TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 9, 2021 – 3:30 o'clock p.m.

In accordance with California Government Code Section 54953 teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will also 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: 846 1620 3775; Passcode: 385000

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	October 2021 Financial Statement Results	10 min.	CFO
6	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	15 min.	Chair

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
	b) Consideration of proposed 2022 Board Meeting Schedule	5 min.	Chair
	c) Approval of Redistricting Proposal with National Demographics Corporation (NDC)	10 min.	Chair/ Board Counsel
	d) Consideration to award Board Scholarship to the Tri-City Hospital Auxiliary in the amount of $10,000.	5 min.	Nancy Miller,Chair Auxiliary Scholarship Committee
7	Old Business – None	--	--
8	Chief of Staff a) November 2021 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on November 22, 2021.	5 min.	COS
9	Consideration of Consent Calendar ***Requested items to be pulled require a second.*** (1) Approval of the addition of Mihir Barvalia M.D., Farah Dawood. M.D., Genaro Fernandez, M.D., Jesse Naghi, M.D., and Dimitri Sherev, M.D. to the currently existing Ed On-Call Coverage Panel for Cardiology-General and STEMI for a term of 12 months, beginning November 1, 2021 and ending October 31, 2022. (2) Approval of the renewal of an agreement with Victor Souza, M.D. as the Medical Director/Covering Physician for the Specialty Care Clinic and Progressive Care Unit a term of 24 months beginning September 1, 2021 and ending August 31, 2023, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163, for an annual cost of $39,120 and a total cost for the term of $78,240. (3) Approval of Resolution 805, a Resolution of the Board of Directors of the Tri-City Healthcare District Re-Ratifying the State of Emergency and Re-Authorizing Remote Teleconference Meetings (4) Approval of the amendment to the agreement with QuadraMed Affinity Corporation for a limited software support renewal for a term of 12 months, beginning January 1, 2022 and ending December 31, 2022, for an annual and term cost of $294,520.63. (5) **Administrative & Board Committees** **A. Policies** **1. Patient Care Services Policies & Procedures** a. Accounting of Disclosure of Patient Information (PHI) Procedure b. Allied Health Students in Patient Care Areas Policy c. Documentation in the Medical Record Policy d. Duty to Warn Potential Victims Policy e. Interdisciplinary Plan of Care IPOC f. Medical Record, Making Corrections to Documentation	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

Procedure
g. Minors Attempting to Leave Without a Parent-Domestic Partner-Legal Guardian Policy
h. Patient Classification (Acuity) Procedure
i. Point of Care (POC) New Test Method Request and Implementation Policy
j. Program Flexibility
k. PureWick Female Urinary Incontinence Management
l. Reporting Suspected Child Abuse/Neglect
m. Reporting Suspected Dependent Adult/Elder Abuse/Neglect
n. tdap (Tetanus, Diphtheria & Pertussis) Vaccine Administration for Antepartum & Postpartum Obstetric Patients Standardized Procedure

2. Allied Health Professional Manual
a. Oncology Standardized Procedure

3. Environment of Care Manual
a. Acquisition of Furniture and Furnishings
b. Battery Management and Disposal
c. Fire Plan – Code Red
d. Disposing of Recalled Products
e. Environment Health and Safety Committee Charter
f. Exit Doors
g. Fire Safety Hazards (DELETE)
h. Handling & Use of Gas Cylinders
i. Hazardous Material and Waste Management and Communication Plan
j. Hazardous Materials Management
k. Hazardous Waste & Material-Ordering, Receiving and Storage
l. Hazardous Waste & Materials Responsibilities
m. Life Safety Management Plan
n. Medical Equipment Management Plan
o. Patient Age Related Hazards
p. Providing a Safe Environment
q. Radioactive Contaminated Waste Handling at Storage Area
r. Reporting Hazmat Incidents
s. Risk Assessment Policy
t. Safety Plan
u. Safety Walk Through Program (DELETE)
v. Security Management Plan
w. Visitor Safety

4. Infection Control
a. Risk Assessment and Surveillance Plan

5. Interventional Radiology
a. Abdominal Angiogram (DELETE
b. Abscess Drainage (DELETE)
c. Acute Stroke Angiogram (DELETE)
d. Angiogram (DELETE)
e. Biopsy (DELETE)
f. Blood Patch (DELETE)
g. Carotid Cerebral Angiogram (DELETE)
h. CAT Scan Guided Biopsy (DELETE)]
i. CAT Scan Guided Bone Marrow Biopsies (DELETE)

	Agenda Item	Time Allotted	Requestor

j. Central Line Insertion (DELETE)
k. Dialysis Graft Fistula Angiogram, Plasty or Thrombus (DELETE)
l. Gowning and Gloving (DELETE)
m. implantable Power Port Access Device (DELETE)
n. Inferior Venacava (DELETE)
o. Mesentric Aortogram (DELETE)
p. Mesentric Aortogram (Embolization) (DELETE)
q. Myleogram (DELETE)
r. Percutaneous Nephrostomy (DELETE)
s. Percutaneous Nephrostomy Stone Removal (DELETE)
t. Pre-Operative Skin Preparation Using Alcohol Based Solution (DELETE)
u. Pulmonary Angiogram (DELETE)
v. Renal Angiogram (DELETE)
w. Renal Angiogram (Embolization) (DELETE)
x. Scrub Person Setup (DELETE)
y. Sterile Tray Setup (DELETE)
z. Surgical Hand Scrub (DELETE)
aa. Trans Jugular Intra Hepatic Portal Cava Systemis Shunt (TIPS) (DELETE)
bb. Tunneled Dialysis Catheter Placement (DELETE)
cc. Ultrasound Guided Biopsies (DELETE)
dd. Upper Lower Extremity Aortogram (DELETE)
ee. Uterine Artery Angiogram (Embolization) (DELETE)
ff. Vascular Catheter Placement (Delete)
gg. Vertebroplasty (DELETE)

6. Laboratory General
a. Laboratory Infection Prevention and Control

7. Medical Staff
a. Credentialing Policy, da Vinci Robotic-Assisted Surgery 8710-563

8. NICU
a. Consultation to Perinatal Unit
b. Family Centered Care – NICU (DELETE)
c. Intrafacility Transport of the NICU Patient
d. Visitation in the NICU

9. Outpatient Behavioral Health
a. Exchange and Replacement of Medication

10. Women & Newborn Services
a. Dinoprostone [Cervidil]
b. Laminaria
c. Obstetrical Hemorrhage
d. Shift Change Responsibilities (DELETE)

(6) Minutes – Approval of:
a) October 28, 2021 Regular Meeting

(7) Meetings and Conferences – None

(8) Dues and Memberships - None

	Agenda Item	Time Allotted	Requestor
	(9) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (November, 2020) (d) Reimbursement Disclosure Report – (November, 2020) (e) Seminar/Conference Reports – None		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1.5 hour	
16	Adjournment		

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2022

Regular Board of Directors Meetings – Open Session to begin at 3:30 p.m.
Closed Session (when necessary) to begin at approximately 2:00 p.m.
(depending on agenda items).

