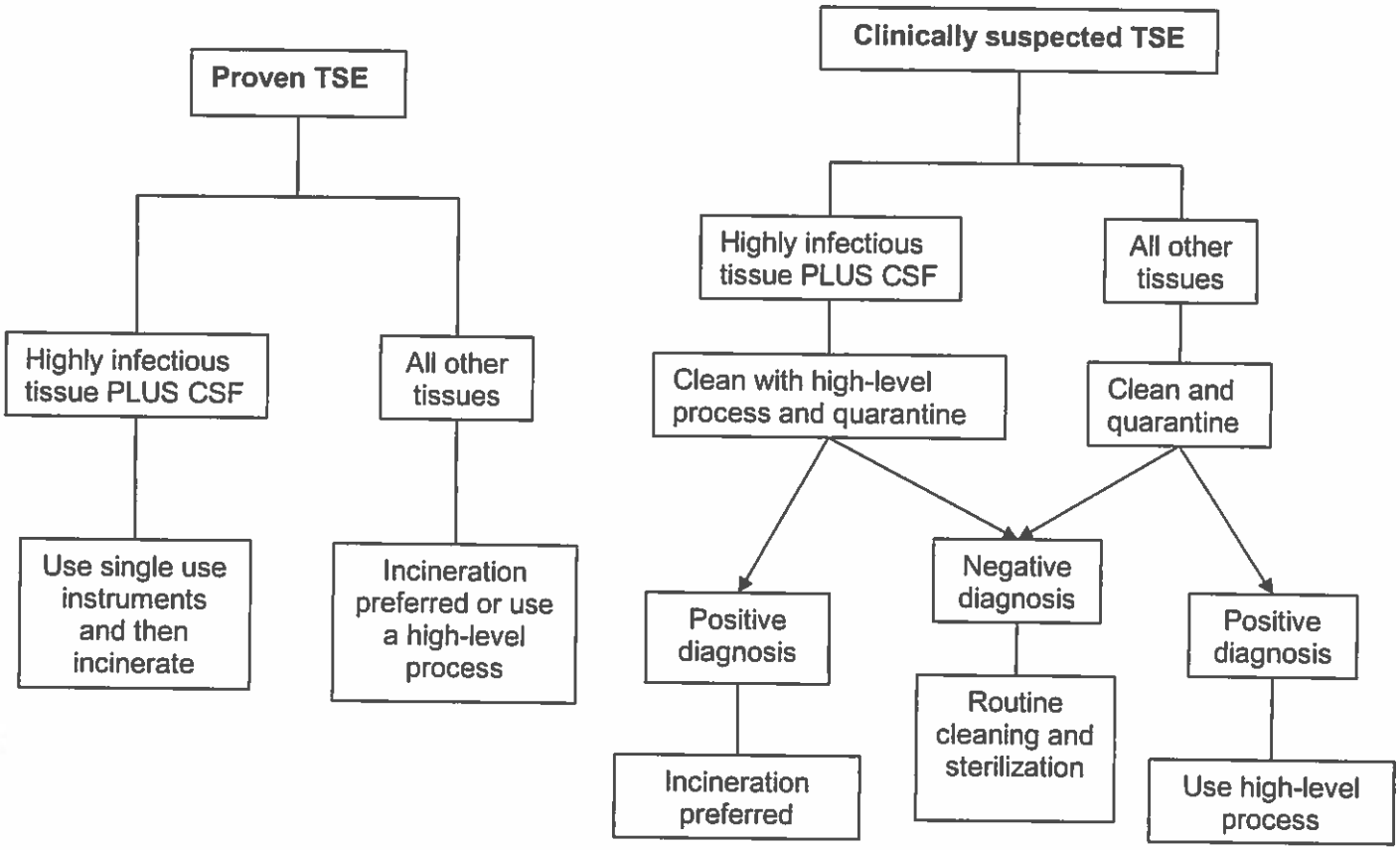
Diagnosis	Procedures	Method and product/devices		Comments
Sporadic CJD; suspected TSE; at risk for CJD asymptomatic; (hormone recipient, dura mater transplant, familial CJD in a first degree relative).	1. Noninvasive procedures 2. Care after death, no postmortem performed 3. Employee sharps injury	1. Use standard cleaning, regular laundering, and routine waste handling. 2. Gently encourage site to bleed, wash with warm soapy water, rinse, and cover with a waterproof bandage.		1. There is no epidemiological evidence that normal contact presents a risk to health care providers. Procedures involving high-risk tissue or fluid, e.g., brain, spinal cord, pituitary, dura mater, retina, and cornea, require use of disposal aprons/gowns, gloves and single-use instruments/equipment. See next section. 2. Refer to special handling of tissue and special handling of the body after pathology procedures and postmortem. 3. Document all incidents. Maintain all files in the Employee Health dept.
Diagnosis	**Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)**	**Other nondisposable equipment**		
Known TSE	• Where possible, avoid performing OR procedure. • If procedure must take place, book case at the end of the day. • The surgeon is to alert Surgery or Interventional Radiology when scheduling procedures. Schedulers are to notify the departments listed on the Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool. • Use dedicated sterile equipment or equipment nearing "end-of-life use" where possible. • Use disposable OR packs, gowns, drapes. • Use nonelectrical (mechanical)	• Cover nondisposable power equipment that must be used with plastic drapes. • Avoid touching surfaces with gloves, which have been in contact with brain, spinal cord and adjacent tissue. If in doubt, change gloves. • Keep the least amount of	Steps, OR Room: 1. Use damp cloth/sponge, superficial cleaning method 2 N NaOH undiluted for surfaces in the OR. 2. At end of case, place cleaning cloths in an "Incinerate Only" box. 3. Chemical disinfection - 2 N NaOH undiluted, disassembled equipment, completely submerged, or continuously wet for 60 min. Rinse in water and wipe dry.	• Consult with Sterile Processing Department (SPD) for supply and use of equipment nearing end-of-life use. (NaOH is highly corrosive). • Cases booked at the end of the day allow for surface decontamination of "touch surfaces" at end of the case with noxious agents (2 N NaOH undiluted for one hour and rinsed with water, non-critical patient care items and surfaces). • 2.5% sodium hypochlorite has been inconsistent in

	hand saws/drills. • Incinerate disposable supplies when procedure is complete. Suction wastewater and treat container with Premicide prior to placing in "Incinerate Only" box. 1. During procedure, use a damp cloth OR sponge-superficial wiping method to keep items clear of debris. Avoid excess handling of instruments. 2. At the end of the procedure, place all disposables in an "Incinerate Only" box and call the waste management vendor for disposal. Do not put any instruments from this case in contact with reusable containers.	equipment in the room. • Completely isolate/drape anesthetic/respiratory equipment near the patient's head to prevent accidental splatter or contamination of the equipment.	4. Confine and contain all effluent for incineration. Treat with Premicide to solidify waste for ease of handling 5. Manual clean instruments in OR area while wearing full face shield or mask and goggles. 6. Steam autoclave reusable items for 18 min. at 134 C; use an open container in a prevaccum sterilizer. 6. Place in an "Incinerate Only" box and transport to SPD for quarantine in the in a designated locked area.	killing the scrapie agent. • Tissue dried on instruments, which have not been inactivated first by NaOH, may have a protective effect on the TSE agent and render the autoclave process ineffective. Keep instruments moist until decontamination occurs.
Diagnosis	**Equipment used for neurosurgery (brain, spinal cord, dura, pituitary, neuroophthalmology)**	**Other procedures, equipment, potential risk**		**Comments**
Suspected TSE	Follow steps as above. SPD 1. Quarantine autoclaved reusable equipment until the diagnosis is finalized. • If confirmed positive, incinerate equipment. • If negative, follow regular cleaning in a washer disinfector, then routine sterilization.	Follow steps as above.		See comments above.
At risk for TSE asymptomatic (hormone recipient, dura mater, corneal transplant,	• Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period). Use disposable instruments wherever possible and follow steps as above.	Follow standard cleaning and sterilization.		• Regular cleaning and disinfection procedures with a hospital grade disinfectant in a basin (contact time according to label recommendation).

familial CJD in a first-degree relative.			• the incubation period for TSE is long. • Asmptomatic patients have very low infectivity. • Upgraded neurosurgical procedure equipment sterilization cycles will provide a margin of safety in the very rare event a TSE diagnosed case is found.
Diagnosis	**Lumbar puncture/biopsies**	**Specimen handling**	**Comments**
Known TSE Suspected TSE At risk for TSE asymptomatic	• Notify Infection Control • Only trained staff aware of TSE hazards should perform these procedures. • Perform procedures in an OR environment whenever possible. • Use disposable, single-use equipment where possible. • Incinerate packs, gowns, barrier drapes after use. • Where possible, avoid performing the OR procedure. • If diagnosis is delayed (long incubation period) use disposable instruments wherever possible or use the NaOH decontamination process (see above procedure for suspected TSE). • Regular cleaning and sterilization	• It is prudent to refer to a specialist neuropathology lab center for brain and tissue biopsy material. • Containment is level 3 for central nervous system (CNS) samples. See department specific P&P. • Other clinical specimens are handled as per standard routine infection control precautions. • Tissue may still be **infectious after fixation**~~infective if fixed~~ in ~~formaldehyde~~ **formalin** and **formic acid**~~then c-steam sterilized~~. • Other clinical specimens are handled as per standard routine infection control precautions. Other clinical specimens are handled as per standard routine infection control precautions.	• Routine disinfection for all non-contaminated surfaces. • Cases booked at the end of the day allow for decontamination of brain tissue contaminated surfaces with a solution of 2 N NaOH undiluted for one hour and rinsed with water, non critical patient care items and surfaces. Pay close attention to technique to avoid contamination and decrease the need for additional use of NaOH. • 2.5% sodium hypochlorite has been inconsistent in killing the scrapie agent.

Instrument Handling Algorithm

Decontamination and disposition of instruments and equipment used with confirmed or suspected Transmissible spongiform encephalopathies (TSEs) patients.



Neurosurgery Transmissible Spongiform Encephalopathies Screening Tool

This information is required when scheduling any patient for non-emergent craniotomy or brain biopsy to identify potential Creutzfeldt-Jakob Disease (CJD), Bovine Spongiform Encephalopathy (BSE), Gerstemenn-Straussler-Scheinder Syndrome (GSS), Kuru, or Fatal Insomnia

	Circle One	
1. Does the patient present with symptoms of TSE (rapidly progressive dementia, cerebella symptoms, spasticity or hyper-reflexia, EEG with periodic sharp-wave complexes, rapid cerebral atrophy on CT scan)?	Yes	No
2. Does the patient have a family history of CJD or CJD-like fatal illness?	Yes	No
3. Is the patient being scheduled for craniotomy or brain biopsy when diagnosis is unknown or uncertain (no specific lesion identified by imaging procedures)?	Yes	No
4. Is the biopsy for the diagnosis of dementia or encephalitis?	Yes	No

Patient Name_____ Today's Date_____

Surgeon providing the screening information_____

Office personnel providing the screening information_____

Print name of scheduler taking the Information_____

A "No" answer may be scheduled as usual.

A "Yes" answer to one of these questions means the patient meets the case definition of suspect Transmissible Spongiform Encephalopathies. Call the following services below to report and reference the policy in the Infection Control Manual, Transmissible Spongiform Encephalopathies.

Service	Phone Number	Message left	Spoke with (name of person) and Comments
Neuro-Speciality Coordinator	5400		
Environmental Services	7295		
SPD Ops Manager	7338		
Histology Supervisor	7914		
Infection Control	~~7410 or~~ 5696		
Pharmacy	3012		

Tri-City Health Care District
Oceanside, California

Infection Control

ISSUE DATE: 09/01 **SUBJECT: Required Reporting**

REVISION DATE: 06/14

Department Approval:	~~09/17~~08/2020
Infection Control Committee Approval:	10/17
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~11/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **PURPOSE:**

1. To promote consistent reporting practices of Reportable diseases required by Title 17, California Code of Regulations for Reportable Diseases and to assist the hospital Infection Control Program to intervene rapidly when appropriate. State law mandates when and how to report (i.e. in writing, by phone, or fax transmission) depending on the disease or condition.

B. **PROCEDURE:**

1. Completing the required reporting to the local public health officer is the responsibility of every healthcare provider (physician, podiatrist, nurse practitioner, physician assistant, registered nurse, nurse midwife, or medical examiner) whom knows of, or in attendance on a case or suspected case of any of the required reportable diseases or conditions.
   a. For inpatients, contact Infection Control ~~(at 760-940-7410 or~~ 760-940-5696~~)~~ for reporting assistance.
2. A list of required reportable diseases for healthcare providers is listed on the Confidential Morbidity Report (CMR) available at:
   ~~a. http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html~~
   SanDiegoCounty.gov
3. The CMR can be used for most reports (see TB and HIV/AIDS below). Forms for reporting are available at the CMR website.
   a. Urgent information should be reported via telephone:
      i. Epidemiology: 619-692-8499
      ii. STD: 619- 692- 8501
      iii. Tuberculosis: 619- 692- 8610
      iv. For diseases that require "immediate" reporting on weekend/holidays contact 858-565-5255.
   b. Most diseases are required to be reported within one working day and can be mailed, faxed or telephoned, refer to the CMR for disease specific reporting time frames.
   c. Mail information to the County of San Diego, Health and Human Services Agency, Public Health Services, 3851 Rosecrans St. San Diego, California 92110. Please note the department (i.e. Epidemiology, STD, TB Control, or Immunizations branch).
   d. "Fax" information to:
      i. Epidemiology: 858-715-6458
      ii. STD: 619- 692- 8541
      iii. Tuberculosis: 619- 692- 5516
4. HIV infection and AIDS are reportable in California using the required form (not CMR). The clinical laboratory or physician can notify Infection Control to report.

~~a. http://www.sandiegocounty.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html~~ **SanDiegoCounty.gov**

5. Tuberculosis (TB) reporting is mandated by the Gotch Bill (AB 804) and requires a special form:
   ~~a. http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport2014.pdf~~ **SanDiegoCounty.gov**
   ~~b.~~**a.** See the Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan for further TB reporting requirements. Notify Infection Control during regular work hours Monday through Friday, or the Administrative Supervisor during holidays and weekends for reporting assistance.
6. Clinical Laboratory
   a. Microbiology will telephone the San Diego County Health and Human Services for communicable diseases listed under Report Immediately or Report Within One Working Day.
   b. Infection Control will be immediately notified of positive Acid-Fast Bacilli (AFB) smears or cultures and positive TB results in order for timely reporting and follow up.
   c. Suspected or known meningococcal infections will be immediately reported to Infection Control or the Administrative Supervisor on evening, night and weekends, and holiday shifts.

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

1. Confidential Morbidity Report (CMR): http://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/community_epidemiology/disease_reporting_requirements_for_health_care_providers.html
2. HIV/Aids Reportable Form: http://www.sandiegocounty.gov/hhsa/programs/phs/hiv_aids_epidemiology_unit/health_care_provider_toolkit.html
3. Tuberculosis Reporting Form: ~~http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport2014.pdf~~ **https://www.sandiegocounty.gov/content/sdc/hhsa/programs/phs/tuberculosis_control_program/reporting.html**

~~3.~~**4.**

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

1. Administrative Policy: Mandatory Reporting Requirements, 236
2. Infection Control Policy: Aerosol Transmissible Disease and Tuberculosis Exposure Control Plan
3. Infection Control Policy: Bloodborne Pathogen Exposure Control Plan

E. **REFERENCE(S):**

1. Consent Manual (2019~~7~~, 464th ed.)California Hospital Association
2. County of San Diego, Public Health Services Reporting Instructions and Requirements (Program specific Information through Community Epidemiology, Tuberculosis Control and Refugee Health Program, and the HIV, STD and Hepatitis Branch).
3. ~~https://archive.cdph.ca.gov/HealthInfo/Documents/Reportable_Diseases_Conditions.pdf~~
3. **https://www.cdph.ca.gov/Programs/PSB/Pages/CommunicableDiseaseControl.aspx**
4. **Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions***
5. ~~California State Department of Health: Communicable Disease Control and Prevention: Title 17 California Code of Regulations Section 2500..~~

Tri-City Medical Center	~~Distribution:~~ Women **and**~~&~~ Newborn Services **Neonatal Intensive Care Unit (NICU)**
PROCEDURE:	**BREAST MILK MANAGEMENT IN THE NICU**
Purpose:	To provide a standardized process for collection, storage and handling of maternal breast milk in the Neonatal Intensive Care Unit (NICU).
~~Supportive Data:~~	~~Mothers giving their babies pumped milk in the hospital setting is part of a wellness program that hospitals support. If circumstances such as separation of mother and baby occur, then the staff is to provide for and educate the mother in proper pumping, handling and storing of human milk.~~
Equipment:	1. Hospital-grade electric breast pump 2. Sterile, rigid, clear plastic (BPA-free) containers with screw-on lid ~~or plastic bags designed for human milk freezing (for collection and storage)~~ 3. Gloves 4. Pre~~-stamped~~**-inted** labels bearing two patient identifiers and bar code 5. Dedicated refrigerator **and freezer** ~~6. dedicated freezer that does not self-defrost~~ ~~7.~~**6.** Bins in refrigerator **and**~~or~~ freezer for expressed breastmilk containers ~~8. BPA-free, single-use, disposable bottles with disposable nipples (for feeding)~~ ~~9.~~**7.** Additional Feeding Supplies as needed (e.g., syringe, ~~feeding bag,~~ feeding tube, syringe pump**, disposable nipples**) ~~10. Breast milk scanner~~ ~~11.~~**8.** Breast milk warmer

A. **DEFINITION(S):**

1. Fresh/Raw Milk – Expressed breast milk.
2. Fresh/Frozen Milk – Freshly expressed breast milk that has been frozen and kept at approximately less than or equal to -20°C (-4° F).
3. Thawed Milk – Breast milk that has been previously frozen. Thawed milk must be used within 24 hours.
4. Heat Processed Milk – Fresh-raw and/or fresh frozen milk that has been heat-treated as per milk banking guidelines.

B. **POLICY:**

1. All mothers should be instructed on the proper techniques of milk collection to minimize bacterial contamination.
2. ~~Discourage breastfeeding for:~~
   - a. ~~Mothers with HIV~~
   - b. ~~Untreated active tuberculosis~~
   - c. ~~Infection with human T-cell lymphotrophic virus type I or type II~~
   - d. ~~Active herpes simplex virus (H SV) lesions on the breast~~
   - e. ~~Mothers who are taking medication that is contraindicated~~
   - f. ~~Mothers who are undergoing radiation therapy or chemotherapy with agents such as antimetabolites that interfere with DNA replication and cell division~~
   - g. ~~Mothers who are using illicit drugs.~~
3. ~~Breastfeeding is also contraindicated when the neonate has inborn errors of metabolism (for example Galactosemia and Phenylketonuria) and must be fed non-lactose based formula.~~
4. ~~Do not store breast milk from mothers who are positive for hepatitis B surface antigen (HBsAg) with breast milk for other neonates because of possible contamination.~~

C. **PROCEDURE:**

1. Storing breastmilk:

Department Review	Perinatal Collaborative Practice	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/03, 05/06, 06/07, 05/08, 04/10, 06/20	02/13, 04/17, 09/20	n/a	05/13, 05/17, 10/20	12/20	06/13, 06/17, n/a	06/13, 06/17

a. Gloves are worn when preparing breast milk or when spillage may occur. General guidelines for determining which breast milk to use, unless otherwise ordered:
   i. Fresh colostrum
      1) Colostrum containers are numbered by the RN in the order it was pumped.
      2) Containers are numbered for 5 days unless milk production is delayed.
      ~~2)~~**3)** ~~.~~The RN assesses ~~the~~ milk for maturity and discontinues numbering once mature milk is visualized.
      ~~3)~~**4)** Each pumping session counts as a single number.
      ~~4)~~**5)** The colostrum is fed to the baby in chronological order.
      ~~5)~~**6)** Chronologic order takes precedence over fresh versus frozen colostrum.
      ~~6)~~**7)** Frozen colostrum shall be thawed and fed in chronologic order.
      ~~7)~~**8)** Care shall be taken to keep colostrum fresh ~~as much as~~**when** possible.
      9) After 48 hours of colostrum feeds, colostrum may be alternated with fresh, mature milk.
   ii. Fresh expressed milk
   iii. Refrigerated milk
   iv. Oldest dated frozen milk

b. **For storage of breastmilk, generate a bin label from the barcoding system that contains the infant's name, medical record number, and a barcode.**

c. Breast milk will be stored fresh whenever possible. Only overstock should be stored in the freezer.

d. At all times, all containers shall be labeled with patient identification label generated from the ~~TCMC~~ breast milk barcoding system. **Milk containers must be scanned ("received") into the breastmilk barcoding system in order to perform any of the following functions: administer, prepare, divide, combine or discharge.**

~~e. Breast milk is discarded only when expired or with a physician or allied health professional's (AHP) order.~~

~~f.~~**e.** Breast milk shall be stored as follows in a designated refrigerator/freezer:

Breast Milk Storage Guidelines	
Method	Pre-Term or Sick Infant
Room temperature less than or equal to 25° C (77° F)	4 hours
Refrigeration of Fresh Milk less than or equal to 4° C (39° F)	96 hours
Completely Thawed & Placed in Refrigerator (plain or fortified)	24 hours
Deep Freezer less than or equal to -20° C (-4° F)	6 months
Freezer compartment inside refrigerator door	Not Recommended

2. Collection of Expressed Breastmilk:

a. **Mothers will be instructed on proper methods for pumping, storing and transporting breastmilk ~~.~~ ~~F~~for their hospitalized infant.** ~~Provide instruction sheet to Mother "Pumping, Storing & Transporting Breast Milk for hospitalized infants.~~

~~b. Provide *Breast Pumping & Daily Feeding Log* Book with instructions.~~

~~c. Encourage mother to bring logbook to NICU. RN and LC (Lactation Consultant) review the pumping log daily, if possible, with mother to monitor progress and to look for areas of need while keeping in mind the goal of 500-1,000ml/day by the end of the first week.~~

~~d. Instruct mother in hand washing before and after pumping.~~

~~e.~~**b.** Instruct mother of baby in hand expression and manual pumping as alternative ways of collecting milk.

~~f.~~**c.** Provide **mother with** individualized labels from the ~~TCMC~~ breast milk barcoding system **for her baby and instructions on how to properly label the pumped breastmilk.** ~~. which include infant's last name/gender and medical record number and mother's last name.~~

~~g. Instruct the mother to place expressed milk in a storage container made specifically for human milk storage.~~

~~h. Instruct mother to write the date and time of collection.~~

d. Encourage MOB to pump at the bedside during visits to the NICU with the available hospital grade pumps.~~.~~

~~i.~~**e.** Instruct mother **how to properly clean her pump parts after each pumping session.**~~in cleaning pump parts.~~

~~j.~~**f.** Breastmilk received from infants transferred to the ~~TCMC~~ NICU from other facilities must be relabeled with labels generated from the ~~TCMC~~ breastmilk barcoding system.

~~k. Educate mother in how to store breast milk in small volumes to minimize waste.~~

3. Hospital Pump Care:
   a. Breast pumps shall be wiped down with a hospital approved germicid**ale wipes according to manufacturer guidelines** prior to each use in the NICU.
   b. If internal contamination is noted, take the pump out of service and send to Biomed for deep cleaning.
4. Handling of Breastmilk
   ~~a. All milk received in the NICU must be labeled upon receipt using labels generated by the TCMC breast milk bar coding system.~~
   ~~b.~~**a. Inform M**mother **of infant's daily milk volume needs and encourage her** ~~will be instructed~~ to bring in fresh milk daily. **If there is insufficient milk, inform mother prior to use of formula.**
   ~~c. Mother will be informed of infant's daily milk/feeding needs.~~
   ~~d. Mother will be contacted if there is insufficient milk prior to use of formula.~~
5. Thawing frozen breast milk:
   a. To thaw **breastmilk**, use a hospital approved milk warmer following the manufacturer's instructions.
   b. If milk warmer is not available, milk may be thawed in the refrigerator. Do not **thaw milk on the counter,**~~place~~ in boiling water or microwave.
   c. Once thawed, swirl the container of milk to mix the cream back in, and distribute the temperature evenly. Do not stir or shake the milk.
   d. Measure volume of breast milk required for feeding into appropriate feeding container. Promptly refrigerate unused portion of thawed breast milk.
   e. When breast milk is transferred from one container to another for administration, **the**~~a~~ patient**'s breastmilk** label must be affixed to the new container using the ~~TCMC~~ breast milk bar coding system.
   f. Once thawed, milk must be used within 24 hours. Never refreeze ~~completely~~ thawed breast milk.
6. Warming Breastmilk:
   a. **Use hospital approved milk warmer to warm breastmilk just prior to ~~when feed is due~~administration. Warmed breastmilk is good for two hours, ~~then~~and then must be discarded.**~~When warming breast milk, follow the same procedure as when thawing breast milk.~~
   b. Do not use microwave oven for warming breast milk.
   ~~c. Prepare the amount of milk needed for the feeding; taking care to warm only the amount of milk needed (see pump feedings).~~
   ~~d. Place the milk container or syringe in approved milk warmer following the manufacturer's directions.~~
   ~~e.~~**c.** Prior to administration, the ~~TCMC~~ breast milk ~~bar coding system will be~~**will be scanned** ~~utilized~~ **in the system to verify correct patient and milk.**~~.~~ In the event the system is unavailable, an ~~independent two~~**independent two** RN check will be utilized and documented in the EMR. ~~Any warmed breast milk that is not used must be discarded.~~
   ~~f.~~**d.** Following the infant feeding, discard the remaining milk within 1 hour ~~after the baby is finished feeding.~~ **of the start of the feeding.**

7. Transporting Breast Milk:
   a. Breast milk must be kept cold or frozen during transport. An insulated cooler or freezer bag with a frozen gel pack is recommended.
   ~~b. Liquid milk must remain cold.~~
   ~~c.~~**b.** Frozen milk must not be allowed to thaw. If milk has thawed, do not refreeze.
8. Fortification of Breastmilk:
   a. Perform hand ~~hygeine~~**hygiene** prior to preparing fortified breast milk.
   b. Combine fortifier with breastmilk according to manufacturer's recommendations **to the ordered calorie concentration**.
   c. **Fortified breastmilk must be used within 24 hours of preparation.** ~~The combination should be refrigerated and used within 24 hours once prepared.~~
9. Continuous and Intermittent Pump Feedings:
   ~~a. Perform Hand Hygeine.~~
   ~~b.~~**a.** Breastmilk that has been checked for correct milk/correct infant is placed in labeled syringes using the ~~TCMC~~ breast milk bar coding system. Gently agitate syringe to dispense fat into the solution.
   ~~c.~~**b.** Draw up only the ordered feeding volume into the syringe.
   ~~d.~~**c.** Position the feeding syringe in the upright position with the tip pointed up during the feeding
   ~~e. When the feeding is complete, push any remaining fat at the tip of the syringe plunger into the extension tubing.~~
   ~~f. Flush the extension tubing with 1-2 ml of air once the feeding is completed.~~
   ~~g.~~**d.** Hang times for continuous feedings of breastmilk should be limited to four hours to reduce bacterial growth.
   e. **Change** ~~Enteral~~**enteral** extension tubing and syringe with each ~~intermittent~~ feeding.
10. **Discharge:**
   ~~h.~~**a.** **At discharge, unused breastmilk will be released to mom and/or banded significant other upon verification of infant's name and medical record number ~~either by utilizing a two RN check or~~ with the breastmilk barcoding system by scanning the patient ID (baby band) and the barcode on each remaining container . In the event the system is unavailable, an independent two RN check will be utilized and documented in the EMR.**

D. **DOCUMENTATION:**
1. Document parent education in patient's Electronic Medical Record (EMR).
2. Document breastmilk identification process in EMR. **Scanning replaces manual documentation of the independent double check verification when used. ~~If using breastmilk barcoding, Independent Double Check verification will be replaced by the barcoding system. Interface data from the breastmilk scanning system indicates administer function is complete.~~**
~~2.~~**3.** Document administration of breast milk in the EMR~~.~~ **as appropriate.**

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Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN~~CHILDREN'S~~ SERVICES ~~MANUAL~~
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: NEONATAL ABSTINENCE SYNDROME, MANAGEMENT OF

ISSUE DATE: 12/08
REVISION DATE: 04/09, 06/11, 08/12, 06/13

Department Approval ~~Date(s)~~:	**~~11/16~~4/20**
Perinatal Collaborative Practice Approval ~~Date(s)~~:	**~~11/16~~05/20**
~~**Division of Neonatology Approval Date(s):**~~	~~**11/16**~~
~~**Department of Pediatrics Approval Date(s):**~~	~~**02/17**~~
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~02/17~~10/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~03/17~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**03/17**

A. **DEFINITIONS:**

1. Neonatal Abstinence Syndrome (NAS):
   a. A condition characterized by a constellation of drug withdrawal symptoms in the neonate, following intrauterine exposure to drugs of abuse.
2. Drugs frequently associated with neonatal withdrawal include the following:
   a. High risk drugs: long-acting opioids and narcotics: codeine, fentanyl, heroin and methadone, meperidine, morphine.
   b. Low risk/other drugs: short-acting opioids, barbiturates, caffeine, cocaine, diazepam and lorazepam, ethanol, marijuana, nicotine and selective serotonin reuptake inhibitors (SSRI).
      ~~i. Withdrawal from these substances typically requires non-pharmacologic treatment only.~~

~~3. Long-acting opioids:~~
   ~~a. Fentanyl transdermal patch~~
   ~~b. Methadone~~
   ~~c. Buprenorphine~~
   ~~d. Oxymorphone hydrochloride extended release (Opana)~~
   ~~e. Oxycodone hydrochloride controlled release (Oxycontin)~~
   ~~f. Morphine sulfate extended release~~
~~4. Short-acting opioids:~~
   ~~a. Hydrocodone~~
   ~~b. Hydrocodone + APAP (Vicodin, Norco)~~
   ~~c. Oxycodone + APAP (Percocet or oxycodone IR)~~
   ~~d. Tramadol~~
   ~~e. Fentanyl (IV)~~
   ~~f. Morphine (IV or immediate release)~~
   ~~g. Codeine~~
   ~~h. Hydromorphone (Dilaudid)~~
~~5. General signs of drug exposure in the infant include:~~
   ~~a. Central nervous system dysfunction, such as high-pitched cry, hyperactive reflexes, irritability, and disturbed sleep patterns.~~
   ~~b. Metabolic, vasomotor and respiratory disturbances, such as sweating, mottling, fever, tachypnea, and sneezing.~~
   ~~c. Gastrointestinal disturbances such as vomiting, loose stools, and poor feeding.~~

~~6. Goals of Neonatal Abstinence Syndrome (NAS) evaluation and management.~~
~~a. Proper feeding and growth.~~
~~b. Facilitate appropriate development.~~
~~c. Foster the maternal-infant bond.~~
~~d. Prevent neurological sequelae.~~

B. **POLICY:**

1. Maternal use of narcotics and/or other illicit substances during pregnancy can result in the birth of infants with drug dependency with the potential for subsequent complications. The proper identification and care of these infants and their families is essential in minimizing medical complications and improving infant and family outcomes. A team approach involving Obstetrics, Neonatology, Newborn Service, Nursing, Social Work and Occupational Therapy will optimize patient outcomes.

~~2. Infants at low risk for NAS from maternal non-narcotic or narcotic short-acting prescription medication can generally remain in couplet care for a period of observation.~~

~~3. Infants at risk for NAS due to maternal use of methadone, heroin, buprenorphine or high dose prescription narcotic exposure should be admitted to the NICU. Infants exposed to multiple psychotropic medication exposure may also need to be considered for NICU admission.~~

~~4.~~2. Proper non-pharmacologic measures may be used to minimize the need for medical treatment and decrease the length of therapy.

~~5.~~3. Proper use of NAS scoring will help in consistency of treatment and weaning of medication used to treat NAS.

~~6. Adherence to NAS medication initiation and weaning protocols may assist in shortening the length of NAS therapy.~~

~~7.~~4. Encouraging families to visit **as frequently as possible**~~daily~~ and care for **their** child may improve infant-parent attachment, **reduce the need for postnatal opioid treatment, ~~.~~and minimize length of stay.**

~~8.~~5. Discharge planning, including Social Services, should be started as soon as an exposed infant is identified. Detailed planning for the discharge of these high-risk infants may minimize readmission or adverse outcomes after discharge.

~~9. Individuals, who appear under the influence of drugs including alcohol, cannot be allowed to handle the infant and in most instances, should be asked to leave the unit at the discretion of the nursing, medical and social work staff.~~

C. **PROCEDURE:**

1. **Screening for NAS should be conducted for:**
   - **a. Infants exposed to narcotics or other illicit substances prenatally**
   - **b. Mothers or infants with any positive drug screen**
   - **c. Infants having withdrawal symptoms, which may include:**
     - **i. Neurologic excitability: tremors, irritability, increased wakefulness, high-pitched crying, increased muscle tone, hyperactive deep-tendon reflexes, seizures, frequent yawning and sneezing**
     - **ii. Gastrointestinal dysfunction: poor feeding, uncoordinated and constant sucking, vomiting, diarrhea, dehydration, poor weight gain**
     - **iii. Autonomic signs: increased sweating, nasal stuffiness, fever, mottling, temperature instability**
   - **d. Mothers who disclose a history of prenatal narcotic or drug use**

~~1. Infants will be identified as at risk for NAS by:~~
~~a. Prenatal identification of mother on narcotic medication.~~
~~b. Mother with positive toxicology screen at delivery not explained as an in-hospital administered medication.~~
~~c. Mother who discloses prenatal narcotic use at delivery~~

2. A urine and meconium toxicology screen will be sent on all infants delivered to mothers with concern for illicit or known drug use:
   - a. Urine Toxicology Screen:

i. After delivery, the RN will place ~~urine collection bag on infant or~~ cotton balls in the diaper **to collect urine for toxicology screen.**
ii. Stool contamination does not preclude assessment
iii. If positive screen, notify attending physician ~~or allied health professional (AHP)~~ and social worker.

3. Meconium Toxicology Screen:
   a. -Use a tongue depressor to scrape meconium into a sterile container
      i. **Store container in drawer of infant's crib or isolette until ready to send to lab.**
   b. Continue collection until all meconium is passed (until transitional stool).
   c. Provider to follow up on result (can take up to 1 week or longer to result)
4. Management of Infants on Mother Baby: Low Risk for NAS (non-narcotic medication, low-dose prescription opiate with a short half-life, THC, methamphetamines):
   ~~a. If an infant develops significant symptoms of withdrawal, the RN will notify the infant's provider for evaluation of the symptoms which may require transferring the infant to the NICU.~~
   ~~b. Infants exposed to marijuana or methamphetamines do not need extended observation.~~
   ~~c. Infants exposed to multiple medications (such as narcotics and benzodiazepines, or narcotics and multiple psychotropic medications) may not show signs of withdrawal until later; consider longer observation in the hospital and close, frequent follow up in the days after discharge.~~
   ~~d. Consideration of medications, dose, exposure, half-life and complicating factors should be weighed when deciding length of hospital observation.~~

~~5. Mother Baby Couplet Care~~
   a. Mother and infant will remain together in couplet care for observation until the mother is discharged.
   b. If ~~an~~ infant develops significant symptoms of withdrawal, the RN will notify the infant's provider for evaluation of the symptoms. ~~which may require transferring the infant to the NICU.~~
   ~~b. Infant will not be on a cardio respiratory monitor.~~
   c. Infant will be monitored for NAS using the **unit approved** ~~Lipsitz~~ scoring **tool** ~~performed by RN every 6 hours and as needed if concern for escalating withdrawal symptoms. First assessment should be done around the time that the infant is transferred to mother baby.~~
      i. Scoring should begin around 2 hours of age if drug exposure is known or suspected or when withdrawal symptoms are first observed.
      ~~i.~~**ii.** Scoring will occur at approximately 30-60 minutes after a feeding, at a time when an infant not at risk for NAS would normally be **calm/asleep** ~~sedate~~.
      ~~ii.~~**iii. Infants will not be woken in order to obtain a score** ~~Sleeping infants will not be disturbed and will receive a score of 0~~.
      ~~iii.~~**iv.** Scoring **should include all signs and symptoms exhibited during the entire time period since the last scoring occurred** ~~for factors such as sneezing, yawning and emesis will be taken into consideration the entire period of evaluation since the last scoring~~.
      ~~iv.~~**v.** Parents can be included when gathering information for the score.
      ~~v.~~**vi. If an** Infant ~~with Lipsitz~~ scores greater than 8, **the neonatologist** -will be **notified and infant evaluated for possible** transfer ~~red and admitted~~ to NICU. ~~with orders from Provider~~.