- January 27, 2022 (Last Thursday)
- February 24, 2022 (Last Thursday)
- March 31, 2022 (Last Thursday)
- April 28, 2022 (Last Thursday)
- May 26, 2022 (Last Thursday)
- June 30, 2022 (Last Thursday)
- July 28, 2022 (DARK)
- August 25, 2022 (Last Thursday)
- September 29, 2022 (Last Thursday)
- October 27, 2022 (No Board Meeting due to November General Election)
- November 17, 2022
- December 15, 2022

The Board may meet "virtually" pursuant to Assembly Bill 361, signed into law September 16, 2021

Special Board Meetings – Special Board Meetings will be scheduled periodically throughout the year for Strategic Planning, Budget Consideration, etc. We will provide as much notice as possible.

Board Committee Meetings: the newly elected Board Chairperson will designate committee assignments.

Proposed Schedule: December 9, 2021
Approved by BOD: _____

LAW OFFICES OF

JEFFREY G. SCOTT

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JEFFREY G. SCOTT

Of Counsel
JAMES R. DODSON

DATE: December 9, 2021

TO: Board of Directors
Steven L. Dietlin, CEO
Susan Bond, General Counsel
Tri-City Healthcare District

FROM: Jeffrey G. Scott, Board Counsel

RE: Consideration of Proposal from NDC for Redistricting Services

Currently, the seven zones that elect members to the Tri-City Healthcare District ("District") Board of Directors are based on the population and demographics of the 2010 Census.

Following completion of the 2020 Census, the District is required by law to update the demographics of the District and take into account increases and changes in the population of the seven zones. The current deadline for completing the rezoning process for the November 2022 election is May 12, 2022.

National Demographic Corporation ("NDC") is familiar with the District and performed the demographics and population analysis that created the current District Zones Map approved by the Board in April 2018.

Attached for Board consideration and approval is a proposal from NDC to analyze and update the data and attend the necessary public meetings to complete the redistricting process for the 2020 election. The base fee is $25,500 plus $2,250 to attend each hearing. It is anticipated that the process should be completed in 2-3 meetings.

It is recommended that the Board approve the NDC proposal.

November 10, 2021

NDC Districting Scope of Work

- Project Setup and coordination:
  - Development of demographic database including Census Bureau and California Statewide Database data of total population, citizen voting age population, voter registration, voter turnout, and socio-economic data on language spoken at home, renters vs homeowners, age, education level, and other factors useful in identifying communities of interest;
  - Incorporation of any Geographic Information System (GIS) data that the jurisdiction wishes to include and provides (often including school locations; school attendance areas; important local landmarks; or local neighborhood boundaries);
  - Initial telephonic discussion with about data, communities of interest, schedule, criteria and special concerns of the jurisdiction;
  - Assist jurisdiction with developing a communications plan for public outreach, including suggestions for webpage content and design, public feedback logistics, and strategies for engaging constituents;
  - Assist jurisdiction with developing a project plan, including a detailed timeline, goals and objectives, and specific deliverables list;
  - Provide progress reports on an as-needed basis as determined by the project manager and meet regularly with project team;
  - Any phone- or web-conference calls to discuss the project's progress or to answer any questions that may arise;
  - Provide education and guidance on required redistricting criteria, and advice on selecting optional redistricting criteria, for staff and elected officials;
- Plan Development:
  - Provide memo on population balance and any potential divisions of "protected class" population concentrations in the existing election areas map;
  - Creation of 2 to 4 initial draft maps;
  - Analysis and preparation for presentation of all whole or partial plans submitted by the public;
  - Conversion of all maps and reports to web-friendly versions;
  - Online posting of all maps to an interactive review website;
  - Create any requested additional and/or revised maps as requested;
- Plan implementation:
  - Provide spatial data in GIS-friendly format of any dataset used or created for this project to staff upon request;
  - Work with the County Registrar of Voters to implement the final adopted plan;
- Project Options
  - Number of virtual or in-person meetings (and resulting per-meeting fee);

Standard Project Pricing

1. **Basic Project Elements** (covers everything except for per-meeting and optional expenses): ..... $ 25,500

2. **Per-Meeting expense:**

- In-person attendance, per meeting ..... $ 3,750
- Virtual (telephonic, Zoom, etc.) attendance, per meeting..... $ 2,250

For each meeting, NDC will prepare meeting materials, including presentation materials and maps; present and explain key concepts, including mandatory and traditional redistricting criteria and "communities of interest"; facilitate conversations; answer questions; and gather feedback on existing and proposed boundaries. Per-meeting prices include all travel and other anticipated meeting-related expenses. Telephone calls to answer questions, discuss project status, and other standard project management tasks do not count as meetings and do not result in any charge.

Exception: "Still Balanced" Jurisdictions

For a few jurisdictions, the existing election areas will still meet the equal population and voting rights act requirements using new 2020 Census data. These jurisdictions have the option simply retain the existing map without drawing and holding hearings on alternative maps. For jurisdictions electing this approach, the project would conclude with that decision.

"Still Balanced" Basic Elements includes all the services listed below:..... $ 7,500

- Compile total population and Citizen Voting Age Population data.
- Import existing election area lines.
- Compile population data by election area and calculate population deviations, prepare memo summarizing findings.
- Assist with staff report language or other materials for the report to the Board.

"Still Balanced" optional project elements and per-meeting expenses

Meeting attendance and optional project elements are not included in the "minimal change" project base fee. If requested, NDC team members participate in "minimal change" project hearings or forums at the same "per meeting" expenses, and optional project elements are provided at the same prices listed for a standard project in the previous section of this proposal.

Proposal Acceptance

The terms of this proposal are available for 90 calendar days from its delivery to you. In most situations, NDC is open to extending that period of time to meet any particular needs of your jurisdiction.

If your jurisdiction has specific contract and/or letter of agreement language you prefer to use, please provide it and ignore the signature block below. If you prefer, simply sign two copies of this proposal in the signature block below and return them to NDC. Once signed by NDC, one copy will be returned to you.

Thank you.

For National Demographics Corporation	For Tri-City Healthcare
_____	_____
Douglas Johnson, President	
_____	_____
Date	Date

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 10, 2021

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/10/2021 – 10/31/2023)

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 12/10/2021 through 10/31/2023:

- **ATTREYA, Akash DO/Family Medicine – Telemedicine (Sound)**
- **BARVALIA, Mihir MD/Cardiology (Sherev Heart and Vascular)**
- **COLEY, Nicholas MD/Pathology (North Coast Pathology)**
- **HOANG, Ngoc MD/Emergency Medicine (TeamHealth)**
- **KOMMANA, Sandhya MD/Internal Medicine – Telemedicine (Sound)**
- **KWON, Steven MD/Internal Medicine – Telemedicine (Sound)**
- **FRY, James DO/Internal Medicine (Kaiser)**
- **GHODSI-SHIRAZI, Anoosha MD/OB/GYN (Kaiser)**
- **LIU, Nina MD/Oncology (Kaiser)**
- **MACINTYRE, Elizabeth MD/Pediatrics (Children's Primary Care Medical Group)**
- **MURALI, Sujatha MD/Oncology (Kaiser)**
- **NAGHI, Jesse MD/Cardiology (Sherev Heart and Vascular)**
- **PASAMBA, Michelle MD/Anesthesiology (ASMG)**
- **PATEL, Mihir MD/Internal Medicine – Telemedicine (Sound)**
- **PRASAD, Rupa MD/Pain Medicine (The Neurology Center)**
- **RAJA, Wasim MD/Internal Medicine – Telemedicine (Sound)**
- **RUSSELL-ROY, Lydia MD/OB/GYN (Kaiser)**
- **ROEDER, Zachary MD/Teleradiology (StatRad)**
- **SHEREV, Dimitri MD/Cardiology (Sherev Heart and Vascular)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
November 10, 2021