~~6.~~**5.** Management of Infant at High Risk for NAS:
   a. Infant at high risk for NAS ~~or infant in couplet care/newborn nursery with Lipsitz score greater than 8 or~~ **who is exhibiting** significant withdrawal symptoms should be admitted to NICU for **further monitoring and possible** pharmacologic treatment, per physician/AHP's orders.
   b. **A unit approved** ~~Finnegan N~~ neonatal ~~A~~abstinence ~~S~~**scoringe tool will be utilized to score infant.** ~~and~~ **Sscores should be recorded** in patient's electronic medical record.

i. The first score should be recorded two hours after birth or **on** admission to ~~Mother-Baby/NBN/~~NICU. This score reflects all behavior up to this first score.
ii. Scoring is dynamic, all signs and symptoms observed during the scoring interval are included in the point total for that time period.
iii. Crying infants should be soothed prior to assess**menting**~~ing~~ of muscle tone, Moro reflex, and respiratory rate**, preferably 30 minutes after the feed**.
iv. Infants will not be woken in order to obtain a ~~Finnegan~~ **s**Score.

6. Breastfeeding/Breastmilk: ~~the following mothers will be encouraged to breastfeed:~~
~~7.~~a. **The use of breastmilk/breastfeeding shall be determined on a case by case basis by the ~~NICU~~ multidisciplinary team.**
~~a. Women engaged in substance abuse treatment program.~~
~~b. Women who plan to continue in their substance abuse treatment program in the postpartum period.~~
~~c. Women who have been abstinent from illicit drug use or licit drug abuse for 90 days prior to delivery and have demonstrated the ability to maintain sobriety in an outpatient setting.~~
~~d. Women who have a negative maternal toxicology testing at delivery except for prescribed medications.~~
~~e. Women who received consistent prenatal care.~~
~~f. Women who do not have HIV or other contraindications to breastfeeding.~~
~~g. Women who are not taking a psychiatric medication that is contraindicated in lactation.~~
~~h. Women on a stable methadone maintenance regimen wishing to breastfeed, regardless of their methadone dose.~~
~~i. Women and their partners should be fully informed about the risk of rapid weaning from breastmilk or exposure to street drugs during lactation.~~

~~8.~~7. Non-Pharmacologic Treatment of Neonatal Abstinence:
a. Use of non-pharmacological interventions should be initiated immediately after birth and prior to use of pharmacological interventions and include but are not limited to the following:
i. Skin to skin contact
ii. Swaddling
iii. Rocking
iv. Massage
v. Decreased sensory/environmental stimulation
vi. Non-nutritive sucking
~~v.~~**vii. Holding**
~~vi. Maintaining temperature stability~~
viii. Protected sleep
~~vii.~~**ix. Rooming in**
~~viii. Avoiding unnecessary handling and abrupt changes in the infant's environment~~
~~ix. Avoiding overstimulation; do one procedure at a time, use partial swaddling with assessment and procedures~~
~~x. When feeding, consider alternating use of pacifier and bottle to help compensate for excessive sucking and to assist with decreasing emesis.~~
~~xi. Use of breastmilk (when appropriate) can help to decrease overall NAS symptoms.~~

~~9. Pharmacological interventions:~~
~~a. Begin pharmacological interventions when Finnegan scores are greater than or equal to 8 x 2, the average of any three consecutive scores is 8 or greater (i.e 9, 7, 8), or greater than or equal to 12 x1.~~
~~b. Refer to Neonatal Narcotic Withdrawal Syndrome, Pharmacological Treatment of (policy #8710-559) for medication interventions.~~

8. Provide education to caregivers
a. Provide parent(s)/guardian(s) with information about the reason for drug withdrawal

b. **Encourage parent(s)/guardian(s) to participate in care as much as they are able**
c. **Instruct parent(s)/guardian(s) in nonpharmacologic care measures both during hospitalization and after.**
d. **If medication needs to be utilized, educate the parent(s)/guardian(s) about the medication, the weaning process, and that the baby will need treatment/medication for an unknown time period. Tell the parent(s)/guardian(s) discharge home will be determined by the Multidisciplinary Team when the time is right.**
e. **Involve social services, case management, and child protective services as appropriate and per local and state law. Establish a safe plan of care and follow up as indicated.**

~~10.~~9. Discharge Planning for infants with diagnosed NAS:

~~a. Discharge criteria:~~
~~i. Infants who are exposed to methadone or buprenorphine but do not show signs of withdrawal severe enough to require narcotic medication should be watched in the hospital for a minimum of 5-7 days.~~
~~ii. Infants who have been treated in the NICU for NAS with narcotics should be monitored closely for a minimum of 48 hours off medication before discharge.~~
~~iii. Term NAS babies do not need a car seat challenge.~~
~~iv. NAS infants are at an increased risk for SIDS and parents or guardians should know the importance of the safe sleep and anti-SIDS measures.~~

~~b.~~ Educate **parent(s)/guardian(s)** ~~parents~~ **on how to distinguish between NAS symptoms of fussiness/crying/difficulty consoling infant from behavior's requiring medical attention or intervention.** ~~regarding the challenges associated with taking on the care of a NAS infant, with weeks of fussiness/ crying/ residual NAS symptoms being commonplace in the weeks following discharge.~~

~~c. Follow up developmental screening via High risk Infant Follow Up program may be indicated and depends on the infant's risk profile.~~

~~d.~~a. ~~If the mother is breastfeeding at discharge inform and provide a copy of the NICU discharge summary to parents for the mother's methadone clinic physician so as to minimize the risk of communication gap regarding breastmilk nutrition or rapid weaning~~
b. **Ensure parent(s)/guardian(s) are connected with community resources (and support) for caring for an infant with NAS prior to discharge.**
c. **Educate parent(s)/guardian(s) to allow family or friends to assist when they need a break. Tell them not to wait until they are struggling or in a crisis.**
d. Provide ~~clear information in the~~ discharge summary for the infant's pediatrician regarding **treatment course and any** ongoing concerns.
~~e. , residual NAS symptoms, medications to be weaned, breastmilk provision, and high risk social situations.~~
~~f.~~e. **Make referrals as appropriate such as home health, social work, therapy, High Risk Infant Follow-up clinic, and/or Regional Center.** ~~Home health referrals for nursing, social work, and therapy (if needed).~~

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Tri-City Medical Center	Women and Newborn Services ~~Manual~~ **Neonatal Intensive Care Unit** (NICU)
PROCEDURE:	**OXYGEN HOOD: NEONATE**
Purpose:	To provide heated and humidified oxygen concentrations to neonatal patients via oxygen hoods—with a precise FiO2 delivered.
Supportive Data:	An oxygen hood is a very good method for administration of controlled oxygen therapy while leaving the infant's body free for nursing care.
Equipment:	Oxygen hood, Hood circuit, oxygen blender, humidification system, flow meter, oxygen analyzer
Issue Date:	03/89

A. **POLICY**

1. The use of an oxygen hood requires ~~an~~ physician/Allied Health Professional order which may be written as:
   a. Specific FiO2 (Fractional Inspired Oxygen)
   b. Titration orders based on oxygen saturation utilizing pulse oximetry
2. Pulmonary services should have the primary responsibility for providing the setup and monitoring of patients on oxygen hoods.
3. The recommended set temperature for the humidifier on an oxygen hood is 31 degrees Celsius.
4. Oxygen analyzers must be used ~~if the FiO2 is 40% or greater.~~

B. **PROCEDURE:**

1. Confirm order.
2. Obtain the proper equipment:
   a. Hood circuit
   b. Oxygen hood
   c. Humidification system
   d. Flow meter
   e. Oxygen blender
   f. Oxygen Analyzer
   g. Oximeter
3. Assemble oxygen hood and circuit.
4. Set flow rate to 10-15 liters/minute
5. Set FiO2 on blender
6. Turn on the humidifier, setting the temperature to 31 degrees Celsius.
7. Spike the sterile water bag and allow the water to flow into the heater chamber.
8 Place oxygen analyzer under hood ~~if FiO2 40% or greater~~
9 Place infant under hood and assess
10. Document every 4 hours in the Hospital Electronic Medical Record.
11. Documentation will occur in the Oxygen Therapy section of Iview.

C. **REFERENCE LIST**

1. Egan's Fundamentals of Respiratory Care, ~~10~~**11th**-edition, ~~2013~~ **2017**, pg.~~931~~ **1228**.

Department Review	Perinatal Collaborative Practice ~~Division of Neonatology~~	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/03, 10/06, 12/08, 9/09, 6/11, 2/15, 02/20	3/15, 11/16, 09/20	n/a	n/a	01/17, 10/20	02/17, 12/20	n/a	1/10, 5/12

Tri-City Medical Center	Women and Newborn Services Manual - NICU
PROCEDURE:	~~**PERCUSSION AND VIBRATION OF THE NEONATE**~~
Purpose:	~~To establish a standard of care to admini~~
Supportive Data:	~~Percussion and vibration involve applicat~~ ~~the use of various electrical or pneumatic~~ ~~augment secretion clearance.~~
Equipment:	~~Percussor or vibrator, suction equipment~~
Issue Date:	~~06/88~~

DELETE – no longer perform

~~A. **POLICY**~~

~~1. All chest physiotherapy (CPT), percussion and vibration of the neonate require a physician/Allied Health Professional (AHP)'s order.~~

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

~~1. Confirm orders.~~
~~2. Assess breath sounds~~
~~3. Gently percuss and/or vibrate infant's anterior or posterior chest (depending upon initial position); avoid percussion/vibration directly over the infant's spine~~
~~4. Continuously assess infant's oxygenation. Determine need for supplemental oxygen. Many infants desaturate during percussion/ postural drainage and may have increased oxygen requirements during treatment. Assess infant's color and pulse oximeter readings, if available.~~
~~5. Turn infant on side. Gently vibrate and/or percuss the lateral chest and under the armpit area.~~
~~6. Turn infant to opposite side and vibrate and/or percuss lateral chest and under the armpit area.~~
~~7. Suctioning if indicated.~~
~~8. Documentation is to occur in the hospital electronic medical record~~

~~C. **REFERENCE LIST**~~

1. ~~Merenstein & Gardner's Handbook of Neonatal Intensive Care 2006, 6th edition, pgs. 604-606.~~

Department Review	Perinatal Collaborative Practice ~~Division of Neonatology~~	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
3/03, 2/06, 4/08, 9/09, 6/11, 2/15, 03/20	11/16, 09/20	n/a	n/a	01/17, 10/20	02/17, 12/20	n/a	6/88,10/96,7/97, 1/10, 5/12

Tri-City Medical Center
Oceanside, California

WOMEN'S AND NEWBORN'S SERVICES (WNS)
NEONATAL INTENSIVE CARE UNIT (NICU)

SUBJECT: Standards of Nursing Care – NICU

ISSUE DATE: ~~NEW~~11/16
REVISION DATE(S):

Department Approval ~~Date(s)~~:	~~08/16~~04/20
Perinatal Collaborative Practice Approval ~~Date(s)~~:	~~08/16~~05/20
~~**Division of Neonatology Approval Date(s):**~~	~~08/16~~
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~09/16~~10/20
Administration Approval:	12/20
Professional Affairs Committee Approval ~~Date(s)~~:	~~10/16~~ n/a
Board of Directors Approval ~~Date(s)~~:	11/16

~~A. **PREAMBLE:**~~

~~1. Neonatal nursing care is delivered in an environment that respects the goals, preferences, and patient rights of the neonate and their family from admission, through the continuum of care, to discharge. The specially trained nursing staff functions within established policies and procedures and adheres to the standards and guidelines set forth by the California Nurse Practice Act and the National Association of Neonatal Nurses. Care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant, and is grounded on evidence based practice.~~

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

1. To provide guidelines that describe the basic level of care all patients can expect to receive.
2. All nursing care is provided in collaboration with the multidisciplinary healthcare team and the family to implement an individualized plan of care. ~~Neonatal n~~Nurses will assess, plan, implement, evaluate, and document the patient's plan of care to promote optimal outcomes.
3. ~~Nursing staff in the neonatal care areas will be knowledgeable about and~~**while** adhereing to all applicable unit and hospital policies.

~~4. Nursing staff will be competent in the care of infants to whom they are assigned.~~

~~C. **DEFINITIONS:**~~

~~1. **Standards of Care:** "Authoritative statements by which the nursing profession describes the responsibilities for which its practitioners are accountable" (ANA, p.77). "Standards of care describe a competent level of nursing care as demonstrated by the nursing process" (ANA, p. 78) and are examples of the nursing professional expected roles and responsibilities for providing patient care.~~

~~2. **Nursing Process:** Encompasses all significant actions taken by nurses in providing care to all clients, and forms the foundation of clinical decision making. The nursing process also defines additional nursing responsibilities for providing cultural and ethnic relevant care, education to patients and their caregivers, maintaining a patient safe environment, and patient health care promotion and the planning for continuity of care. "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and~~

~~above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care" (ANA, 2010).~~

~~a. The nursing process includes the following:~~

~~i. **Assessment:** The neonatal nurse collects comprehensive data on the healthcare needs of the infant and family.~~

~~ii. **Diagnosis:** The neonatal nurse analyzes the assessment data in determining nursing diagnosis.~~

~~iii. **Outcomes Identification:** The neonatal nurse identifies expected individualized outcomes of care based on needs of the infant and infant's family.~~

~~iv. **Planning:** The neonatal nurse develops a plan of care that prescribes interventions to attain expected outcomes.~~

~~v. **Implementation:** The neonatal nurse implements the interventions identified in the plan of care.~~

~~vi. **Coordination of Care:** The neonatal nurse coordinates care across the continuum by providing information to families.~~

~~vii. **Health Teaching and Health Promotion:** The neonatal nurse employs strategies to promote a healthy, safe and nurturing environment.~~

~~viii. **Evaluation:** The neonatal nurse evaluates the progress of the infant and family toward the attainment of established, expected outcomes.~~

~~3. **Patient:** Recipient of nursing care.~~

~~4. **Health Care Providers:** Individuals with special expertise who provide healthcare services or assistance to clients.~~

~~5. **Significant Others:** Family members and/or those significant to the patient.~~

~~6. **Reasonable and a Timely Manner:** Defined as within 4 hours after completion of assessments or care provided.~~

~~7.~~1. **Extremely Low Gestational Age Newborn (ELGAN):** defined as any neonate born at less than 28 completed weeks' gestation.

~~D.~~B. PATIENT ADMISSION:

~~1. Outcome criteria:~~

~~a. Neonatal nurses will provide ongoing nursing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The plan of care is continuously evaluated and updated.~~

~~2. Process criteria: The admitting neonatal nurse will~~

~~a.~~1. Perform ~~an initial comprehensive, age-appropriate,~~**a complete** physical assessment ~~of all systems, including vital signs and pain, within 10-30 minutes~~**immediately upon admission. Document within 4 hours and prior to shift change or transfer of care.** ~~and document within 2 hours of admission to the NICU.~~

2. **Assess and document the following within 30 minutes of admission:**
   - **a. Weight, length, head circumference, abdominal girth, gestational age**
   - **b. Vital Signs, including pain assessment**
   - **c. Allergies**
   - **d. Medication Reconciliation**

~~b. Assess and record vital signs (HR, RR, T, BP) on admission and every 1hour until stabilized.~~

~~c. Temperature on the Extremely Low Gestational Age Newborn (ELGAN) should be done more frequently (i.e. q15 mins for 1st hour) to ensure temperature stability.~~

~~d. Measure and record length, weight, head circumference, and gestational age on the appropriate growth chart and in the medical record.~~

~~e. Complete a blood glucose test upon admission (Critical Level = < 45 mg/dl, > 180 mg/dl).~~

~~f.~~3. Complete a Ballard exam within 12 hours of delivery, if applicable.

~~g.~~4. Ensure that an emergency medication reference is completed based on current weight within 2 hours and posted in designated area. The emergency medication reference is updated weekly with the current weight.

~~h. Check that two identification bands are present on the infant.~~

~~i.~~5. Initiate a computerized multidisciplinary plan of care ~~upon admission.~~.

~~j.~~6. Ensure that the admission history is completed within 24 hours of admission.
~~3.~~7. Orient/**educate** parents/families to the unit ~~and inform parents/families regarding hand washing and visitation policies. Document parent orientation to unit.~~ **and processes**

C. **PATIENT SAFETY:**

1. **Transfer of Care**
   a. Provide a report to the oncoming ~~neonatal~~ nurse~~, per hospital policy,~~, including review of the patient's plan of care and outcome goals following the situation, background, assessment, and recommendation format.
   b. Review **the following with on-coming/off-going nurse:**
      i. ~~a~~All ~~physician/AHP~~ orders placed throughout the shift and verify status.
      ii. ~~Review the m~~Medication administration record.
      iii. Assess the integrity of all vascular access sites, tubes, and drains.
         1) **Look at all sites with off-going nurse and walk all IV lines (verify correct fluid/rate according to the electronic medical record).**
2. **Perform environmental checks at start of the shift and document accordingly. Verify:**
   a. **Presence of 2 ID bands**
   b. **Bag/Mask functional at bedside**
   c. **Suction equipment functional at bedside**
   d. **Cardiorespiratory alarm limits set and audible.**
      i. **HR: 80-220 ≥35 corrected weeks**
         100-220 <35 corrected weeks
      ii. **Apnea: 20 second delay**
      iii. **RR: 10-100**
      iv. **Oxygen saturation parameters:**
         1) **23-30 weeks gestation: 85%-92%**
         2) **30+1-35 weeks gestation: 88%-96%**
         3) **>35+1 weeks gestation: 92%-100%**
      v. **Ensure that the patient's emergency drug sheet is updated and at the bedside.**
   e. **Do not leave infants unattended on any scale or flat, unprotected surface.**
   f. **Ensure that bed wheels are locked at all times except during transfer.**
   g. **Ensure that side rails on radiant warmers and open cribs are up at all times unless a caregiver is next to the bedside.**
   h. **Locks on incubator doors, portholes, and warmer walls will be used at all times.**
   i. **Use safety belts when infants are placed in swings, car seats, vibrating chairs, or strollers.**
   j. **Scan all medications, breast milk, and blood (if applicable) per hospital policy prior to administration.**

D. **PATIENT ASSESSMENT:**

~~4.~~1. **All documentation should be completed in a reasonable and timely manner (within 4 hours of completion of assessment/care provided).**

~~**ONGOING PATIENT CARE:** Ensure that critical alarms include HR and apnea are set as follows unless otherwise ordered:~~
~~HR: 80-220 if non-ventilated and 32 corrected weeks or greater or if 38 weeks or greater (on positive pressure or not)~~
~~100-220 all other infants~~
~~Apnea: 20 second delay~~
~~Audibility of HR and apnea alarms on monitors will be validated by ensuring each is set as a crisis alarm (in alarm parameter levels) and 70% volume adjusted up or occasionally down as warranted for audibility in the pod.~~
~~Critical alarms will be checked at the beginning of each 12 hour shift and more frequently as the patient condition warrants for alarm limits, function and audibility. This check will be validated and documented in the medical record when limits are recorded.~~
~~**EMERGENCY EQUIPMENT:**~~

~~Outcome criteria~~
~~Neonatal nurses have appropriate emergency equipment available for patient use.~~
~~Process criteria:~~
~~A neonatal crash cart will be available on the unit at all times and checked according to hospital policy.~~
~~Admission bed supplies are checked at the beginning of each shift.~~
~~Emergency equipment present at the bedside should include~~
~~Mechanical suction with suction catheters~~
~~Oxygen~~
~~Resuscitation bag and appropriately sized mask~~
~~Bulb syringe~~

~~E.~~

~~1. Outcome criteria:~~

~~a.~~**1.** Neonatal nurses will provide ongoing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The care plan update is documented a minimum of every 24 hours to reflect the patient's current needs.

~~b. Maintain vital signs within parameters:~~
~~i. RR 30-60~~
~~ii. HR~~
~~1) Term: 80-160~~
~~2) Pre-term: 100-160~~
~~iii. Axillary temperature should be maintained at~~
~~1) 36.5 °C-37.5 °C (97.7 °F-99.5 °F) in full term infants~~
~~2) 36.5 °C-36.9 °C (97.3 °F-98.6 °F) in preterm infants.~~
~~2. Process criteria: The neonatal nurse will~~

2. Perform ~~an initial shift~~**a visual** assessment ~~on~~ **within two hours of any change in caregiver.**
- **a. Visual assessment will include monitored vital signs (heart rate-HR, respiratory rate- RR, & oximetry reading) & skin/air probe temperatures. State, color, work of breathing, and position should be documented if changed from previous assessment.**

3. Assessment frequency is based on acuity as determined by designated acuity tool.
- **a. Level 4 Acuity: Unstable infants requiring constant interventions**
  - **i. Vital Signs including pain documented hourly**
  - **ii. Full "hands on" physical assessment with peripheral blood pressure & auxiliary temperature every 4 hours (as tolerated) or every 6 hours (ELGANs)**
  - **iii. Visual Assessment every hour**
- **b. Level 3 Acuity: Moderately unstable infants requiring above average interventions**
  - **i. Vital Signs including pain documented every 1-2 hours**
  - **ii. One peripheral BP a shift, unless unstable**
  - **iii. Full "hands on" physical assessment & auxiliary temperature every 3-6 hours**
  - **iv. Visual Assessment -every 1-2 hours on unstable infants and every 3-4 hours on stable infants**
- **c. Level 2 Acuity: Stable infants requiring average to minimum interventions**
  - **i. Vital Signs including pain and physical assessment documented every 3-4 hours with feeds**
  - **ii. One peripheral BP a shift**
- **d. Level 1 Acuity: Stable infants requiring minimal intervention**
  - **i. Vital Signs including pain and physical assessment documented every 3-4 hours with feeds**
  - **ii. One peripheral BP a shift**

~~a. patients who are NPO within one hour from the beginning of the shift, to include complete systems assessment and update of the patient plan of care.~~

~~b. Complete systems assessment at the time of first feeding during the shift on patients who are not NPO. If more than three hours will lapse before the next feeding, then monitor vital signs will be recorded within one hour of the start of the shift.~~

~~c. Weigh patients nightly unless an order indicates otherwise, document weight in the patient's medical record and appropriate growth chart.~~

~~d. Measure head circumference and length weekly (Sunday night) and document on the appropriate growth chart and in the patient's medical record.~~

~~e. Document a complete physical assessment every 3-6 hours based on acuity.~~

~~f. Complete a visual assessment every 1 - 4 hours, based on acuity. Visual assessment will include state, color, work of breathing, and position.~~

~~g. Skin and air temperatures should be recorded with visual assessments.~~

~~h. Assess and record vital signs (HR = heart rate; RR = respiratory rate) as follows:~~

~~i. Apical Pulse with first hands-on assessment~~

~~ii. BP q shift minimum (see cardiovascular section)~~

~~iii. HR/RR q 1-2 hour for 1:1 acuity~~

~~iv. HR /RR q 2 hour for 1:2 acuity~~

~~v. HR /RR q 3-4 hours for 1: 3 acuity~~

~~vi. Axillary temperatures with full assessments and prn~~

~~i. Assess pain using the NPASS tool with every routine vital sign and prn. Reassess and document patient's pain level 30 minutes after a score of > 3.~~

~~j.~~4. Cluster care by coordinating touch times with necessary care team members (i.e., physician/allied health provider (AHP), RCP, OT/PT) to minimize procedure-related stimuli for any infant less than 34 weeks or that is medically unstable:

~~i.~~a. Utilize facilitated tucking techniques to support infant throughout.

~~ii.~~b. Provide rest periods for infant indications of stress.

~~k.~~5. ~~Complete blood glucose test as follows~~**Blood Glucose Monitoring**: ~~(Critical Levels: < 45 mg/dl, > 180 mg/dl)~~

a. Obtained on admission

~~i.~~**b. Check 2-4 hours after hanging/changing fluids containing dextrose.** ~~Q 12 hours and prn while on IV fluids containing dextrose~~.

~~ii. Q 12 hours and prn while on steroids.~~

~~iii.~~**c.** ~~30 minutes after dextrose solution bolus or per physician/AHP order.~~

~~iv. Within 2 hours of change in dextrose concentration or any new bag containing dextrose.~~

~~v. Within 2 hours of changing the IV rate, if clinically indicated.~~

~~vi.~~ Discontinuation of IV fluids containing dextrose ~~:~~

~~1)~~ ~~For infants without a diagnosis of hypoglycemia, blood glucose testing will be done before feedings, times one. No further testing will be needed if glucose is > 45.~~

~~2)~~ ~~F~~for infants with a diagnosis of hypoglycemia, a blood glucose will be done before feedings, times two. If glucose is > 50, no further testing is needed. If glucose is < 50, a third glucose test will be done before the next (third) feeding. If glucose remains <50, notify physician/AHP.

~~**A pulse oximeter should be in use for every infant.**~~

~~l. Reposition infant with every hands on assessment. If this is not possible due to a patient's condition, pressure reducing measures should be implemented.~~

~~m. Replace monitor leads and the oxygen saturation probe during baths or when items become loose or soiled.~~

~~n. Reposition the pulse oximeter probe at minimum every 8 hours.~~

~~i. Infants less 32 weeks or 1500gms, pulse oximeter may be repositioned with each hands-on assessment or PRN, as tolerates.~~

~~o. Provide oral care with colostrum/breastmilk or sterile water at least every 4 hours and as needed, per physician/AHP order.~~

~~p. Notify the physician/AHP and the charge nurse regarding significant changes in a patient's condition.~~

~~q. Document any physician/AHP notification in the patient's medical record, including any further assessment or treatment ordered.~~

d. ~~Facilitate a patient care conference between the family and caregivers any time there is a change in the patient's health status and/or other needs arise or at the family's request.~~

6. **Measurements**
   a. Weigh patients ~~nightly unless an order indicates otherwise, document weight in the patient's medical record and appropriate growth chart.~~ **nightly and document accordingly.**
   b. Measure head circumference and length weekly (Sunday night) and document ~~on the appropriate growth chart and in the patient's medical record~~**accordingly.**
   c. **Abdominal girths should be obtained with gastrointestinal concerns/changes from the patient's normal baseline or as ordered.**
7. **Neurological Assessment:**
   a. **Level of consciousness and behavior with vital signs and PRN unless ordered otherwise**
   b. **Assess once a shift and PRN: anterior fontanel, muscle tone, cry, & symmetrical movement**
   c. **Suck reflex present upon admission and suck-swallow coordination with oral feedings**
8. **Cardiovascular Assessment:**
   a. **Monitor and assess heart sounds, color, capillary refill time, perfusion, and murmur with hands-on assessment. Document on initial assessment and with changes.**
   b. **Arterial Lines:**
      i. **Infants with arterial lines in place will have a transducer in-line. Calibrate the blood pressure transducer once a shift, with change of IV tubing, and as indicated.**
      ii. **Arterial blood pressure should be correlated with cuff pressure once a shift or as indicated.**
      iii. **Transducer should be maintained at the level of the heart.**
      iv. **Document arterial pressures hourly and PRN.**
   c. **Document blood pressures hourly for infants on continuous infusions of vasopressors.**
   d. **Four extremity blood pressures should be obtained on admission for any suspected cardiac diagnosis or as ordered.**
   e. **Print monitor strips if an arrhythmia occurs.**
9. **Respiratory Assessment:**
   a. **Assess breath sounds & respiratory effort with "hands-on" assessment. Document on initial assessment and with changes.**
   b. **Assess episodes of apnea, bradycardia, and/or desaturation. Intervene as needed and document episodes and any actions taken.**
   c. **Infants on respiratory support should be visually assessed at least every 2 hours by an RN or RCP.**
   d. **Mechanical Ventilation via Endotracheal Tube (ETT)**
      i. **ETT should be measured by RCP & RN with every ventilator check/hands-on care and PRN to ensure proper placement. Document measurement accordingly.**
      ii. **Two licensed health care personnel are required for securing and/or changing the ETT holder.**
      iii. **Two licensed health care personnel, inclusive of one RCP, are required for ETT adjustment. ETT adjustments require a physician/AHP's order.**
      iv. **Two care providers must be present for patient position changes, x-rays, and weighing, with one person holding the ETT at the lip.**
   e. **Suctioning:**
      i. **All intubated patients will have an in-line suctioning device set up upon intubation. Depth to suction is measured by matching numbers on ETT to those on in-line catheter. Suction depth should be posted at bedside.**

ii. FIO2 requirements will be adjusted to maximize patient's tolerance of suctioning procedure.
iii. Suctioning should be performed as needed and with head midline.
iv. Suction pressure should be no greater than 80-100 mm Hg.

10. Gastrointestinal Assessment
    a. Auscultate all abdominal quadrants for bowel sounds once a shift or as needed if feeding intolerance, increased abdominal girth, or change in frequency or characteristics of stool occurs.
    b. Inspect and document any abdominal abnormalities or discoloration.
    c. Monitor frequency of stools and notify physician if absence >48 hours.
11. Nutritional Assessment
    a. Document NICU Calorie Count form each morning.
    b. Verify tube placement prior to the first feeding of the shift.
    c. Assess for feeding intolerance, notify physician of:
        i. Repeated episodes of emesis
        ii. Increased apnea/bradycardia with feeds
        iii. Increased oxygen requirement with feeds
        iv. Bilious, coffee ground, frank blood residuals
        v. Presence of bowel loops, change in bowel sounds, tenderness to abdomen and discoloration
        vi. Stool pattern (increased or decreased frequency)
        vii. Changes in clinical presentation such as increased HR or lethargy
    d. Assist with establishing and maintaining milk supply by:
        i. Encourage pumping within 3-6 hours of delivery
        ii. Pumping 8-12 time in 24 hours, including after breastfeeding with the goal of complete breast emptying at each pumping session.
        iii. Promote breast massage and hand expression techniques used in conjunction with pumping.
        iv. Encourage use of hospital grade pump.
        v. Provide containers and labels to collect milk.
        vi. Encourage skin to skin as often as possible.
        vii. Monitor milk supply totals, initiate early intervention for decrease in milk supply (milk supply should increase by 3-5 days postpartum).
        viii. Facilitate lactation consultations as needed.
        ix. Utilize colostrum/breastmilk in the order pumped for the first two weeks of feeding.
        x. Introduce breastfeeding before bottle feeding; bottle feeding is to be avoided for infants less than 34 weeks unless otherwise ordered by physician/AHP.
        xi. Initiate non-nutritive or "dry" breastfeeding when infant is 32 weeks PCA and physiologically stable when held.
        xii. Initiate nutritive breastfeeding when infant is able to handle own secretions and shows sucking behavior on a finger, pacifier, or the emptied breast.
12. Intake & Output (I&O)
    a. Check diapers as needed and weigh if keeping accurate intake and output, otherwise record diaper counts.
    b. Maintain strict I&O on all:
        i. Infants receiving steroids
        ii. Infants receiving diuretics
        iii. Infants receiving continuous IV therapy
        iv. Infants who are NPO
        v. Infants less than 1500 grams unless otherwise ordered by Physician/AHP.
    c. Notify the physician/AHP if urine output is <1 mL/kg/hr.
        i. Use birth weight until the infant surpasses this weight, then daily weight, to calculate I&O for previous 24 hours.
13. Skin Care~~Process criteria: Neonatal nurses will~~

a. Assess document skin color, temperature, turgor, moisture, integrity, & mucous membrane color and description once a shift and PRN.
b. Document overall skin condition on the Neonatal Skin Condition Scale each shift.
c. Complete Neonatal Skin Risk Assessment form ~~daily~~ every Sunday..
d. Bathing
    i. Delay first bath for the first 24 hours of life and once infant is stable. Infants visibly soiled with meconium or blood can be bathed once stable after 2-4 hours of life.
    ii. Gloves should be worn when touching all infants that have not been bathed.
    iii. Routine bathing should occur every 3-4 days with the use of:
        1) Mild non-alkaline cleanser for greater than or equal to 32 weeks.
        2) Warm bottled ~~sterile~~ water for less than 32 weeks (for the first 2 weeks of life) using a rinsing technique.
    iv. Last bath date will be relayed to on-coming RN during shift report.
    v. Avoid removal of vernix
    vi. Immersion/swaddle bathing is the preferred method for stable infants without central lines (.immersion bathing does not delay cord healing or increase the risk of infection in a healthy newborn).
e. Perform eye care daily and prn with sterile water
    i. Infants on a paralytic medication shall have lubricant eye ointment administered per physician order.
f. Umbilical Cord Care
    i. Keep umbilical cord clean and dry. Clean with water and gauze if soiled.
    ii. Keep cord exposed to air or loosely covered with clean clothes. Keep diaper folded under the cord.
    iii. Assess site for signs of infection
g. ~~Diaper Dermatitis~~Perineal Skin Care
    i. Check for wet of soiled diapers with clustered caregiving and change as needed.
    ii. Use appropriate method to gently cleanse the diaper area.
        1) Infant greater than or equal to 32 weeks, use disposable diaper wipes, gentle cleanser, or soft cloth and water.
        2) For infants less than 32 weeks, use soft cloth and warm bottled water (for the first two weeks of life).
    iii. Refer to Diaper Dermatitis Protocol to treat perineal skin breakdown.
h. Disinfectants
    i. Use Chlorhexidine gluconate (CHG) 2% or povidone-iodine 10% aqueous solution (betadine) to disinfect skin surfaces prior to invasive procedures such as insertion of central venous catheters, placement of PIV, umbilical line catheterization, chest tube insertion, injections, venipuncture, or heel sticks for laboratory samples. Wipe away all disinfectants with sterile water or saline wipes once procedure is complete.
    ii. Avoid use of alcohol as primary disinfectant or for removing povidone-iodine or CHG.
i. Medical Adhesives
    i. Avoid solvents for adhesive removal and bonding agents (i.e. Benzoin & Mastisol) that increase adhesive adherence.
    ii. Remove adhesives slowly and carefully with water-soaked cotton balls or gauze, saline wipes or petrolatum.
    iii. Minimize use of tape and minimize contact with skin by "backing" tape or applying cotton to adhesive.
    iv. Use hydrocolloid barriers for skin protection when securing NG/OG tubes and cannulas.
    v. Use semi-permeable dressings to anchor umbilical lines, PIVs, PICCs, nasal cannulas, nasal or oral gastric tubes.

j. Emollients for dry skin, cracking or fissures on skin surfaces
   i. For infants less than 32 weeks, use a preservative-free topical ointment sparingly per physician/AHP order.
   ii. For infants greater than 32 weeks or after 30 days of age, petrolatum may be used at the discretion of the physician/AHP.

k. Preventing Skin Breakdown/Injury
   i. Rotate devices when possible.
      1) Reposition pulse oximeter probe at least every 8 hours according to manufacturer recommendations.
   ii. Reposition patients with hands-on cares and as tolerated.
   iii. Utilize positioning aids as appropriate to reduce pressure points.
   iv. Assess for moisture accumulation and take steps to manage excess moisture.
   v. Monitor infants for nasal/septum breakdown while on respiratory support.

a. -Assist in reducing Transepidermal Water Loss in the infant less than or equal to 32 weeks or less than 1500gms by using the following :
   i. Infants <32 weeks shall be admitted to giraffes and placed in humidity of 70% for first seven days. Humidity may be increased up to 85% for infants <1000gms if needed, per physician/AHP orders. Emollients are not used during this time unless ordered by physician/AHP.
   i. Use only sterile water in humidifier reservoir and check level each shift.
   i. Humidity may be decreased to 50% after first seven days of life and continued until infant reaches 28 days of life per physician/AHP orders if needed. Petrolatum may be used at this level of humidity if there is evidence of skin breakdown.
   i. If rainout occurs, decrease humidity by 5% until no further rainout is present.