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2022 –12/31/2023)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2022 through 12/31/2023, 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:

- **BONOMO, Rica, MD/Emergency Medicine/Active**
- **BRION, Paul, MD/Rheumatology/Active**
- **CHAYA, Nina, MD/Anesthesiology/Active**
- **GUERENA, Michael, MD/Urology/Active**
- **GUPTA, Anuj, MD/Pain Medicine/Refer and Follow**
- **HEIFETZ, Susan, MD/Internal Medicine/Refer and Follow**
- **HELGAGER, James, MD/Orthopedic Surgery/Active**
- **LAWLER, Abigail, MD/Neurology/Active**
- **MILLER, Donald, MD/Pediatrics/Active**
- **MORRIS, Jeffrey, MD/Ophthalmology/Refer and Follow**
- **PADILLA, Patrick, MD/Orthopedic Surgery/Provisional**
- **PEREIRA, Isabel, MD/Internal Medicine/Active**
- **PERKOWSKI, David, MD/Cardiothoracic Surgery/Active Affiliate**
- **ROTUNDA, Edward, MD/Emergency Medicine/Active**
- **SHUEN, Jessica, MD/Emergency Medicine/Provisional**
- **STERN, Mark, MD/Neurological Surgery/Active**
- **THALKEN, Gregory, MD/Teleradiology/Provisional**
- **ZENZEN, Charles, MD/Ophthalmology/Provisional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
November 10, 2021

Attachment B

RESIGNATIONS: (Effective date 12/31/2021 unless otherwise noted)

Automatic:

Voluntary:

- **BRUNO, Gillian, MD/Internal Medicine**
- **GLASSER, Judd, MD/Emergency Medicine**
- **GUNTA, Sujana, MD/Pediatrics**
- **JARIWALA, Amar, MD/Pathology**
- **LEON, Josue, MD/Obstetrics & Gynecology**
- **LUSCHWITZ, Brian, MD/Pediatrics**
- **MCCAMMACK, Bradley, MD/Pediatrics**
- **MOREIRA, Lucila, DO/Pediatrics**
- **RAHIMI, Nassrin, MD/Pediatrics**
- **SNYDER, Bradley, MD/Teleradiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
November 10, 2021

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of **December 10, 2021**

- **AFRA, Robert, MD** — **Orthopedic Surgery**
- **MOUKARZEL, Elias, MD** — **Uro-Gynecolgoy**
- **SILLDORFF, Morgan, MD** — **Orthopedic Surgery**

ADDITIONAL PRIVILEGE REQUEST (Effective 12/10/2021, unless otherwise specified)

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

- **RAJAMANICKAM, Anitha, MD** — **Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
November 17, 2021

PROCTORING RECOMMENDATIONS

- **BRAHMBHATT, Hetal, MD** — **Tele-Psychiatry**
- **GIRGIS, Alexander, MD** — **Anesthesiology**

TCHD Board of Directors
DATE OF MEETING: December 9, 2021
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, GENERAL & STEMI

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

Vendor's Name: Mihir Barvalia MD, Farah Dawood MD, Genaro Fernandez MD, Jesse Naghi MD, Dimitri Sherev MD

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

Term of Agreement: 12 months, Beginning, November 1, 2021 – Ending, October 31, 2022

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

Rate/Day	Panel Annual Cost	Panel Term Cost
$300 - General	$109.500	$109,500
$1,000 - STEMI	$365,000	$365,000
	Total Term Cost	$474,500

Description of Services/Supplies:

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

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

Person responsible for oversight of agreement: Eva England, Cardiovascular Services Service Line Administrator / Gene Ma, M.D., Chief Medical Officer

Motion:
I move that the TCHD Board of Directors approve the addition of Mihir Barvalia MD, Farah Dawood MD, Genaro Fernandez MD, Jesse Naghi MD, and Dimitri Sherev MD, to the currently existing ED On-Call Coverage Panel for Cardiology-General and STEMI for a term of 12 months, beginning November 1, 2021 and ending October 31, 2022.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: DECEMBER 9, 2021
PHYSICIAN AGREEMENT FOR SPECIALTY CARE CLINIC & PROGRESSIVE CARE UNIT

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

Physician's Name: Victor Souza, M.D.

Area of Service: Specialty Care Clinic and Progressive Care Unit

Term of Agreement: 24 months, Beginning, September, 1, 2021 – Ending, August, 31, 2023

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	XX month (Term) Cost
$163	20	240	$3,260	$39,120	$78,240

Position Responsibilities:

- Participates in daily UR on the inpatient unit with the CDCR patients as needed.
- Participates in risk management investigation and evaluation of events.
- Establishes and reviews policies and procedures for medical care.
- Participates in quarterly or more frequent meetings with CDCR and Sheriff Departments.
- Communicates as needed with attending and referring physicians; provides oversight of chart audits, and peer review and delinquencies in documentation.
- Assists in introducing new services/programs requested by the vendors.

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: Jacque Bender, MSN, Clinical Nurse Manager, Specialty Care Clinic & Progressive Care Unit / Candice Parras, Chief Patient Care Services

Motion:

I move that the TCHD Board of Directors approve the renewal of an agreement Dr. Victor Souza as the Medical Director/Covering Physician for Specialty Care Clinic and Progressive Care Unit for a term of 24 months beginning September 1, 2021, and ending August 31, 2023. Not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $163, for an annual cost of $39,120 and a total cost for the term of $78,240.