~~r. Monitor infants for while on respiratory supportVerify.~~

14. IV Assessment
   a. Off-going & on-coming nurse will conduct IV rounds at the beginning of each shift.
      i. Always physically trace each IV line from the solution, through the pump and into the patient and reconcile the accuracy of the solution and pump settings against electronic medical record.
      ii. Program volume to be infused not to exceed ~~41~~ hours ~~of fluid to infuse~~ at a time.
   b. Assess IV and site every hour and document assessment at least every 2 hours.
   c. IV tubing:
      i. Replace IV tubing sets, including add-on devices, every 96 hours.
      ii. Replace IV tubing used to administer fat emulsions every 24 hours.
      iii. Label IV tubing with change date sticker indicating which day tubing is due to be changed
   d. Flush peripheral IVs every 4-6 hours.
   e. Notify Physician/AHP of IV infiltrates requiring medical evaluation and/or intervention.

E. <u>FAMILY-CENTERED CARE/TEACHING</u>

1. Assess and support the infant-parent bonding process. Provide support as needed.

~~Neonatal nurses will provide ongoing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The care plan update is documented a minimum of every 24 hours to reflect the patient's current need~~

   a. Assess and document the patient and family's psychosocial status upon admission and daily in the patient's medical record.
   b. Foster continual, open, and honest communication about medical, psychosocial and ethical issues relevant to the infant and family.
   c. Listen to family concerns in a supportive manner.

d. Encourage parents and families to participate in care as appropriate.
e. Give emotional reassurance to families as needed.
f. Identify family support systems upon admission and as needed.
g. Orient to NIC-View camera system. Obtain signed consent prior to participation.
h. Enter appropriate consults/referrals into the patient's medical record as needed.
i. Social Work Consultation will be ordered on admission for coordination of family support and resource identification.

2. Recognize parents as the primary caregiver.
   a. Educate parents regarding patient's/parent's rights and responsibilities on admission. Parents are considered full members of the health care team.
   b. Parent visitation is encouraged at any time. Sibling visitation is encouraged in accordance with the NICU Visitation Policy.
      i. Refer to NICU Visitation Policy.
   c. Encourage phone calls to the unit when parents are unable to be at the bedside.
   d. Parent education and involvement with their infant's basic care is an integral part of their partnership in the healthcare team.
   e. Encourage families to be involved in the development of the plan of care from admission through discharge and whenever changes in the plan are needed at the level they choose.
   f. Provide ongoing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The care plan update is documented a minimum of every 24 hours to reflect the patient's current needs.
   g. Parents should be taught on admission to recognize pain in their infant and shown strategies for alleviating pain through comfort measures.
   h. Parents are encouraged to provide feedback about their baby to staff without fear of judgment.
   i. Parents are taught all aspects of the developmental care plan and are encouraged to watch educational videos on how to care for the infant.
   j. Physical Accommodations
      i. A private space for families to meet with caregivers for consultation and family discussions will be available.
      ii. A comfortable space for families and visitors to utilize during their visit will be provided. Privacy, space, and appropriate furniture will be provided to support skin-to-skin contact experiences and to promote a relaxed environment to support and facilitate breast-feeding.

3. Staffing Considerations:
   a. Staffing assignments for physicians and nurses should promote consistency and predictability to promote continuity of care.
   b. All possible efforts will be made so that each infant and family will have a primary team of nurses during a patient's stay.
      i. Primary Nurses are:
         1) Encouraged for infants with an anticipated length of stay >7 days.
         2) Responsible for ensuring the plan of care, teaching plan, and discharge plan are well orchestrated.
         3) Key in coordinating care with the multidisciplinary team and family.
   c. Staff should be encouraged to seek out assistance from other staff when faced with difficult situations and recognize the individual differences of the families whose infants require NICU care.

~~Education~~

~~Include the family and/or caregiver in teaching to increase their understanding of the infant's needs during hospitalization and upon discharge.~~

~~Neonatal nurses will provide ongoing care in collaboration with the multidisciplinary team and family to implement an individualized plan of care. The care plan update is documented a minimum of every 24 hours to reflect the patient's current needs.~~

~~F. NEUROLOGICAL ASSESSMENT:~~

~~a. Outcome criteria~~

i. Neonatal nurses continually assess all data pertinent to the patient's neurological function and update the nursing care plan to promote optimal neurological status.
b. Process criteria: Neonatal nurses assess
i. The anterior fontanel every shift and as needed.
ii. Level of consciousness/behavior with vital signs and as needed unless ordered otherwise.
iii. Muscle tone, cry, and symmetrical movement each shift.
iv. Suck, swallow reflex present upon admission and with feedings via nipple or breast.
v. Midline positioning for the first 72 hours for all infants less than 32 weeks or less than 1500gms.

G. **CARDIOVASCULAR ASSESSMENT:**
1. Outcome criteria
a. Neonatal nurses continually assess all data pertinent to the patient's cardiovascular system and update the nursing care plan to promote optimal cardiac function.
2. Process criteria: The neonatal nurse will
a. Ensure that all patients are on cardio/respiratory monitor for the duration of their stay in the NICU.
b. Document heart rate, respiratory rate, color, capillary refill time, perfusion, oxygen saturation, and any changes in heart sounds in the patient's medical record.
c. Assess blood pressure at least every 12 hours:
i. Infants with arterial lines in place will have a transducer in line. Blood pressure should be documented at least every 2 hours for these patients.
ii. Document blood pressure every 4 hours or per order for infants on steroids or anti-hypertensives.
iii. Document blood pressure every hour if the infant is on vasopressors/ antihypertensive drips.
d. Calibrate the blood pressure transducer with change of caregiver, change of IV tubing, and as indicated.
e. Print monitor strips if an arrhythmia occurs.

H. **RESPIRATORY ASSESSMENT:**
1. Outcome criteria
a. Neonatal nurses continually assess all data pertinent to the patient's respiratory system and update the nursing care plan to promote optimal respiratory function.
2. Process criteria: Neonatal nurses assess
a. Breath sounds at least every 4 hours and as needed.
b. Status of respiratory effort with each infant interaction (at least every 4 hours).
c. Oxygenation saturation and document the values every 2 hours for infants on oxygen and at least every 4 hours for infants on room air. A pulse oximeter should be in use for every infant.
d. Episodes of desaturation, whether on oxygen or room air, should be assessed; any action taken for recovery must be documented.
e. Any necessary respiratory support at least every 2 hours. This may be done by the nurse or respiratory care practitioner (RCP).
f. Ventilator Parameters:
i. The RCP will be responsible to set up equipment.
ii. Transcutaneous monitoring as needed per physician/AHP's order.
iii. All ventilator settings are determined per physician/AHP's order with the exception of needed or necessary FiO2 changes by RN/RCP.
iv. An RN and an RCP must transport mechanically ventilated patients.
g. ETT
i. Stabilization:
1) Two licensed health care personnel are required for securing and/or changing the ETT holder.
2) Two licensed health care personnel, inclusive of one RCP, are required for ETT adjustment. ETT adjustments require a physician/AHP's order.
ii. Suctioning:
1) All intubated patients will have an in-line suctioning device set up upon intubation.
2) Suction depth should be posted at bedside.
3) FIO2 requirements will be adjusted to maximize patient's tolerance of suctioning procedure.
4) Frequency and duration of suctioning should be limited and only when needed based on clinical symptoms.

5) Suction pressure to be no greater than 80 mmHg.
6) For ELGAN infants, suction pressure to be no greater than 60 mm Hg.
h. Oxygen saturation parameters:
i. 23-30 weeks gestation:
1) Target saturation goals: 88%-90%
2) Alarm settings: 82%-92%
ii. 30+1-35 weeks gestation:
1) Target saturation goals: 90%-94%
2) Alarm settings: 88%-96%
iii. >35+1 weeks gestation
1) Target saturation goals: 94%-98%
2) Alarm settings: 92%-98%

I. **GI/GU ASSESSMENT:**
1. Outcome criteria
a. Neonatal nurses continually assess all data pertinent to the patient's GI/GU system and update the nursing care plan to promote optimal GI/GU function.
2. Process criteria: Neonatal nurses will
a. Measure abdominal girth, at the umbilicus, upon admission and as needed for feeding intolerance.
b. Inspect and document abdominal abnormalities.
c. Auscultate all abdominal quadrants for presence and character of bowel sounds every shift and as needed if feeding intolerance, increased abdominal girth, or change in frequency or characteristics of stool occurs.
d. Notify Physician/AHP if no stools within 48 hours.

J. **SKIN AND TISSUE INTEGRITY:**
1. Outcome criteria:
a. Neonatal nurses continually assess all data pertinent to the patient's skin and tissue integrity and update the nursing care plan to promote and maintain optimal skin and tissue integrity.
2. Process criteria: Neonatal nurses will
a. Complete a "Neonatal skin condition scale" every shift.
b. Complete a "Neonatal skin risk assessment" ad hoc form weekly (Sunday day shift).
c. Perform baths using the following criteria:
i. Initial bath will be given no sooner than 24 hours of life and only if the infant is stable including stable temperature and respiratory status. Infants visibly soiled with meconium or blood can be bathed once stable after 2-4 hrs. of life.
ii. Gloves should be worn when touching all infants that have not been bathed.
iii. Use mild non-alkaline cleanser for greater than or equal to 32 weeks.
iv. Use warm sterile water for less than 32 weeks: avoid rubbing.
v. Removal of vernix is not necessary.
vi. Routine bathing two times weekly individualized to infant schedule and stability.
vii. Immersion/swaddle bathing is the preferred method for stable infants without central lines.
d. Perform eye care daily and prn with sterile water.
i. Infants on a paralytic medication shall have lubricant eye ointment administered a minimum of once per shift, per physician/AHP orders.
e. Disinfect skin surfaces with Chlorhexadine Gluconate (CHG) 2% or povidone-iodine 10% aqueous solution prior to invasive procedures such as insertion of central venous catheters, placement of PIV, umbilical line catheterization, chest tube insertion, injections, venipuncture, or heel sticks for laboratory samples. Wipe away all disinfectants (CHG, alcohol, betadine) with sterile water or saline wipes once procedure is complete.
f. Use only commercial heel warmers for warming extremities, per manufacturer's guidelines.
g. Avoid use of alcohol as primary disinfectant or for removing povidone-iodine or CHG. Isopropyl alcohol has been shown to be less effective in reducing infection and carries a risk of damage to the stratum corneum.
h. Use semi-permeable dressings to anchor umbilical lines, PIVs, PICCs, nasal cannulas, nasal or oral gastric tubes.
i. Use hydrocolloid barriers for skin protection when securing NG/OG tubes and cannulas.

j. Minimize use of tape and minimize contact with skin by "backing" tape or applying cotton to adhesive.
k. Avoid use of solvents for adhesive removal. Remove adhesives slowly and carefully with water soaked cotton balls or gauze, saline wipes or petrolatum.
l. Avoid use of enhanced bonding agents (Benzoin, Mastisol) as much as possible.
m. Assist in reducing Transepidermal Water Loss in the infant less than or equal to 32 weeks or less than 1500gms by using the following :
i. Infants <32 weeks shall be admitted to giraffes and placed in humidity of 70% for first seven days. Humidity may be increased up to 85% for infants <1000gms if needed, per physician/AHP orders. Emollients are not used during this time unless ordered by physician/AHP.
ii. Use only sterile water in humidifier reservoir and check level each shift.
iii. Humidity may be decreased to 50% after first seven days of life and continued until infant reaches 28 days of life per physician/AHP orders if needed. Petrolatum may be used at this level of humidity if there is evidence of skin breakdown.
iv. If rainout occurs, decrease humidity by 5% until no further rainout is present.
n. Use emollients for dry skin, cracking or fissures on skin surfaces:
i. For infants less than 32 weeks, use a preservative free topical ointment sparingly per physician/AHP order.
ii. For infants greater than 32 weeks or after 30 days of age, petrolatum may be used at the discretion of the physician/AHP.
o. Use natural drying for umbilical cord care.
i. Expose umbilical stump to air by keeping diaper folded off of umbilical stump.
ii. If the umbilical cord stump becomes soiled with urine or stool, clean the area with water.
iii. After cleansing with water, dry thoroughly with clean absorbent gauze to remove excess moisture, and then discard the gauze.
p. Notify Physician/AHP of IV infiltrates requiring medical evaluation and/or intervention.
q. Notify physician/AHP of any nasal or septum breakdown. Infants on NCPAP will need more frequent assessment of skin integrity around the nasal septum and behind the ears.

K. **NUTRITION**:
1. Outcome criteria:
a. Neonatal nurses continually assess all data pertinent to the patient's nutrition and update the nursing care plan to promote optimal nutrition.
2. Process criteria: Neonatal nurses will
a. Reconfirm tube placement prior to the first feeding of the shift by measuring the distance from the tip of the nose to base of the ear, then halfway between the xiphoid process and the umbilicus.
b. Measure and record abdominal girth at umbilicus prior to feedings for infants at risk for or demonstrating signs of feeding intolerance.
c. Adhere to the following residual protocol:
i. Check residuals with all NG feedings on preterm infants. Residuals on continuous feeds are not checked.
ii. Acceptable Findings:
1) Residual volume of < 5ml regardless of infant's feeding volume.
2) Residual volume of ≤ 30% of feeding volumes (if there are no additional signs of feeding intolerance and the clinical evaluation is normal.)
3) Residuals ≤ 30% shall be refed and continue with feeding order without deducting residual from feeding volume.
4) Residuals >30% shall be refed and subtracted from the feeding volume.
5) Do not refeed residuals that are bloody, brown and/or dark green bilious.
6) Residuals that appear light green or yellow are considered a normal gastric residual.
d. Notify the physician/AHP for any of the following signs/symptoms:
i. Residuals that are bloody, brown and/or dark green bilious.
ii. Residuals greater than 50%.
iii. Residuals that persist at 30-50% x 2 consecutive feedings of the current feeding volume.
iv. Abnormal abdominal exam as evidenced by but not limited to:
1) Increased distension: greater than 2 cm increase in abdominal girth
2) Discoloration (i.e., red and/or grayish black/blue)

3) New onset visible bowel loops
4) Tenderness
v. Repeated emesis
vi. Change in characteristic of stool
vii. The nurse may notify the physician/AHP at any time there is concern of feeding intolerance.
e. Assist with establishing and maintaining milk supply by:
i. Encourage pumping within 3-6 hours of delivery
ii. Pumping 8-12 time in 24 hours, including after breastfeeding with the goal of complete breast emptying at each pumping session.
iii. Promote breast massage and hand expression techniques used in conjunction with pumping.
iv. Encourage use of hospital grade pump.
v. Provide containers and labels to collect milk.
vi. Encourage skin to skin as often as possible.
vii. Monitor milk supply totals, initiate early intervention for decrease in milk supply (milk supply should increase by 3-5 days postpartum).
viii. Facilitate lactation consultations as needed.
ix. Utilize colostrum/breastmilk in the order pumped for the first two weeks of feeding.
x. Introduce breastfeeding before bottle feeding, bottle feeding is to be avoided for infants less than 34 weeks unless otherwise ordered by physician/AHP.
xi. Initiate non-nutritive or "dry" breastfeeding when infant is 32 weeks PCA and physiologically stable when held.
xii. Initiate nutritive breastfeeding when infant is able to handle own secretions and shows sucking behavior on a finger, pacifier, or the emptied breast.

L. **FLUID AND ELECTROLYTE:**
1. Outcome criteria:
a. Neonatal nurses continually assess all data pertinent to establish and maintain homeostasis as evidenced by:
i. Weight gain 15-45 gms/day (average).
ii. Soft, flat fontanel; sutures approximate
iii. Urine output 1-5 ml/kg/hr
iv. Good skin turgor
2. Process criteria: Neonatal nurses will
a. Maintain strict I&O on all:
i. Infants receiving steroids
ii. Infants receiving diuretics
iii. Infants receiving continuous IV therapy
iv. Infants who are NPO
v. Infants less than 1500 grams unless otherwise ordered by Physician/AHP.
b. Notify the physician/AHP if urine output is <1 mL/kg/hr.
c. Assess and document peripheral IV and PICC site status every hour. Assess and flush saline lock insertion sites with each hands-on assessment.
d. Use birth weight until the infant surpasses this weight, then daily weight, to calculate I&O for previous 24 hours. A "NICU Calorie Count" ad hoc form is to be completed every morning in patient's medical record.
e. Always physically trace each IV line from the solution, through the pump and into the patient and reconcile the accuracy of the solution and pump settings against a source document, e.g., order, medication record.

M. **PSYCHOSOCIAL SUPPORT:**
1. Outcome criteria
a. Neonatal nurses continually assess all data pertinent to the patient and family's psychosocial needs in a supportive manner.
2. Process criteria: Neonatal nurses should
a. Assess and document the patient and family's psychosocial status upon admission and daily in the patient's medical record.

~~b. Listen to family concerns in a supportive manner.~~
~~c. Encourage parents and families to participate in care as appropriate.~~
~~d. Give emotional reassurance to families as needed.~~
~~e. Identify family support systems upon admission and as needed.~~
~~f. Enter appropriate consults/referrals into the patient's medical record as needed.~~
~~g. Refer to social work as needed.~~

4.

~~N. PATIENT EDUCATION:~~

~~1. Outcome criteria~~

~~a. The family/caregivers will have their educational needs regarding the patient's hospitalization addressed in a timely manner.~~

~~2. Process criteria: Neonatal nurses will~~

a. Encourage families to be involved in the development of the plan of care from admission through discharge and whenever changes in the plan are needed at the level they choose.