RESOLUTION NO. 805

RESOLUTION OF THE BOARD OF DIRECTORS OF TRI-CITY HEALTHCARE DISTRICT RE-RATIFYING THE STATE OF EMERGENCY AND RE-AUTHORIZING REMOTE TELECONFERENCE MEETINGS

WHEREAS, Tri-City Healthcare District ("District") is committed to preserving and fostering access and participation in meetings of its Board of Directors; and

WHEREAS, Government Code section 54953(e) makes provisions for remote teleconferencing participation in meetings by members of a legislative body without compliance with the requirements of Government Code section 54953(b)(3), subject to the existence of certain emergency conditions; and

WHEREAS, a required condition is that a state of emergency is declared by the Governor pursuant to Government Code section 8625, proclaiming the existence of conditions of disaster or of extreme peril to the safety of persons and property within the state caused by conditions as described in Government Code section 8558; and

WHEREAS, a proclamation is made when there is an actual incident, threat of disaster, or extreme peril to the safety of persons and property within the jurisdictions that are within the District's boundaries, caused by natural, technological, or human-caused disasters; and

WHEREAS, it is further required that state or local officials have imposed or recommended measures to promote vaccines, masking, and social distancing, and that meeting in person at the hospital would present imminent risks to the health and safety of attendees; and

WHEREAS, the Board of Directors previously adopted Resolution No. 803 on September 30, 2021, finding that the requisite conditions exist for the Board of Directors of the District to conduct remote teleconference meetings without compliance with paragraph (3) of subdivision (b) of Government Code section 54953; and

WHEREAS, as a condition of extending the use of the provisions found in Government Code section 54953(e), the Board of Directors must reconsider the circumstances of the state of emergency that exists in the District, and the Board of Directors has done so; and

WHEREAS, emergency conditions persist in the District and vaccine compliance, masking, and social distancing measures are required to be followed on the premises of the hospital for the continued health and safety of the patients, workers, and public; and

WHEREAS, as a consequence of the local emergency persisting, the Board of Directors does hereby find that the District shall conduct its meetings without compliance

with paragraph (3) of subdivision (b) of Government Code section 54953, as authorized by Government Code section 54953(e), and that such meetings shall comply with the requirements to provide the public with access to the meetings as prescribed in Government Code section 54953(e);

THEREFORE, BE IT RESOLVED by the Tri-City Healthcare District Board of Directors as follows:

Section 1: Recitals. The Recitals set forth above are true and correct and are incorporated into this Resolution by this reference.

Section 2: Affirmation that a Local Emergency Persists. The Board of Directors hereby considers the conditions of the state of emergency in the District and proclaims that a local emergency persists throughout the District.

Section 3: Re-Ratification of the Governor's Proclamation of a State of Emergency. The Board of Directors hereby ratifies the Governor's Proclamation of a State of Emergency.

Section 4: Remote Teleconference Meetings. The District's Chief Executive Officer is hereby authorized and directed to take all actions necessary to carry out the intent and purpose of this resolution, including conducting open and public meetings in accordance with Government Code section 54953(e) and other applicable provisions of the Ralph M. Brown Act.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of Tri-City Healthcare District held on December 9, 2021, by the following roll call vote:

AYES: Directors_____

NOES: Directors_____

ABSTAIN: Directors_____

ABSENT: Directors_____

_____
Rocky J. Chavez, President
Board of Directors

ATTEST:

_____
Tracy M. Younger, Secretary
Board of Directors

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 9, 2021
AFFINITY LIMITED SOFTWARE SUPPORT RENEWAL PROPOSAL

Type of Agreement		Medical Directors		Panel	X	Other: Software Support
Status of Agreement		New Agreement	X	Renewal – New Rates *(reduction)*		Renewal – Same Rates

Vendor's Name: QuadraMed-Affinity Corporation

Area of Service: Patient Accounting

Term of Agreement: 12 months, Beginning, January 1, 2022 – Ending, December 31, 2022

Maximum Totals:

Quarterly Cost	Annual Cost	Total Term Cost
$73,630.16	$294,520.63	$294,520.63

Description of Services/Supplies:

- Amendment to agreement dated 2/23/1996 to renew limited software support for current patient billing system scheduled to terminate on 12/31/2021, for a term of 1 year.
- Limited Support is 8:00 am to 5:00 pm, EST, Monday through Friday, excluding holidays. All patient billing activities come out of Cerner. Affinity is kept as historical archive and for regulatory considerations.
- The renewal rate reflects an **$87,800 decrease from previous renewal**.

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

Person responsible for oversight of agreement: Mark Albright, VP-Information Technology / Ray Rivas, Chief Financial Officer

Motion:
I move that the TCHD Board of Directors authorize the amendment to the agreement with QuadraMed Affinity Corporation for limited software support renewal for a term of 12 months, beginning January 1, 2022 and ending, December 31, 2022 for an annual and term cost of $294,520.63

ADMINISTRATION CONSENT AGENDA
November 30th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Accounting of Disclosure of Patient Information (PHI) Procedure	3 year review	Forward To BOD For Approval
2. Allied Health Students in Patient Care Areas Policy	3 year review, practice change	Forward To BOD For Approval
3. Documentation in the Medical Record Policy	3 year review, practice change	Forward To BOD For Approval
4. Duty to Warn Potential Victims Policy	3 year review, practice change	Forward To BOD For Approval
5. Interdisciplinary Plan of Care IPOC	3 year review, practice change	Forward To BOD For Approval
6. Medical Record, Making Corrections to Documentation Procedure	3 year review, practice change	Forward To BOD For Approval
7. Minors Attempting to Leave Without a Parent-Domestic Partner-Legal Guardian Policy	3 year review, practice change	Forward To BOD For Approval
8. Patient Classification (Acuity) Procedure	3 year review, practice change	Forward To BOD For Approval
9. Point of Care (POC) New Test Method Request and Implementation Policy	3 year review, practice change	Forward To BOD For Approval
10. Program Flexibility	3 year review, practice change	Forward To BOD For Approval
11. PureWick Female Urinary Incontinence Management	3 year review, practice change	Forward To BOD For Approval
12. Reporting Suspected Child Abuse/Neglect	3 year review, practice change	Forward To BOD For Approval
13. Reporting Suspected Dependent Adult/Elder Abuse/Neglect	3 year review, practice change	Forward To BOD For Approval
14. Tdap (Tetanus, Diptheria & Pertussis) Vaccine Administration for Antepartum & Postpartum Obstetric Patients Standardized Procedure	2 year review, practice change	Forward To BOD For Approval
Allied Health Professional Manual		
1. Oncology Standardized Procedures	2 year review	Forward To BOD For Approval
Environment of Care Manual		
1. Acquisition of Furniture and Furnishings	3 year review, practice change	Forward To BOD For Approval
2. Battery Management and Disposal	3 year review, practice change	Forward To BOD For Approval
3. Fire Plan - Code Red	3 year review, practice change	Forward To BOD For Approval
4. Disposing of Recalled Products	3 year review, practice change	Forward To BOD For Approval
5. Environmental Health and Safety Committee	3 year review,	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
November 30th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Charter	practice change	
6. Exit Doors	3 year review, practice change	Forward To BOD For Approval
7. Fire Safety Hazards	DELETE	Forward To BOD For Approval
8. Handling & Use of Gas Cylinders	3 year review	Forward To BOD For Approval
9. Hazardous Material and Waste Management and Communication Plan	3 year review, practice change	Forward To BOD For Approval
10. Hazardous Materials Management	3 year review, practice change	Forward To BOD For Approval
11. Hazardous Waste & Material-Ordering, Receiving and Storage	3 year review, practice change	Forward To BOD For Approval
12. Hazardous Waste & Materials Responsibilities	3 year review, practice change	Forward To BOD For Approval
13. Life Safety Management Plan	3 year review, practice change	Forward To BOD For Approval
14. Medical Equipment Management Plan	3 year review, practice change	Forward To BOD For Approval
15. Patient Age Related Hazards	3 year review, practice change	Forward To BOD For Approval
16. Providing a Safe Environment	3 year review, practice change	Forward To BOD For Approval
17. Radioactive Contaminated Waste Handling at Storage Area	3 year review, practice change	Forward To BOD For Approval
18. Reporting Hazmat Incidents	DELETE	Forward To BOD For Approval
19. Risk Assessment Policy	3 year review, practice change	Forward To BOD For Approval
20. Safety Plan	3 year review, practice change	Forward To BOD For Approval
21. Safety Walk Through Program	DELETE	Forward To BOD For Approval
22. Security Management Plan	3 year review, practice change	Forward To BOD For Approval
23. Visitor Safety	3 year review, practice change	Forward To BOD For Approval
		Forward To BOD For Approval
Infection Control		Forward To BOD For Approval
1. Risk Assessment and Surveillance Plan	1 year review, practice change	Forward To BOD For Approval
Interventional Radiology		
1. Abdominal Angiogram	DELETE	Forward To BOD For Approval
2. Abscess Drainage	DELETE	Forward To BOD For Approval
3. Acute Stroke Angiogram	DELETE	Forward To BOD For Approval
4. Angiogram	DELETE	Forward To BOD For Approval
5. Biopsy	DELETE	Forward To BOD For Approval
6. Blood Patch	DELETE	Forward To BOD For Approval
7. Carotid Cerebral Angiogram	DELETE	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
November 30th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
8. CAT Scan Guided Biopsy	DELETE	Forward To BOD For Approval
9. CAT Scan Guided Bone Marrow Biopsies	DELETE	Forward To BOD For Approval
10. Central Line Insertion	DELETE	Forward To BOD For Approval
11. Dialysis Graft Fistula Angiogram, Plasty or Thrombus	DELETE	Forward To BOD For Approval
12. Gowning and Gloving	DELETE	Forward To BOD For Approval
13. Implantable Power Port Access Device	DELETE	Forward To BOD For Approval
14. Inferior Venacava	DELETE	Forward To BOD For Approval
15. Mesentric Aortogram	DELETE	Forward To BOD For Approval
16. Mesentric Aortogram (Embolization)	DELETE	Forward To BOD For Approval
17. Myleogram	DELETE	Forward To BOD For Approval
18. Percutaneous Nephrostomy	DELETE	Forward To BOD For Approval
19. Percutaneous Nephrostomy Stone Removal	DELETE	Forward To BOD For Approval
20. Pre Operative Skin Preparation Using Alcohol Based Solution	DELETE	Forward To BOD For Approval
21. Pulmonary Angiogram	DELETE	Forward To BOD For Approval
22. Renal Angiogram	DELETE	Forward To BOD For Approval
23. Renal Angiogram (Embolization)	DELETE	Forward To BOD For Approval
24. Scrub Person Setup	DELETE	Forward To BOD For Approval
25. Sterile Tray Setup	DELETE	Forward To BOD For Approval
26. Surgical Hand Scrub	DELETE	Forward To BOD For Approval
27. Trans Jugular Intra Hepatic Portal Cava Systemis Shunt (TIPS)	DELETE	Forward To BOD For Approval
28. Tunneled Dialysis Catheter Placement	DELETE	Forward To BOD For Approval
29. Ultrasound Guided Biopsies	DELETE	Forward To BOD For Approval
30. Upper Lower Extremity Aortogram	DELETE	Forward To BOD For Approval
31. Uterine Artery Angiogram (Embolization)	DELETE	Forward To BOD For Approval
32. Vascular Catheter Placement	DELETE	Forward To BOD For Approval
33. Vertebroplasty	DELETE	Forward To BOD For Approval
Laboratory General		
1. Laboratory Infection Prevention and Control	2 year review, practice change	Forward To BOD For Approval
Medical Staff		
1. Credentialing Policy, da Vinci Robotic-Assisted Surgery 8710-563	3 year review	Forward To BOD For Approval
NICU		
1. Consultation to Perinatal Unit	2 year review	Forward To BOD For Approval
2. Family Centered Care -NICU	DELETE	Forward To BOD For Approval
3. Intrafacility Transport of the NICU patient	2 year review, practice change	Forward To BOD For Approval
4. Visitation in the NICU	2 year review, practice change	Forward To BOD For Approval
Outpatient Behavioral Health		
1. Exchange and Replacement of Medication	Practice change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
November 30th, 2021

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Women & Newborn Services		
1. Dinoprostone [Cervidil]	3 year review, practice change	Forward To BOD For Approval
2. Laminaria	3 year review, practice change	Forward To BOD For Approval
3. Obstetrical Hemorrhage	3 year review, practice change	Forward To BOD For Approval
4. Shift Change Responsibilities	DELETE	Forward To BOD For Approval

Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**ACCOUNTING OF DISCLOSURE OF PATIENT INFORMATION (PHI)**
Purpose:	To outline the procedure for capturing information on disclosures of patient information which Tri-City Medical Center (TCMC) is required to account and track
Supportive Data:	Reporting reference included on reverse side of form.
Equipment:	Form – TCMC Accounting of Disclosures Form

A. **PROCEDURE:**

1. Clinical Departments and Nursing Units:
   a. Complete and forward the attached form for each disclosure referenced, to the Privacy Officer.
   b. Record the patient identifying information (patient name, medical record number, account number).
   c. Record specific information relating to the recipient of the disclosed information.
      i. Name of Requestor (person's name)
      ii. Name of Entity (facility name)
      iii. Current Address (location of the entity)
   d. Record the purpose of the disclosure by marking off the appropriate box on the form. Check only one box per disclosure.
   e. Record the reason for the disclosure by marking off the appropriate box.
      i. State or Federal law or regulation
      ii. Court order (attach accompanying supporting documentation)
      iii. Other – specify reason for the disclosure
   f. Record a description of the information disclosed (i.e., lab results, Form #1234)
   g. Record the treatment date for the information disclosed.
   h. Identify the originating location of the information disclosed (i.e., medical record for lab results).
   i. Record the method of disclosure by marking off the box that describes how the information was disclosed. Multiple answers to this question may apply and can be recorded on the single form.
   j. Print the name, department, and date of disclosure.
   k. Forward the completed sheet to the Privacy Officer for data entry into the Release of Information database.
2. Privacy Office/Release of Information
   a. Stamp the Accounting of Disclosures form upon receipt.
   b. Log into the **electronic health record (EHR)**~~Cerner of Information/Correspondence module~~.
   c. Identify the patient based upon the identifying information provided on the disclosure form.
   d. Insert/Add the disclosure utilizing the following information:
      i. Name of Entity (Organization)
      ii. Purpose of Disclosure (response that begins with prefix PRI)
      iii. Reason for Disclosure
      iv. Description of Information disclosed
      v. Method of Disclosure
      vi. Name of Person who disclosed (record in comments field)
   e. Date and initial entry of the information into the tracking system
   f. Scan completed document to the patient's medical record.