~~b.~~a. Include the family and/or caregiver in teaching to increase their understanding of the infant's needs during hospitalization and upon discharge.

~~c.~~a. Orient parents and families to the unit guidelines/routines upon admission and throughout hospitalization.

~~d.~~b. Explain all procedures and interventions and the plan of care and encourage questions and discussion.

~~e.~~c. Assess learning needs upon admission and regularly thereafter. Document needs in the patient's medical record.

d. Provide the family/caregiver with educational materials as needed regarding the ongoing care of the infant and discharge information.

i. **Education provided to Parent/Caregiver(s) should be individualized to family's strengths and competencies.**

~~f.~~ii. **Provide an opportunity for families to ask questions about their NICU experience and share concerns that may arise.**

~~g.~~e. Begin discharge education as soon as the parents are able to participate in care and may include but is not limited to the following topics:

i. Hearing Screening (Ages and Stages)
ii. Newborn Metabolic Screen
iii. CPR
iv. Car Seat Challenge (< 37 weeks gestation or < 2500gms)
v. Safe Sleep Guidelines
vi. Car Seat Safety
vii. Shaken Baby Syndrome prevention
viii. Breast feeding support/education/resources

~~h.~~ Document all teaching and response to learning in the patient's medical record.

~~1) PATIENT SAFETY:~~

~~3. Outcome criteria~~

~~a. Neonatal nurses continually provide care in a safe manner.~~

~~4. Process criteria: Neonatal nurses will~~

~~a. Complete environmental checks whenever a change of caregiver occurs. Environmental checks include ensuring that two infant identification bands are on the infant and that the cardiopulmonary/oxygen saturation monitor is attached to patient.~~

~~b. Ensure that critical alarms include HR and apnea are set as follows unless otherwise ordered:~~

~~i. HR: 80-220 if non-ventilated and 32 corrected weeks or greater or if 38 weeks or greater (on positive pressure or not)~~

~~ii. 100-220 all other infants~~

~~iii. Apnea: 20 second delay~~

~~iv. Audibility of HR and apnea alarms on monitors will be validated by ensuring each is set as a crisis alarm (in alarm parameter levels) and 70% volume adjusted up or occasionally down as warranted for audibility in the pod.~~

~~v. Critical alarms will be checked at the beginning of each 12 hour shift and more frequently as the patient condition warrants for alarm limits, function and audibility. This check will be validated and documented in the medical record when limits are recorded.~~

~~e. EEnsure that all continuous infusions are clearly labeled with the name of the medication that is infusing as close as possible to the medication infusion site.~~

~~d. Ensure that the patient's emergency drug sheet is updated and the bedside.~~

~~e. Do Nnot leave infants unattended on any scale or flat, unprotected surface.~~

~~f. Ensure that bed wheels are locked at all times except during transfer.~~

~~g. Ensure that side rails on radiant warmers and open cribs are up at all times unless a caregiver is next to the bedside.~~

~~h. Use locks on isolette doors, portholes, and warmer side rails all times.~~

~~i. Utilize appropriate shielding and protection with use of x-ray equipment.~~

~~j. Use volume control infusion pumps with all IVs. No more than 1 hour of fluid infusion should be set.~~

~~k. Use safety belts when infants are placed in swings, car seats, vibrating chairs, or strollers.~~

~~l. Scan all medications and breast milk per hospital policy prior to administration.~~

~~O.~~A. **EMERGENCY EQUIPMENT:**

1. Outcome criteria
a. Neonatal nurses have appropriate emergency equipment available for patient use.
~~2.~~1. Process criterial:
a. A neonatal crash cart will be available on the unit at all times and checked according to hospital policy.
~~b.~~a. Admission bed supplies are checked at the beginning of each shift.
~~c.~~a. Emergency equipment present at the bedside should include
i. Mechanical suction with suction catheters
~~ii.~~i. Oxygen
~~iii.~~i. Resuscitation bag and appropriately sized mask
~~iv.~~i. Bulb syringe

f.

F. **NEONATAL SPECIAL POPULATIONS -- SMALL BABY CARE**

1. **General definitions**
   a. **ELGAN (extremely low gestational age newborn): any neonate born at less than 28 weeks gestation.**
   b. **VLBW (very low birth weight): any neonate born weighing less than 1500 grams.**
   c. **ELBW (extremely low birth weight): any neonate born weighing less than 1000 grams.**
2. **For the purposes of this guideline, the term "small baby" will be used to represent any neonate born less than 32 weeks gestation or weighing less than 1500 grams.**
3. **RNs attending deliveries and caring for the small baby will be competent in the care of these infants and principles specific to this population.**
4. **Small baby care begins at delivery and incorporates the golden hour concept of care. The following interventions are evidence based practices that decrease the risk of complications in the small baby population.**
   a. **Delayed cord clamping**
      i. **Discuss process/plan with attending neonatologist and obstetrician**
   b. **Thermoregulation**
      i. **Maintain body temperature between 36.5 °C and 37.5 °C**
      ii. **Refer to Thermoregulation policy and procedure and NRP guidelines**
   c. **Respiratory support**
      i. **Prepare and assist with interventions that help meet the goals of appropriate tidal volumes and decrease work of breathing while avoiding apnea, invasive ventilation, and lung parenchyma damage.**

ii. Maintain suction pressure < 60 mm Hg.
iii. Refer to respiratory support policy and procedures and NRP guidelines

d. Cardiovascular support, specially maintaining perfusion
i. Hypotension is poorly defined in the small baby. The following evidence based interventions are more appropriate for assessing and maintaining perfusion:
1) Delayed cord clamping
2) Timely intravenous access and initiation of maintenance fluids
3) Assess capillary refill, muscle tone, skin color.

e. Intraventricular hemorrhage prevention
i. Maintain thermoregulation
ii. Maintain midline head position for first 72 hours
iii. Take care to withdraw blood and infuse fluids at a slow rate to prevent rapid swings in blood pressure
iv. Refer to Neuroprotective Developmental Support policy and procedure.

f. Optimal early nutrition, specifically preventing hypoglycemia
i. Measure blood glucose between 30 and 60 minutes of life.
ii. Initiate dextrose solution, ideally TPN
iii. Refer to NICU Standard of Care

g. Decreasing risk of infection
i. Promote hand washing, use of hand gels
ii. Use of respiratory, central line and other NICU bundles

h. Integration of the family in the care of the infant
i. Family presence should be allowed as much as possible
ii. Update, support, communicate with family as appropriate

5. Assessment/Documentation
a. Refer to NICU Standards of Care

~~P. TRANSFER OF CARE:~~
~~1. Outcome criteria~~
~~a. Neonatal nurses assess all information pertinent to the transfer of care. They will communicate accurate and correct patient information to facilitate and support safe care, situational awareness, collaborative decision making, and continuity of care.~~
~~2. Process criteria: Neonatal nurses will~~
~~a.~~ Provide a report to the oncoming neonatal nurse, per hospital policy, including review of the patient's plan of care and outcome goals following the situation, background, assessment, and recommendation format.
~~b.~~ Review all physician/AHP orders placed throughout the shift and verify status.
~~c.~~ Review the medication administration record.
~~Assess the integrity of all vascular access sites, tubes, and drains.~~ **~~Extremely Low Gestational Age Newborn (ELGAN):~~** ~~defined as any neonate born at less than 28 completed weeks' gestation.~~
~~Temperature on the Extremely Low Gestational Age Newborn (ELGAN) should be done more frequently (i.e. q15 mins for 1st hour) to ensure temperature stability.~~
~~Assist in reducing Transepidermal Water Loss in the infant less than or equal to 32 weeks or less than 1500gms by using the following:~~
~~Infants <32 weeks shall be admitted to giraffes and placed in humidity of 70% for first seven days. Humidity may be increased up to 85% for infants <1000gms if needed, per physician/AHP orders. Emollients are not used during this time unless ordered by physician/AHP.~~
~~Use only sterile water in humidifier reservoir and check level each shift.~~
~~Humidity may be decreased to 50% after first seven days of life and continued until infant reaches 28 days of life per physician/AHP orders if needed. Petrolatum may be used at this level of humidity if there is evidence of skin breakdown.~~
~~If rainout occurs, decrease humidity by 5% until no further rainout is present.~~

~~d.~~

~~Q.~~G. REFERENCES:

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~~4.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC ~~FORENSIC CLINIC~~

ISSUE DATE: 05/11

SUBJECT: Decontamination and Sterilization of Instruments

REVISION DATE~~(S)~~:

Department Approval:	**03/20**
Infection Control Committee Approval:	**08/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**11/20**
Administration Approval;	**12/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. In compliance with infection principles, this document outlines the safe and effective method of cleaning, decontamination, and sterilization of surgical instruments used in clinic procedures.

B. **POLICY:**

1. The clinic will follow infection control principles when handling contaminated instruments.
2. Competent and qualified clinic staff will observe the principles of cleaning, decontamination and sterilization.

C. PROCEDURE:.

1. Instruments used in the clinic's procedures will be placed in the covered tray immediately after each use and germicidal solution will be added.
2. Hinged instruments will be placed in an open position for effective soaking.
3. Disposable instruments will be discarded according to hospital policy.
4. **A qualified person wearing protective equipment will prepare the instruments to be transported to SPD. Instruments will be initially wiped clean of gross contamination at time of use. Tools will be placed in puncture proof container and sprayed with hospital approved gel cleanser to keep them moist. The puncture proof container will be kept in the soiled equipment cabinet until delivered to SPD.**
5. Containers holding soiled instruments will be collected at the end of each day **and delivered back to SPD by clinic staff.** ~~by clinic staff using appropriate personal protective equipment (PPE) and brought to the soiled utility area for cleaning~~.
   ~~person will clean the instruments of all debris using appropriate PPE, rinse, air dry, and wrap in a covered container for transport to Sterile Processing for proper decontamination and sterilization~~.
6. Sterile Processing will be responsible for sterilization of the clinic's instruments and performing biological indicator testing and other testing to ensure proper functioning of sterilizers.
7. ~~The clinic staff will pick up the sterilized instruments and store them properly in the designated clean area for future use.~~
8. ~~7.~~ The Clinic will follow the event-related procedures for sterile products/equipment per Infection Control Manual.

Tri-City Medical Center
Oceanside, California

OUTPATIENT SPECIALITY SERVICES CLINIC~~FORENSIC CLINIC~~

ISSUE DATE: 05/11

SUBJECT: Infection Prevention & Control Activities

REVISION DATE~~(S)~~:

Department Approval:	**03/20**
Infection Control Committee:	**08/20**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**11/20**
Administration Approval;	**12/20**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Comprehension of and compliance with infection control principles is an essential component of the quality of care provided in the Clinic. The purpose of this document is to:
   a. Delineate the role in and scope of infection prevention and control activities.
   b. Define the infection control and prevention measures to be followed to prevent cross-infection among patients.
   c. Provide procedures to be adhered to by the staff of the clinic for protection from illnesses/conditions related to working with and caring for patients seem in the clinic.

B. **POLICY:**

1. A patient will not be denied access to the clinic *unless* the patient has an active infectious communicable airborne disease such as tuberculosis or has any other active communicable disease that cannot be safely managed by the clinic. The patient will be assessed on the initial visit for any infectious communicable airborne diseases.
2. All healthcare workers shall comply with the hospital's infection control policies and procedures.
3. The clinic shall follow infection control department policies and procedures related to compliance with State regulations for reporting of specified conditions.

C. **ACCOUNTABILITY:**

1. The RN is responsible for implementing and monitoring compliance with all infection control policies and procedures.
2. The RN is responsible for ensuring the appropriate infection control education/training is provided to all personnel.
3. The RN will consult with the hospital's infection preventionist as needed.
4. The infection control policy is submitted to the Infection Control Committee as often as the hospital requires.

D. **PROCEDURE:**

1. Patient Considerations
   a. Patients with a known or suspected infectious communicable airborne disease/condition (or any other condition that cannot be safely managed in the clinic) shall *not* be permitted in the Clinic until medically cleared by a qualified physician.
   b. Patients with known or suspected infection/condition that can be safely managed in the clinic shall be seen, and appropriate precautions shall be taken to prevent cross-infection. These include, but are not limited to, MRSA, VRE, and HIV.
   c. Cultures are obtained from patients with open wounds/soft tissue infections or suspected bone infections for treatment purposes and to identify potential communicability.
2. Occupational/Employee Health

a. All personnel shall comply with hospital policies related to the occupational health, safety, and well-being of healthcare workers as delineated in such policies as those found in the:
   i. Infection Control Manual and include those related to:
      1. Employee health
      2. Hepatitis B vaccine program
      3. Post-blood exposure management
   ii. Environment of Care (EOC) Manual:
      1. Blood-borne pathogens exposure control plan
      2. Tuberculosis and airborne transmissible disease (ADT)

3. Infection Transmission Reduction Methods: All staff members are expected to fully support the hospital's infection control efforts and to clearly understand the role they play in the infection control program. All clinic personnel shall comply with:
   a. Hospital transmission-based precautions such as Standard (with Universal), Droplet and Contact Precautions.
   b. The Blood-borne Pathogens Exposure Control Plan
   c. The hospital's hand hygiene policy
   d. The proper handling of biohazardous waste as defined in the Infection Control Manual.
   e. Aseptic sterile and clean technique
   f. Visitor and traffic control policies

4. Listed below are the minimum requirements recommended during controlled situations to protect the healthcare worker from potentially infectious agents. This list is not all-inclusive. If the situation indicates, increased infection control measures may be indicated, e.g., additional barrier protection in less-controlled situations.

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Vital signs - TPR & BP	R				
Phlebotomy	R	R			
Handling specimens	R	R			
Routine dressing changes	R	R	S		
Dressing changes large amount draining	R	R	R	**	**
Handling medical waste	R	R	S		
Decontamination instruments	R	R	S	**	**
Cleaning equipment	R	R	S		
Applying pressure to control bleeding	R	R	S		
Assisting with procedures such as wound debridement	R	R	S	**	**
Wound irrigation	R	R	S	**	**
Suture/staple removal clean, dry wound	R	R			
Capillary blood glucose testing	R	R			
Cleaning work surfaces	R	R			
Cleaning up small blood spills	R	R			
Cleaning large blood spills	R	R	R	**	**

Category	Hand-washing	Gloves	Gown	Mask	Eye Protection
Legend **R = routinely** **S = If soiling likely** **** = If splattering likely**					

5. Decontamination and Sterilization
   a. Utilizing appropriate personal protective equipment (PPE), only trained personnel shall clean and decontaminate the clinic's surgical instruments and equipment.
   b. Decontaminated instruments shall be transported safely to Central Supply/Processing in a covered container.
   c. Central Supply shall decontaminate and sterilize all instruments used in the clinic.
   d. The hospital's "Event-Related Sterility" policy will be followed.
6. Housekeeping
   a. Routine environmental cleaning is performed by the designated housekeeping staff using hospital-approved germicidal products.
   b. Germicidal agents with "Hepatitis B" claim shall be used for cleaning blood or OPIM spills.
   c. Exam chairs are disinfected between patients by the clinical staff using approved germicidal wipes/solution. Linen may be placed on the chair for protection from large draining wounds.
   d. The clinical staff shall disinfect reusable items such as BP cuffs, stethoscopes, and electronic thermometers daily, or more frequently as needed.
   e. Work surfaces are cleaned/disinfected daily and as needed by the clinic staff using the hospital-approved germicide.
   f. The cleaning/decontamination of medical equipment is the responsibility of the clinic staff.
   g. Biohazardous waste is handled according to policy in the Infection Control Manual.
7. Surveillance Activities
   a. The clinic shall participate in the surveillance activity of the Infection Control Department, as requested by the Infection Control Committee.
   b. Any unusual microbial patterns or isolated findings shall be reported to the Infection Control Department/practitioner.
8. Infection Control Education/Training
   a. All personnel shall attend the infection control orientation program upon hire.
   b. All personnel shall complete the annual infection control module.
   c. Additional infection control in-service presentations and consultation shall be provided as needed.

E. **REFERENCES:**

1. Centers for Disease Control and Prevention (CDC), Guideline for Isolation Precautions in Hospitals, 1996
2. Centers for Disease Control and Prevention (CDC), Guideline for Infection Control in Health Care Personnel, 1998
3. OSHA Bloodborne Pathogens Standard, 1997
4. Title 17 California Code of Regulations, 2001

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: ~~8~~/97 **SUBJECT: Pulmonary – Scope of Services**

REVISION DATE(S): 08/97, 01/00, 09/03, 08/06, 09/08, 09/09, 11/11, 05/12, ~~2/17, 3/20~~

Department Approval ~~Date(s)~~:	**06/20**
~~**Clinical Policies and Procedures Approval Date(s):**~~	
~~**Nurse Executive Committee Approval Date(s):**~~	
~~**Medical Staff Department/**~~**Division of Pulmonary Approval ~~Date(s)~~:**	**n/a**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**11/20**
Administration Approval:	**12/20**
Professional Affairs Committee Approval ~~Date(s)~~:	~~**09/17**~~ **n/a**
Board of Directors Approval Date(s):	~~**1/10, 5/12,**~~ **09/17**

A. **OVERVIEW OF THE DEPARTMENT:**

1. The department of Pulmonary services provides diagnostic and therapeutic services to inpatients, outpatients, and emergency department patients under the direction of a licensed pulmonary physician. Services are provided to neonates, infants, adolescents, adult and geriatric age groups. Service settings include all hospital areas. Pulmonary services ~~proved~~ **provide** a 24-hour/7 day service designed to meet the needs of our patients.