B. **FORMS:**

Patient Care Services Content Expert ~~Revision Dates~~	**Clinical Policies & Procedures**	**Leadership Nursing ~~Executive Council~~**	**Medical Staff Department or Division**	**Pharmacy & Therapeutics Committee**	**Medical Executive Committee**	**Admini stration**	**Professional Affairs Committee**	**Board of Directors**
7/03; 3/06; 3/09, 4/16	7/11; 5/16, **10/21**	8/11; 5/16, **11/21**	n/a	n/a	n/a	**11/21**	9/11; 6/16, **n/a**	9/11; 6/16

1. Accounting of Disclosures Form
2. Disclosure Tracking References Form

TCMC - Accounting of Disclosures Form

Complete and submit to Medical Records/Health Information (Attn: Privacy Officer)
NOT PART OF THE PERMANENT RECORD

Disclosures to be entered in the Accounting:

Patient's Name: _____
Last First MI
Patient MRUN: _____ Acct #: _____

Disclosure made to:

Name of Requestor: _____ Name of Entity: _____

Current Address: _____
City: _____ State: _____ Zip Code: _____ Phone #: _____

Purpose of Disclosure (check only one)

- ☐ Animal Bites
- ☐ Assault & Battery to on-duty Health Care Personnel
- ☐ Assault Victims – Domestic Violence
- ☐ Child Abuse (suspected)
- ☐ Chromosomal Defects in Fetus or Infant
- ☐ Drug Use (illegal)
- ☐ Elder and Dependent Abuse
- ☐ Firearms reporting
- ☐ Infectious Diseases (reportable)
- ☐ Lapses of Consciousness/Seizures
- ☐ Locating suspects, fugitives, and witnesses
- ☐ Mental Health Holds beyond 24 hours
- ☐ Missing Patient
- ☐ Multiple bee stings
- ☐ Neural Tube Defects in a Fetus
- ☐ Newborn Screening Test Refusal (PKU)
- ☐ Occupational Injuries/Illnesses (if not for payment)
- ☐ Patient Death (not LifeSharing and Funeral Homes/Directors - standard releases)
- ☐ Patient Injury/Death due to faulty equipment
- ☐ Patient Transfer Violation
- ☐ Pesticide Poisoning
- ☐ PKU Specimen not obtained
- ☐ Research if done without authorization
- ☐ Reye Syndrome
- ☐ Threat to Kill
- ☐ Unusual occurrences that threaten the welfare of the patient, staff or visitors
- ☐ Vendors/Contractors (if not for Treatment, Payment, Operations)
- ☐ Other (specify)

_____

Why Disclosure Made: (check only one)

☐ State or Federal law or regulation ☐ Court Order ☐ Other _____

Brief Description of Information Disclosed:

_____

This record was for treatment date: _____
This information is in a: ☐ Medical Record ☐ Billing Record ☐ Other (specify) _____
Method of Disclosure: ☐ Phone Call/Verbal ☐ Form Submission/Fax ☐ Other (specify) _____
Person Disclosing Records: (please print)

_____ **Last Name**
First Name **Department** **Date**

	Disclosure Tracking References			
	Disclosure Type	**Disclosed by**	**Disclosed To**	**Method of Disclosure**
1	Animal Bites	Emergency Department Business Office	Humane Society	Phone Call
2	Assault & Battery to on-duty Health Care Personnel	Security Department - Director	Law Enforcement, Employee Health, Risk Management	Phone call
3	Assault Victims - Domestic Violence	Emergency Department Business Office Registrars, Social Services, Security, Risk Management	Law Enforcement	Phone Call with written report follow-up
4	Cancer Reporting-Neoplasms	Oncology Data Registry	Dept of Health Services Cancer Protection Service	Data Abstract/Cnet
5	Certificate of Birth	Birth Certificate Clerk	San Diego County Registrar	Birth Certificate/AVSS
6	Child Abuse (suspected)	Social Services, Health Practitioner, Child Care Custodian	Child Protective Services, Local Law Enforcement	Phone Call with written report follow-up
7	Chromosomal Defects in Fetus or Infant	Lab performing the analysis or physician making diagnosis	Dept of Health Services	
8	Drug Use (Illegal)	Security Department	Oceanside Police	Phone Call with written report follow-up
9	Elder and Dependent Adult Abuse	Social Services, Health Practitioner, Care Custodian	County Adult Protective Services	Phone Call with written report follow-up
10	Firearms Reporting	BHU Nurse Designee	Dept of Justice	Firearms Report
11	Infectious Diseases (Reportable)	Physician, Nursing Staff, Emergency Department, Infection Control, Laboratory	Public Health Dept	Phone Call with written report follow-up
12	Lapses of Consciousness/Seizures	Central source of Medical Staff Support Services	Department of Motor Vehicles	Form (PM110) completed and faxed
13	Locating suspects, fugitives, and witnesses	Privacy Officer, Risk Management	Law Enforcement	Verbal with written report follow-up
14	Mental Health Holds beyond 24 hours	Director of Emergency Services	Dept of Health Services	Phone Call with written report follow-up
15	Missing Patient	Security Department	Law Enforcement	Phone Call with written report follow-up
16	Multiple bee stings	ED Nursing Staff Designee	Dept of Health Services	Phone Call with written report follow-up
17	Neural Tube Defects in a Fetus	MRD/HIM Director	Dept of Health Services - Alpha-Feto Protein Screening Program	Written report
18	Newborn Screening Test Refusal (PKU)	Maternal/Child Health Representative	Department of Health Services - Genetic Disease Branch	Written report (#NBS-PR)
19	Occupational Injuries/Illnesses (if not for payment)	Physician	Employer & Employee, Insurer	Written report
20	OSHPD (Office of State Healthwide Planning & Development)	MRD/HIM - semi-annually	OSHPD	Data Abstract/Electronic
21	Outbreaks or undue prevalence of infectious or parasitic disorder	Infection Control	Dept of Health Services	Form (PM110) completed and faxed
22	Patient Deaths	Health Care Practitioner, Physician	LifeSharing (organ donation), Medical Examiner, Funeral Homes/Directors, Dept of Health Services as required	Phone immediately
23	Patient Deaths due to unusual circumstances	Health Care Practitioner, Risk Manager	Law Enforcement, Medical Examiner, Dept of Health Services, HCHA (if relate	Phone Call with written report follow-up
24	Patient Injury/Death due to faulty equipment	Health Practitioner, Risk Manager	Federal Drug Admn - Medical Device & Lab product problem reporting program	Phone Call with written report follow-up
25	Patient Transfer Violation	Risk Manager	Dept of Health Services, HCFA	Phone Call with written report follow-up
26	Pesticide Poisoning	Emergency Department Nurse	Dept of Agriculture Health Officer	Phone Call
27	PKU Specimen not Obtained	Maternal/Child Health Representative	Dept of Health Services - Genetic Screening Branch	Form (BS-No-90)
28	Research if done without authorization	IRB Coordinator	Regulatory Agencies	Written
29	Reye's Syndrome	ED Dept, Central Source - Medical Staff Support Services	Dept of Health Services	Form (CBC Reye Syndrome) completed and submitted
30	Subpoenas, court orders, discovery request of other lawful process (unless authorization is provided)	MRD/HIM Release of Information Desk	Entities as outlined in the subpoena/court order.	Copy service copies as designated or copy mailed/delivered to court.
31	Threat to Kill	Psychotherapist, Behavioral Health Manager, Security, Risk Manager	Law Enforcement, Intended Victim	Phone immediately with written report follow-up.
32	Unusual occurrences that threaten the welfare of the patient, staff or visitors	Health Care Practitioner, Risk Manager	Dept of Health Services, Law Enforcement	Phone Call with written report follow-up