B. **DIAGNOSTIC SERVICES INCLUDE:**

1. Pulmonary function testing (outpatients scheduled 2 **days** ~~3 days~~/week: Tuesday & Thursday and inpatients as ordered). **If there is a need, more days will be opened to serve community and patient needs.**
2. Non-invasive oxygen assessment (Pulse Oximetry).
3. Home oxygen assessment.
4. Blood gas sampling and analysis.
5. Sleep screening (limited sleep ~~study~~ **screen**– inpatients only).
6. Bronchoscopy.
~~6.~~**7. CPAP set up and education**
~~7. EKGs.~~

C. **THERAPEUTIC SERVICES INCLUDE:**

1. Patient pulmonary assessment.
2. Patient respiratory education.
3. Medical gas administration.
4. Aerosol therapy.
5. Hyperinflation therapy.
6. Pulmonary hygiene.
7. Airway maintenance and support.
8. Ventilatory support.
9. CPR.
10. COPD Discharge Education
~~11. *Exception:* Full sleep studies are not performed at TCMC. Patients are referred to Palomar or Scripps.~~

D. **PROVIDERS OF SERVICE:**

1. All providers of respiratory therapy are appropriately oriented to the department and are licensed as required by law. Respiratory Care Practitioners (RCPs) acquire additional training and continuing education to ensure the proper care of patients. RCPs function under the direction of a medical director who specializeds in pulmonary medicine. The medical director acts in that role for ~~one~~ **two** years as described in the medical center by-laws. RCPs also function under the direction of an operations manager and director.
2. The pulmonary services department staff work in 12-hour shifts. The number of staff scheduled each shift is based on **the** total **workload calculated from the Respiratory Therapy Workload Summary report.** ~~RVUs or "sums" which are reviewed as part of the department information management system, "Medi-Serve."~~
3. Qualified RCPs are available 24 hours a day, 7 days a week. ~~RCPs re4port to a lead therapist or shift supervisor on both shifts.~~
4. ~~Additional M~~members of the pulmonary management services team include the following:

~~3.~~5. ~~RCP coordinators:~~
   ~~a. Clinical educator.~~
   a. **Pulmonary** Operations **Manager**/Clinical Educator
   b. ~~ICU~~

~~4.~~6. ~~The role of the RCP at Tri-City Medical Center and additional pulmonary support staff is described in the job descriptions and policies and procedures.~~ The department of pulmonary services is composed of professional, technical, clerical, and support staff in the following categories:
   a. Director
   ~~b. Ops~~ **Pulmonary Operations manager /Clinical**~~manager~~**Educator**
   ~~c. Educator~~
   ~~d. Coordinators~~**Critical Care Specialist/Adult and Neonatal**
   ~~e. Leads~~**Leads**
   ~~f.~~**b.** Registered/**C**certified pulmonary function technologists
   ~~g.~~**c.** Registered respiratory therapists (RRTs)
   ~~h.~~**d.** Certified respiratory therapists (CRTs)
   e. Cardiopulmonary assistants (equipment technicians)
7. **Job descriptions are on file for each of the above job categories.**

E. **EQUIPMENT:**

1. The pulmonary services department provides services utilizing medical equipment that is maintained in proper operational condition per preventative maintenance schedules and manufacturer's recommendations. Equipment inventory includes disposable and non-disposable equipment.

F. **STANDARDS AND PRACTICE GUIDELINES:**

1. Effective and efficient patient care is provided based on current standards of respiratory care and practice. TCMC pulmonary services adheres to federal and state regulatory imperatives and standards including the Respiratory Care Practice Act, Title 22, and Title 17, Center for Disease Control (CDC) and OSHA, and JCAHO. Patients can expect care that is delivered in a manner consistent with the American Association of Respiratory Care (AARC) Guidelines for Therapy whereby patients are assessed so that individual needs are met. The patient is evaluated to ensure that therapy is appropriate, indicated, and objectives clearly defined.
2. Patients and patient families can expect to be treated with dignity and respect (per "Patients' Rights") by the RCPs who also provide education and explanation of services for their customers.
3. In addition to the national guidelines, policies/procedures and protocols are based on expert consensus, ~~documentation team review~~ and community standards. Policies and procedures are reviewed ~~every year~~ and revised as needed to accommodate new evidence, standards, and/or guidelines. ~~Policies are discussed among the management team with input from RCPs then the hospital documentation team before they are finalized.~~ Final versions are communicated to the staff through email, staff meetings, ~~notes on bulletin boards, and "lunch" and "dinner" meetings~~**and daily huddles on each shift**.

~~3.4.~~ **All policies and procedures are posted online after submitting to house wide review and board approval.**

Tri-City Medical Center
Oceanside, California

PULMONARY SERVICES

ISSUE DATE: 07/03

SUBJECT: Respiratory Care Students in the Patient Care Areas

REVISION DATE(S):04/08, 01/10, 05/12, 07/17

Department Approval:	~~03/17~~,02/20
Division of Pulmonary Approval:	~~04/17~~09/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~10/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **AUTHORIZED TO PERFORM:**

1. All respiratory therapy students under supervision of a licensed Tri-City Healthcare District (TCHD) Respiratory Care Practitioner (RCPs).

B. **DEFINITION:**

1. Respiratory therapy students attending the residency program through an accredited college for Respiratory Care are sent to TCHD for clinical rotation experience. It is a requirement that each school have a current contract on file in order for TCHD to allow their students on site.
   a. A list of which level of rotation the students are on and written clinical objectives are sent to the pulmonary services department from the college prior to the student's arrival at the hospital.
      i. Example: observation only, general care, critical care, pulmonary function, pulmonary rehabilitation.
   b. Authorization to perform: different levels of rotation and what students are authorized to complete.
      i. Observation Only: able to follow licensed RCPs throughout the hospital in different settings to observe situations and/or procedures. No therapy may be given by the student.
      ii. General Care: floor care, (floor care is all general respiratory care, non-critical). Examples: aerosol therapy, hyperinflation therapy, bronchial hygiene therapy, and oxygen therapy.
      iii. Critical Care: floor care and critical care procedures: ventilators, Non-Invasive ventilation, intubation assist with physician and in presence of licensed RCP, observation of ABG's.
      iv. ~~Branch~~**Bronchoscopy**/PFT: may observe and/or assist the licensed RCP in completing these procedures (PFTs, bronchoscopy, Oximetry studies, Bedside Spirometry testing, and patient education)
      v. NICU: respiratory students may only observe patients in this setting.
   c. All care provided to patients by respiratory students must be supervised by a licensed respiratory care practitioner. The licensed RCP will enter all charting in the hospital computer charting system.

Tri-City Medical Center
Oceanside, California

This policy is moving from the Security Policy Manual to Administrative Policy Manual.

~~SECURITY~~
~~SAFETY~~
ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: May 05, 2002~~ ~~Reviewed: 5/03, 11/06, 3/09, 6/11~~ ~~Revision:~~ ~~Approvals: Director of Security~~	~~Subject: Storage of Legal Weapons~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM # 507~~

ISSUE DATE: 05/02

SUBJECT: Storage of Legal Weapons

REVIEW DATE: 05/03, 11/06, 03/09, 06/11
REVISION DATE(S): 08/12

POLICY NUMBER: 507

Department Approval ~~Date(s)~~:	**~~02/16~~05/20**
Environmental Health and Safety Committee Approval:	**08/20**
Administrative Policies and Procedures Committee Approval ~~Date(s)~~:	**10/20**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**12/20**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s)~~:	

A. **PURPOSE:**
1. To establish a set of guidelines for the Security Department Personnel to provide temporary storage of weapons at Tri-City Medical Center **(TCMC)** for **patients** or private Security Agencies while at ~~Tri-City Medical Center~~**TCMC**.

B. **DEFINITION(S):**
1. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors 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.~~C. **POLICY:**
1. It is the policy of TCMC that the Security Department utilizes the following procedure in the temporary storage of weapons at TCMC.

~~C.~~D. **PROCEDURE:**
1. Anytime a Security Officer learns of or discovers a patient/**visitor/Private Security/Workforce Member** who is in possession of a legal firearm or deadly weapon, the **Security** Officer will immediately make contact with the patient and advise the patient of the following:
   a. ~~The Officer will inform the patient that t~~The storage or custody of a weapon within the Medical Center by persons other than ~~an On-Duty a~~ Law Enforcement Peace Officer is prohibited.

b. ~~The Officer will inform the patient that t~~The weapon may be released to a responsible family member or person designated by the patient for the weapon's immediate removal from the facility.

~~c.~~**i.** If the weapon is to be released to a family member or other person, the **Security** Officer will inform the patient that the Security Department must take custody of the weapon until such time that the person arrives to take the weapon.

~~i.~~**1)** The weapon will be made safe and stored in the Emergency Department Security Office.

~~ii.~~**2)** A Property Custody form will be completed with a copy given to the patient or placed in the chart by the nurse.

2. Anytime a Security Officer learns of or discovers any visitor who is in possession of a legal firearm or deadly weapon, the Officer will immediately make contact and inform the visitor of the following:

a. ~~The Officer will inform the visitor that t~~The storage or custody of a weapon within the Medical Center by persons other than ~~an On-Duty~~ a Law Enforcement Peace Officer is prohibited.

b. ~~The Officer will inform the visitor that t~~The weapon may be released to a responsible family member or person designated by the visitor for the weapon's immediate removal from the facility.

~~c.~~**i.** If the weapon is to be released to a family member or other person, the **Security** Officer will inform the visitor that the Security Department must take custody of the weapon until such time that the person arrives to take the weapon.

~~i.~~**1)** The weapon will be made safe and stored in the Emergency Department Security Office.

~~ii.~~**2)** A Property Custody form will be completed with a copy given to the visitor.

3. Anytime a Security Officer learns of or discovers a Private Security Officer who is in the possession of a firearm or deadly weapon, which is not in the performance of a legitimate business purpose within the Medical Center, the **Security** Officer will inform the Private Security Officer of the following:

a. ~~The Officer will inform the Private Security Officer that t~~The storage or custody of a weapon within the Medical Center by persons other than ~~an On-Duty~~ a Law Enforcement Peace Officer is prohibited.

b. ~~The Officer will inform the Private Security Officer that t~~The weapon may be released to a responsible family member or person designated by the Private Security Officer for the weapon's immediate removal from the facility.

~~c.~~**i.** If the weapon is to be released to a family member or other person, the **Security** Officer will inform the Private Security Officer that the Security Department must take custody of the weapon until such time that the person arrives to take the weapon.

~~i.~~**1)** The weapon will be made safe and stored in the Emergency Department Security Office.

~~ii.~~**2)** A Property Custody form will be completed with a copy given to the Private Security Officer.

~~D.~~**E. FORM(S):**

1. **Property Custody Form**

Tri-City Medical Center
Security Department

Property Custody Record

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

Officer Receiving Property:	Date Received:	Time Received:

Property Received from:

❑ Owner: _____

❑ Other: _____

Location / Reason Property Obtained:

_____

_____

_____

❑ Property Received for Safekeeping

Item #	Qty	Description / Condition:	SN / Tag #

Property Disposition:

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

Property Returned By:		
Officer:	Badge:	Date:

Property Received By:	
Signature:	Date:

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

Revised: 11/20
Security Policy: Property Custody

Tri-City Medical Center
Oceanside, California

DELETE – no longer required

SECURITY
SECURITY OPERATIONS

SUBJECT: Vehicle Jumpstart

ISSUE DATE:	04/94	POLICY NUMBER: 234
REVIEWED DATE(S):	10/97, 5/03, 11/06, 3/09, 6/11, 07/15	
REVISION DATE(S):	10/97, 7/03, 09/15	

Department Approval Date(s):	~~07/15~~05/20
Environmental Health and Safety Committee Approval Date(s):	~~08/15~~08/20
Administration Approval:	10/20
Professional Affairs Committee Approval Date(s):	~~09/15~~ n/a
Board of Directors Approval Date(s):	09/15

~~A. PURPOSE:~~

~~1. To set guidelines for Security Department personnel to utilize when a request for assistance for a dead battery is made.~~

~~B. POLICY:~~

~~1. It is the policy of the Security Department to follow the procedures of this policy while providing requested services with assistance for a dead battery.~~

~~C. PROCEDURE:~~

~~1. Security Officers will not leave Medical Center owned or operated property to assist with a dead battery.~~

~~2. All Jump Starts will be conducted on an "as-available" basis by mobile patrols and will not be performed if the Security Department has higher priority calls for service, duties, activities, or assignments pending.~~

~~3. Security Officers will not be authorized to attempt to push or tow a vehicle in an attempt to start the vehicle.~~

~~4. Security will only make a reasonable attempt to Jump Start a vehicle.~~

~~5.~~1. ~~Security Officers will only be authorized to utilize the provided Jump Start Battery Pack; no other Jump Start methods will be utilized.~~

Tri-City Medical
Oceanside, Califo

DELETE
Use Elsevier Online Skills:
Radiation Safety (Perioperative)

SURGICAL SERVICES POLICY & PROCEDURE MANUAL

ISSUE DATE: 01/94

SUBJECT: Safety Measures: Radiation

REVISION DATE(S): 02/05; 06/09; 11/12

Department Approval:	03/20
Operating Room Committee Approval:	03/20
Department of Anesthesiology Approval:	n/a
Department of Radiology Approval:	09/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	10/20
Administration Approval:	12/20
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. ~~PURPOSE:~~

~~Ionizing radiation is useful for diagnostic, interventional, and therapeutic procedures. Ionizing radiation can damage living tissues and produce long-term effects. Patients and personnel should be protected from unsafe levels of radiation that are not medically indicated because of the potentially hazardous effects of ionizing radiation exposure on tissue over time. The goal of radiation safety is to keep the risks from ionizing radiation as low as reasonably achievable. Guidelines for radiation safety are based on the principles of time, distance, and shielding. This policy describes the radiation safety measures for personnel and patients in the surgical area.~~

~~*B. RADIATION POLICY:*~~

~~1. Appropriate safety measures will be instituted to minimize the level of radiation to which personnel and patients are exposed in the OR.~~

~~a. Reports on employee/staff exposure are received monthly by the Director of Surgical Services for those employees who wear radiation badges on a regular basis. They are the Endoscopy nurses, the Urology coordinator, and any other employee who requests to wear a radiation badge.~~

~~b. Employees will be notified if excessive exposure has occurred.~~

~~2. Personnel shall wear lead aprons and thyroid shields in cases where x-ray is used.~~

~~3. Patients exposure to radiation should be limited to situations where it is medically indicated and to the anatomical structures being treated.~~

~~4. Protect abdomen and gonad region of fertile male and female patients by placing a lead shield over this area when surgery does not include this area.~~

~~5. Scrubbed personnel step into a substerile room if not wearing a lead apron.~~

~~6. Non scrubbed personnel may step into a substerile or scrub room next to the OR where filming is taking place if circulating/watching events in the room through the window in the door, in case immediate intervention is required in the room.~~

~~7. Use lateral cassette holder when feasible so that personnel can move away from the imaging area.~~

~~8. Record the type of imaging procedure (portable or fluoroscopy) on the operative record.~~

~~9. Pregnant Personnel:~~

This policy and procedure is set forth to encourage early disclosure of pregnancy of any employee working with ionizing radiation. Although there are no regulatory requirements which address radiation dose limitations to the fetus of a pregnant woman, Tri-City Medical Center adheres to the recommendation of the National Council on Radiation Protection and Measurements (NCRP) to limit total radiation dose to the fetus of an occupationally exposed woman to 500 millirem (0.5 rem) during the pregnancy.

a. Due to the increased sensitivity of a fetus to radiation during the first trimester of pregnancy, female employees working with ionizing radiation are encouraged to disclose, in confidence, their pregnancy (or possible pregnancy) as soon as possible to their supervisor.

b. The employee's work load will then be reviewed by their supervisor to allow for that employee to handle cases that would be less hazardous to their condition. Pregnant employees should not participate in or perform: table side fluoroscopy, mobile x ray examinations, the holding of a patient during fluoroscopic or radiographic examinations, elution of radionuclide generators, any procedure involving a patient who contains radioactive materials in therapeutic amounts, or the decontamination of major spills or disaster victims.

c. If possible, the supervisor will adjust or revise the workload and/or responsibilities of the pregnant employee in accordance with these guidelines so as not to assign her to a case involving radiation, for the entire term of pregnancy.

C. RADIATION SOURCES BY THE RADIATION ONCOLOGIST IN THE SURGICAL SUITE:

1. Brachytherapy utilizing radioactive seed implantation into the prostate gland will be performed under the supervision and direction of a physician. The following instructions must be observed:

a. After a pre-volumetric ultrasound procedure, a therapy plan will be developed by the physician. The dose (i.e., type, number, and activity of seeds) will be determined. The physician will complete the form "**Radioactive Seeds Order Form**", which must contain an authorization number and signature from the insurance carrier or agent before the seeds can be ordered. The form will be forwarded to the Radiation Safety Officer (RSO) at TCMC for authorization. The RSO will forward the form to the purchasing agent who will issue a purchase order and contact the vendor. A copy of the form with shipment and delivery information completed will be forwarded to the RSO for the files.

i. The radioactive seeds will be delivered to TCMC, Nuclear Medicine Department and properly secured. An authorized radioactive source handler will open the shipment, verify the contents, assay the sources, and proceed to load the sources into the appropriate handling equipment. He will attach proper labels and complete appropriate paperwork for documentation.

ii. The source handler will arrange for the sterilization of the sources and the delivery to the assigned surgical suite when the patient arrives.

iii. The sealed source sterilizations and preparation areas must be posted with appropriate signs and surveyed with a GM meter after procedure. Measured radiation levels must be documented. High levels (exceeding 0.5 mR/hr in the absence of any stored radioactive material are to be reported to the physicist and/or RSO.

2. Following ALARA principles, adequate shielding will be provided at all times. All personnel involved in the procedure will wear radiation exposure monitoring devices and their exposures reviewed. Appropriate signs will be posted on all doors to the suite.

a. No pregnant personnel or anyone under the age of 18 years shall be involved in the procedure.

b. Visitors are not permitted in the room.

c. The patient's medical record shall be flagged with appropriate notices indicating the source and activity of the radioactivity.

d. During the recovery procedure, the patient must not be located adjacent to any pregnant patients or any patients under 18 years of age. The brachytherapy patient should be a minimum of two (2) meters from the surrounding patients.

3. Post-procedure:

a. The surgical suite must be monitored with the appropriate survey meter to identify any lost seeds.

b. Nothing is to be removed from the room until checked for radioactivity. The suite cannot be cleaned or turned over for the next case until released by the RSO or designee.

c. All surgical dressings, bodily fluids, equipment, and instrument trays must be monitored for any residual radioactivity.

d. After the patient is removed from the surgical suite:

i. The room must be surveyed for any remaining seeds. Any seed located in the room, in any equipment or disposable item must be properly disposed.

ii. Final room radiation survey must be performed and findings documented in MR/hr.

iii. Room can be released for cleaning and turnover if readings are below 2-3 times background.

e. All readings must be documented. Copies of all documentation must be forwarded to the Radiation Safety Office for filing.

4. Patient Discharge:

a. A patient can be released from the hospital who has received a permanent implant:

i. Without restrictions, if the exposure rate is 2 mR/hr or less at 1 meter as measured from the umbilicus, or

ii. With oral and written instructions, if the exposure rate is between 2 mR/hr and 5 mR/hr at 1 meter as measured from the umbilicus.

b. Prior to release, all patients are to receive verbal as well as written instructions regarding radiation exposure to other persons, especially family members. Particular attention to minimizing exposure to children and to pregnant women during the first half life (I-125 = 60 days, Pd-103 = 17 days) is to be addressed.

c. All documentation must be kept on file with the RSO.

D. PREGNANCY PRECAUTIONS IN THE OR:

1. A pregnant employee will not be assigned to rooms which will have prolonged radiation exposure (i.e., c-arm or radium implants).

2. In the event of an on-call shift a c-arm case is scheduled the pregnant nurse may circulate only. She must step immediately outside the OR room donning a wrap-around lead apron readily available to her scrub while the c-arm is turned on.

3. In the event of portable x-rays, she will stand immediately outside the OR room during the film taking process – readily available to her scrub.

4. When methylmethacrylate (bone cement) is utilized she will stand immediately outside the OR room during the mixing process –readily available to her scrub. If feasible she will not be assigned to the room.

5. In the event of an anesthetic gas spill she will promptly exit the immediate area to avoid inhaling the fumes. Another nurse will be assigned until the gases clear.

6. She will avoid areas where a formaldehyde spill has occurred.

E. REFERENCES:

AORN Perioperative Standards and Recommended Practices, 2011 Edition.

Community Healthcare & Alliance Committee (No meeting held in December, 2020)

Audit, Compliance & Ethics Committee
(No meeting held in December, 2020)

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

November 19, 2020 – 5:00 o'clock p.m.
Meeting Held via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 5:00 p.m. on November 19, 2020.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director George W. Coulter
Director Rocky J. Chavez
Director Leigh Anne Grass
Director Julie Nygaard
Director Larry W. Schallock
Director Tracy M. Younger

Absent was Director Rosemarie V. Reno

Also present were:

Steve Dietlin, Chief Executive Officer
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Executive Protection Agent

1. The Board Chairperson, Director Grass, called the meeting to order at 5:00 p.m. via teleconference with attendance as listed above.

2. Public Comments – Announcement

2. Approval of agenda.

It was moved by Director Chavez 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 Reno absent.

Oral Announcement of Items to be discussed during Closed Session

Chairperson Grass made an oral announcement of the item listed on the November 20, 2020 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Evaluation: Chief Executive Officer

5. Motion to go into Closed Session

It was moved by Director Nygaard and seconded by Director Schallock to go into Closed Session at 5:05 p.m. The motion passed (6-0-0-1) by a roll call vote.

6. At 5:35 p.m. the Board returned to Open Session with teleconference attendance as previously noted.

7. Report from Chairperson on any action taken in Closed Session.

   Chairperson Grass reported the Board in Closed Session considered the annual evaluation of the Chief Executive Officer and directed Counsel to draft an amendment to the agreement for consideration at the next meeting.

8. There being no further business, Chairperson Grass adjourned the meeting at 5:40 p.m.

_____
Leigh Anne Grass
Chairperson

ATTEST:

_____
Julie Nygaard
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

November 12, 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 November 12, 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
Ray Rivas, Chief Financial Officer
Dr. Gene Ma, Chief Medical Officer
Roger Cortez, Chief Compliance Officer
Susan Bond, General Counsel
Dr. Mark Yamanaka, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant
Richard Crooks, Executive Protection Agent

1. The Board Chairperson, Leigh Anne Grass, called the meeting to order at 3:35 p.m. via teleconference with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Nygaard to approve the agenda as presented. Director Chavez seconded the motion. The motion passed unanimously (7-0) via roll call vote.

3. Pledge of Allegiance

   Director Reno led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Grass read the Public Comments section listed on the November 12, 2020 Regular Board of Directors Meeting Agenda.

5. Special Recognition

1) Honoring Directors, Julie Nygaard, RoseMarie V. Reno and Larry W. Schallock

- Director Julie Nygaard – 2012-2020
- Director RoseMarie V. Reno – 1984-2020
- Director Larry W. Schallock – 2002-2020

Chairperson Grass recognized Directors Julie Nygaard, RoseMarie V. Reno and Larry W. Schallock for their dedication, commitment and service to the Tri-City Healthcare District Board of Directors and commented on their individual honors and accomplishments over the years. Each Board member will receive a plaque recognizing their service to the Tri-City Healthcare District Board of Directors.

6. September, 2020 Financial Statement Results – Mr. Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $74,860
- Operating Expense - $80,539
- EBITDA - $526
- EROE – ($3,343)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 144
- Adjusted Patient Days – 24,264
- Surgery Cases – 1,376
- ED Visits – 11,044

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $25,823
- Operating Expense - $27,319
- EBITDA – $364
- EROE – ($930)

Mr. Rivas reported on current month Key Indicators as follows:

- Average Daily Census – 151
- Adjusted Patient Days – 8,119
- Surgery Cases – 474
- ED Visits – 3,557

- Net Patient Accounts Receivable - $35.6
- Days in Net A/R – 51.5

Chairperson Grass requested clarification on the monthly percentage of self-pays. Mr. Rivas and Mr. Dietlin provided clarification and responded the number is a percentage of gross at 2.2%.

There were no further questions or comments by Board members.

6. New Business –

a) Fiscal 2020 Financial Statement Audit – Moss Adams

Mr. Ray Rivas provided an Executive Summary of the audit that was just completed for FY ended June 30, 2020. He stated we were favorable to our budget for the first two quarters up until the pandemic. However, in March we halted our elective procedures and almost immediately began losing about $7 million per month in net patient revenue. During the period March through June we lost more than $29 million of net patient revenue and incurred over $2 million in direct COVID related expenses which included specific types of PPE, COVID testing and special beds. Mr. Rivas stated the District did receive a CARES Act Grant of $7 million to offset those expenses but the net impact of COVID for March – June was a deficit of approximately $24 million. Mr. Rivas stated that we did end up the year with an EROE loss however there were some positives. We reported a positive EBIDTA of $3.2 million (a measure of cash flow versus expense) and were able to do that through very strict expense controls including flexing, voluntary furloughs and adjusted our pharmacy and supply expenses to meet the volume at the time. Additionally we were able to improve our financials steadily each month after March. Mr. Rivas stated we ended the year by improving liquidity by more than $3 million over the prior year while at the same time investing approximately $6.5 million in capital acquisitions

Mr. Dietlin reiterated that it has been an extremely difficult year for all healthcare institutions in the COVID era. He complimented the team on their flexibility and rising to action. He stated that first and foremost it was about making sure there was proper protection, testing, and the safety of all of our employees and patients as well. It was necessary to reset the protocols operationally, separating COVID and non-COVID patients to make sure everyone is safe and secure and we have been very successful in avoiding widespread outbreaks in employees and physicians. Mr. Dietlin stated the key regarding the pandemic is flexibility. We want to make sure that everyone is safe and that we are adequately staffed but at the same time flexible to what the actual volumes are. With respect to furloughs, Mr. Dietlin stated the majority of staff who were furloughed have been brought back and we actually have 100 positions open that we are filling currently at the hospital. On a comparative basis our hospitalization mortality rate is favorable compared to both locally and nationally. Mr. Dietlin stated we managed sustainability through the end of the fiscal year and into the next fiscal year. We are keeping ourselves fiscally sound while managing the COVID-19 pandemic.

Mr. Rivas introduced Ms. Stacy Stelzriede, Engagement Partner with Moss Adams and Kyle Rogers, Manager on the audit. They presented the results of the year-ended June 30, 2020 Fiscal Year Financial Statement Audit. Ms. Stelzriede reported the Auditors will issue an unmodified opinion which reflects the Financial Statements are presented fairly and in accordance with US Generally Accepted Accounting Principles. Mr. Stelzriede also reported there were no material weaknesses or proposed adjustments. The report issued on time in accordance with our debt agreements.

Ms. Slezerieide stated the timing of today's presentation is later than usual which is a direct result of the pandemic. She stated there were some challenges however the delay was not

because of anything management did or didn't do. It was solely related to the timing of information both sides needed from the federal government related to the CARES Act Grant the District received.

The presentation included information on the following:

- Auditor Opinions & Reports
  - Scope of Services
  - Auditor Report on the Financial Statements
  - Other Auditor Reports
- Communications with Those Charge with Governance
  - Our Responsibility
  - Planned Scope & Timing of the Audit
  - Significant Accounting Policies & Unusual Transactions
  - Management Judgments & Accounting Estimates
- Exhibit: Management Representation Letter
- Other Information.
- Snapshot of Financial Information

The auditors also provided general CARES Act consulting as there is a lot of complexity with respect to the reporting requirements with the grant we received.

With regards to the single report there are two other opinions that are issued. The GAGAS Report on Internal Controls over Financial Reporting and on Compliance and Other Matters. There were no financial reporting findings to communicate and no compliance findings to communicate. Ms. Stelzriede stated that even though they haven't issued the single audit yet they have completed the work for the HUD Loan.

Ms. Stelzriede reviewed the Significant Audit Areas as follows:

- Patient Revenue and Receivables
- Cost Report Settlements and Supplemental Funding
- Self-Insured Liabilities
- Line of Credit and Long Term Debt
- MOB Legal Proceedings
- CARES Act Grant Funding (Revenue Recognition and Single Audit)
- Compliance with Federal Laws and Regulations
- Medicare Accelerated Payments (Subsequent Event)

Lastly, Ms. Stelzriede reviewed the Financial Ratios & Metrics as follows:

- Days Cash on Hand – 60 days (which would have been 100 days) had we received the $30.6 million Medicare Accelerated Payment by June 30th-.
- Current Ratio – 1.35 (anything greater than 1 is considered good)
- Debt to Capitalization – 54% which is up slightly due to our loss in the current year
- Days in Accounts Receivable – 46 (down from last year which reflects management is doing good job of collecting receivables and not letting them age out).
- Excess/Deficiency of Revenue over Expenses (EROE) plus Depreciation and Interest as a % of Operating Income – 1.0%

  Ms. Stelzriede stated that to be able to show a positive margin under these circumstances is remarkable.

Director Schallock stated he is very pleased with the audit results considering the circumstances we have been through for most of the year. He asked that auditors address the comments that were made by a candidate during the recent election campaign that there was $4-5 million dollars that was not accounted for. The auditors said they did not find cash that was unaccounted for and did not believe that to be a valid statement. .

Lastly, Director Schallock stated that typically the Audit Committee asks management to leave the room so the auditors can advise the committee of any issues they should be aware of. Ms. Stelzriede stated due to present circumstances they were unable to meet with the Audit Committee however there were no concerns with getting information needed, receiving accurate information or any concerns regarding the integrity of management.

Director Reno stated she is ecstatic to hear of the Days Cash on Hand. She requested clarification on the unused revolver which was answered by Mr. Rivas.

Director Chavez expressed his appreciation to the Moss Adams team for putting the audit together and highlighting the numbers which reflect how well we are doing. He commented on recent misinformation on Tri-City that was unfounded.

Director Younger commented that it was a great report and as always the report was very articulate and thorough.

Director Coulter thanked Director Schallock for his insightful questions and comments related to the unfounded misinformation made by a candidate in the recent election. He also expressed his appreciation to everyone who worked on the audit.

Chairperson Grass congratulated everyone in the C-Suite, Finance and Accounting for a great job.

Mr. Dietlin stated the Audit Committee members were invited to today's meeting and he wanted to provide them with the opportunity to participate fully in the process and ask any questions they might have. Mr. Stanley Dale, Audit Committee member stated he did not have any questions and he concurs with the compliments of the C-Suite, staff and auditors for an excellent job.

It was moved by Director Schallock to accept the FY2020 Financial Statement Audit. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Nygaard, Schallock and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Reno**
ABSENT:	**Directors:**	**None**

7. Old Business – None

8. Chief of Staff

a) Consideration of October 2020 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on October 26, 2020.

Dr. Yamanaka reported the October Credentialing Actions and Reappointments were included in the agenda packet for information only as they were previously approved by the Board Chair, CEO and Chief of Staff through e-mail communication due to no scheduled Board meeting in October.

9. Consideration of Consent Calendar

It was moved by Director Nygaard to approve the Consent Agenda. 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**

10. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

11. Comments by Members of the Public

There were no comments by members of the public.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported we have treated over 370 inpatient positive COVID-19 patients. A multitude of items such as safety protocols, PPE, workforce and multiple testing platforms have come together to provide excellent service to our community with very good outcomes. He expressed his appreciation to all the team members that make that happen including the Board, Medical Staff, Foundation, nurses, clinical staff, the Auxiliary and many others.

Mr. Dietlin recognized the finance and accounting staff for their efforts in the audit process. He commented that it has been eight (8) straight years with no restatements or proposed adjustments which is truly remarkable.

Lastly, Mr. Dietlin expressed his appreciation to the three outgoing Board members, Directors Nygaard, Reno and Schallock for their 60+ years of service to Tri-City. He stated in December we will be welcoming in three new Board members.

13. Board Communications

Director Reno commented on her last 36 years of service to Tri-City and read a letter into the record which will be attached to the file copy of these minutes. She stated it was an honor and a privilege to serve.

Director Schallock reported he recently sat in on a recent Medical Executive Committee meeting to personally thank the Medical Staff for their work. He also expressed his appreciation to the nurses and front line staff for providing the day to day care.

Director Schallock expressed his appreciation for the opportunities given to him at Tri-City from being an employee to a Board Member as well as the ability to be actively involved in various community activities and organizations.

Director Nygaard commended Mr. Dietlin for the excellent job he has done during the pandemic. She stated she feels secure in knowing Tri-City Medical Center is here to care for her and her family. She encouraged everyone to stay socially distanced and masked for the health of our community and workers.

Director Nygaard also congratulated and welcomed the incoming Board Members and congratulated Chairperson Grass on her reappointment.

Director Chavez expressed his appreciation to Directors Reno, Schallock and Nygaard for their superior dedication to the Tri-City Healthcare District Board.

Director Younger also expressed her appreciation to Directors Reno, Schallock and Nygaard for their mentorship and guidance.

Director Coulter expressed his appreciation to outgoing Board members Directors Nygaard, Reno and Schallock.

Director Coulter also expressed his appreciation to Administration, physicians, nurses and staff for their efforts during the COVID-19 pandemic.

14. Report from Chairperson

Chairperson Grass reported collectively outgoing Board members Nygaard, Reno and Schallock have served the District 62 years and have accomplished so much. She extended her appreciation.

Chairperson Grass also congratulated staff on the outstanding audit.

In closing Chairperson Grass wished everyone a happy Thanksgiving and encouraged everyone to count their blessings!

15. Move to adjourn

It was moved by Director Chavez and seconded by Director Schallock 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 4:50 p.m.

_____
Leigh Anne Grass, Chairperson

ATTEST:

_____
Julie Nygaard, Secretary

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	50.9	52.7	50.7									51.3	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	55.3	57.4	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY21	107.1	103.1	101.1	99.6									102.7	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	108.0	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)	($923)	($930)	$508									($2,835)	$ (7,576)
FY20	($476)	($494)	($759)	($311)	($1,036)	($1,040)	($860)	($735)	($4,467)	$1,921	($2,982)	$170	($2,039)	

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%	-3.74%	-3.60%	1.78%									-2.74%	-7.75%
FY20	-1.65%	-1.66%	-2.71%	-1.08%	-3.91%	-3.75%	-2.85%	-2.69%	-17.32%	9.94%	-14.31%	0.69%	-1.77%	

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)	$291	$302	$1,738									$2,140	$ (2,818)
FY20	$686	$681	$412	$683	$62	$128	$367	$551	($3,164)	$3,159	($1,774)	$1,383	$2,462	

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%	1.18%	1.17%	6.09%									2.07%	-2.88%
FY20	2.38%	2.30%	1.47%	2.36%	0.24%	0.46%	1.22%	2.02%	-12.27%	16.35%	-8.51%	5.59%	2.13%	

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	5.66	5.40	5.87									5.58	6.65
FY20	7.04	6.80	6.21	6.90	6.58	6.44	6.71	6.82	7.02	7.27	5.61	5.51	6.73	

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	$57.4	$83.5	$76.9									
FY20	$52.4	$44.8	$43.7	$45.6	$38.2	$31.9	$35.2	$35.8	$34.8	$51.2	$62.3	$60.4	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending October 31, 2020

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	47,421.57	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)	35,388.70	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	06/30/25	**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)	19,894.94	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
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 7,000	$4.12	(a)	37,908.00	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	$2.59	(a)	3,754.00	02/01/20	10/31/20	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**$ 195,251.56**				

(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 October 2020

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	CHEMOTHERAPY RENEWAL	102520 EDU	103.00	80795	MARIA MERCADO
6185	CHEMOTHERAPY RENEWAL	101920 EXP	103.00	81437	KAROLINA WASILEWICZ
7010	CNOR EXAM	91720 EDU	395.00	28045	ANGELICA MARIN
7010	GERIATRIC EMERGENCY NURSING EDUCATION	83120 EDU	200.00	43855	DORIS TURNER
7010	GERIATRIC EMERGENCY NURSING EDUCATION	83120 EDU	200.00	43855	MARIA SELLER
7894	ONS/ONCC CHEMOTHERAPY IMMUNOTHERAPY	92320 EDU	458.00	82458	MELISSA WARD

**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.