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES POLICY MANUAL

ISSUE DATE: 5/06

SUBJECT: Allied Health Students in Patient Care Areas

REVISION DATE: 7/08; 05/11; 01/15, 01/17

~~**POLICY NUMBER: VIII.O**~~

Patient Care Services Content Expert ~~Department~~ Approval:	~~09/16~~06/~~18~~12/20
Clinical Policies & Procedures Committee Approval:	~~10/16~~10/21
Nursinge Leadership~~Executive Council~~ Approval:	~~10/16~~11/21
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/16~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~01/17~~ n/a
Board of Directors Approval:	01/17

A. **POLICY:**

1. Students from several allied health schools are affiliated with Tri-City Medical Center (TCMC) Allied Health Services (hereafter referred as "allied health").
2. The specific allied health department retains responsibility for allied health care services and related duties where the student is providing care.
   a. For Respiratory Students see Pulmonary Care Services Authorization To Perform (Respiratory Care Students)
   b. Emergency Medical Services (EMS)
      i. Patient care procedures within the Paramedic scope of practice (as established by the State of California and the County of San Diego) may be performed by a Paramedic intern under the direct supervision and guidance of the EMS program instructor, supervising physician or the RN assigned to that patient.
      ii. Emergency Medical Technician (EMT) students in the Emergency Department are only allowed to observe Emergency Department staff in the performance of patient care. EMT students do not provide patient care.
   c. Allied Health Students may only observe in the Pre-Operative Setting.
   d. Imaging Services
      i. Students are required to perform procedures in accordance with published imaging procedure protocols.
      ii. Imaging procedures may be performed by the students under the supervision and guidance of the Clinical Instructor or assigned staff in accordance with the following:
         1) Students use equipment and accessories, employ techniques and perform procedures in accordance with accepted equipment use and radiation safety practices to minimize radiation exposure to patients, selves and others
         2) Medical imaging procedures are performed under **direct supervision** of a qualified practitioner **until** a radiography student achieves competency.
         3) Medical imaging procedures are performed under **indirect supervision** of a qualified practitioner **after** a radiography student achieves competency.
         4) Radiography students repeating unsatisfactory radiographs are under the direct supervision of a qualified practitioner

3. The faculty and students of affiliated schools are responsible for knowing and complying with TCMC Policies and Procedures.
4. The allied health school is responsible for planning the education program and providing Allied Health Services with outlined goals and objectives relating to the clinical experience. The clinical coordinator is responsible for updating and reviewing clinical goals for each student for all department rotations.
5. The allied health clinical coordinator is responsible for establishing orientation dates for the student. Orientation shall include time spent in the department to learn the standards, physical layout, fire and code responsibilities, communication skills, methodology of patient care, documentation system, daily schedules and roles of the staff and students. The student must review the Hospital Orientation for Non Employees of Tri-City HealthCare District Orientation Manual and complete the appropriate orientation paperwork
6. Each student will be assigned a preceptor or specified allied health staff member in their department who will be accountable for all of the student's actions (hereafter referred to as "preceptor").
7. The preceptor has the right and responsibility to intervene or prevent a student from performing any allied health activity that appears inappropriate or potentially injurious to patients. ~~The~~ **Department Leadership**~~Director/Operations Manager~~ or designee has the option to discuss behavioral or practice issues with students, preceptors, and school instructors. Staff issues identified by the preceptor are to be directed to the Operations Manager or Director of the unit.
8. Students shall report to work at a specified time to receive report on their assigned patients. The preceptor shall also receive a report (if applicable), which provides current information related to the patient population and identifies potential learning activities for the students. Students shall report to their preceptor before leaving the department.
9. Student Responsibilities:
    a. Goal setting, evaluation, communication, and clinical competency.
    b. Participate in primary care of assigned patients including accurate documentation under supervision of preceptor as applicable.
    c. Communicate all pertinent information including finding problems, concerns, and questions or learning needs to preceptor.
    d. Work with all health care and team members in an effective/professional manner.
10. Handoff/Communication:
    a. Students must communicate any/all changes in patient status to preceptor.
    b. Students are not to leave the department without reporting to preceptor.
    c. Documentation must be reviewed and co-signed by preceptor as applicable.
    d. All unfinished work is to be reported to the preceptor.
11. Limitations of Function:
    a. Students shall not perform any procedures/functions identified without the preceptor present.
        i. Radiography students may perform medical imaging procedures under **indirect supervision** of a qualified practitioner **after** a radiography student achieves competency.
    b. Students may not take verbal or telephone orders.
    c. Students may not perform any procedure requiring specialized certification.
    d. Students may not perform procedures without a physician's order.
12. Medication Administration:
    a. All medications shall be administered under the direct supervision of the preceptor following Patient Care Services "Medication Administration" Policy.
    b. Students may only access medications from Pyxis under direct supervision of the preceptor. **Students are not given access to Pyxis MedStation.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Documentation in the Medical Record

REVISION DATE: 06/03, 12/03, 02/04, 08/04, 01/05, 02/07, 07/10, 08/12, 09/16, 01/18

~~POLICY NUMBER: IX.I~~

Patient Care Services Content Expert~~Department~~ Approval:	**~~02/17~~07/21**
Clinical Policies & Procedures Committee Approval:	**~~10/17~~10/21**
Nursing Leadership~~Executive Committee~~ Approval:	**~~10/17~~11/21**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/17~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval:	**~~01/18~~ n/a**
Board of Directors Approval:	**01/18**

A. **PURPOSE:**

1. To maintain documented information for each patient that is accurate, timely, legible, readily accessible, and is performed by authorized personnel.
2. To ensure the medical record contains sufficient information to identify the patient, support the diagnosis, plan of care, continuity of care justify treatment and document the course and outcome of treatment.

B. **DEFINITION(S):**

1. Activity View: A set of clinical data elements related to a specific activity that may include required documentation elements.
2. Annotation: Ability to add a comment to documentation.
3. Authentication: Review process of documentation completed by a student or other caregiver requiring review by a licensed staff or instructor.
4. Carry forward functionality: fields which bring forward the last charted data.
5. Clinical Range Bar: Indicates the date range of displayed information.
6. CPOE: Computerized Provider Order Entry.
7. Duplicate Results: Allows clinician in Iview to copy and paste data to a different time column for review and signing.
8. Edit Fields: The ability to modify or delete documented fields.
9. EHR: Electronic Health Record
10. Encounter: Each patient visit/admission is assigned a Financial (FIN)/encounter number.
11. Erasing fields: To delete or "unchart" information placed in a current field currently or from a carry forward function.
12. Iview: An interactive view for clinical documentation that allows direct charting.
13. MAR: Medication Administration Record.
14. ~~Patient Access List (PAL)~~/Care Compass: An interactive screen available to the nursing staff to view and perform patient care tasks by selecting icons, which launch a form or screen for completion of the task.
15. PowerForm: Electronic forms with one or many sections. Each section provides data entry options for documenting assessments, procedures, and other patient care events.
16. Task List: An electronic list of tasks or reminders within a specified time frame that may be attached to a form or activity.

C. **POLICY:**

1. Documentation is the primary communication medium. Each practitioner is responsible for accurate documentation of care provided. All entries manual or computerized are permanent.
2. Documentation will be complete and reflect patient specific care, support the medical diagnosis, course of treatment, and Plan of Care.
3. Documentation shall be efficient with minimal to no duplication of charting.
4. Documented patient information must be readily accessible to all providers rendering care.
   a. For management of patient's medications information includes:
      i. Age
      ii. Sex
      iii. Diagnosis
      iv. Sensitivities
      v. Current medications
      vi. Height and weight
      vii. Pregnancy and lactation information (as applicable)
      viii. Lab results
5. Documentation in the Medical Record shall include key components such as:
   a. The patient's initial admission information, transfer information, and discharge summary, with a full and accurate description of the patient's condition and responses at the time.
   b. Any change in the patient's condition.
   c. A record of communication with physicians, patient or family.
   d. Upon discharge, clear documentation of understanding of all discharge education and instructions to patient/responsible party.
   e. When an unexpected event occurs, complete the following:
      i. Document the facts of occurrence in the Medical Record and complete an incident report/quality review report.
      ii. Do not document or reference that an incident report/quality review report has been completed in the medical record (See Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275).
6. Documentation in the patient's record shall be complete, factual, accurate, and legible.
   a. When charting on paper, do not pre-date or back date patient information. (See Late Entry into the Medical Record).
      i. In the manual record, document on the next available space.
      ii. Do not skip lines
7. Tri-City Healthcare District (TCHD) care providers shall document in **the electronic health record (EHR)**~~Cerner~~ when online documentation forms/screens/IView bands are available.
   a. Exceptions to the practices are areas using paper flow sheets or other hard chart forms. Refer to unit specific policies and procedures.
   b. Powerforms shall be accessed from the task or Care Compass when available. If not available on the task list or via Care Compass, access the forms from AdHoc. Some of the Powerform titles may vary slightly to indicate a patient or area specific document.
   c. All access and documentation in **EHR**~~Cerner~~ shall be reflected by the user identification.
   d. Each user must define/update an encounter relationship to access a patient's chart.
      i. Some positions are assigned a default relationship.
   e. Users are required to use only their log-on to document in the patient's record.
8. Documentation shall be timed and dated to reflect the actual time events occurred.
   a. It is recommended that all shift assessments, reassessments, as the occasion arises (PRN) assessments, and/or care provided be documented after completion of the care in a timely manner.
   b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity document the patient care and assessment as soon as reasonably able to do so.

c. Activity Views in IView will be used to help guide required data documentation for key assessments and reassessments.
d. Reasonable and timely manner may be defined as within four (4) hours after completion of assessments or care provided ~~or as defined in unit specific policies and/or procedures~~.
e. Discharge documentation must be completed within four hours of discharging the inpatient.

9. Documentation in the patient record shall not include:
   a. Issues affecting credibility, including inconsistency in documentation, contradiction or blaming of other practitioners.
   b. Issues affecting professionalism, including intentional documentation of inadequate care, unprofessional verbal communications among practitioner, judgment or emotional statements about patients or their families, or "sloppy" charting practices in the manual chart (squeezing in an entry where there is not adequate space, or charting in advance of an intervention or treatment).
   c. Issues which imply information or events are being hidden (i.e., obliterating a chart entry [in the manual chart], or failure to document an untoward event, such as a fall or change in vital signs).
   d. Duplication of results in IView.
10. Late entry into the Medical Record (See: Patient Care Services Procedure: Medical Record, Making Corrections in Documentation).
   a. When a pertinent entry is missed or not written/entered into the electronic health record (EHR) in a timely manner, a late entry shall be documented in the Medical Record.
11. If an entry is made for another practitioner (by proxy), the entry must include the original practitioner's name and reason for proxy entry.
   a. Name of person making revision, date and time of entry and practitioner's (proxy's) unique log-on will be tracked by the system.
12. Refer to departmental specific documentation procedures for unit or departmental documentation requirements.
13. Refer to Patient Care Services Policy: Cerner Downtime for specific downtime documentation requirements.
14. Authenticating documentation is a process for authenticating the person, identified by name and relationship (discipline), who is responsible for ordering, providing or evaluating a clinical service rendered to a patient.
   a. The TCHD health care provider shall authenticate information entered into a powernote, powerform, IView or clinical note by students.
15. The following are authorized to document in the Medical Record **according to job description/responsibilities, including but not limited to,** :
   a. Advanced Care Technician (ACT)
   b. Audiologist
   c. Behavioral Health Liaison (BHL)
   d. Case Managers
   e. Certified Nurse Midwife (CNM)
   f. Chaplain
   g. Clinical Informatist
   ~~g.~~**h.** Clinical Nurse Specialist (CNS)
   ~~h.~~**i.** Dentist
   ~~i.~~**j.** Department Specific Technologist (i.e., Cath Lab, Cardiology, Radiology, etc.)
   ~~j.~~**k.** Dietician
   ~~k.~~**l.** Doctor of Osteopathic Medicine (DO)
   ~~l.~~**m.** Dosimetrist
   ~~m.~~**n.** Technician
   ~~n.~~**o.** Interpreter
   ~~o.~~**p.** Lactation Consultant

~~p.~~**q.** Licensed Vocational Nurse (LVN)
~~q. Lift Team~~
r. Marriage Family Therapist (MFT)
s. Marriage Family Therapist Intern
t. Medical Assistant
u. Doctor of Medicine (MD)
v. Medical Physicist
w. Mental Health Worker (MHW)
x. Monitor Technicians (MT) per unit specific policy
y. Neurophysiologist
z. Nursing Instructor
aa. Nurse Practitioner (NP)
bb. Nursing Assistant (NA)/Certified Nursing Assistants (CNA)/Student Nurse Technician
cc. Organ Procurement Representative
dd. Orthopedic Assistant
ee. Ophthalmologist
ff. Pharmacist
gg. Physical/Occupational/Speech/Recreational Therapist (PT/OT/ST/RT)
hh. Physician's Assistant (PA)
ii. Podiatrist
jj. Psychologist
kk. Respiratory Care Practitioner (RCP)
ll. Registered Nurse (RN)
mm. Research Coordinator (credentialed by TCHD Medical Staff)
nn. Resident Physician
oo. Social Worker
pp. Student in approved clinical rotation.
qq. Transcriptionist
rr. Transporter
ss. Unit Secretary
tt. Contracted services that have completed the process as outlined in the Administrative Policy: Non-TCHD Workers' Orientation and Identification Badge Process 8610-451.

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

1. Administrative Policy: Disclosure of Unanticipated Adverse Outcomes to Patients/Families 8610-275
2. Administrative Policy: Non-TCHD Worker's Orientation and Identification Badge Process, Non-Employees 8610-451
3. Patient Care Service: Cerner Downtime Policy
4. Patient Care Services: Medical Record Making Corrections to Documentation Procedure

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 02/18 **SUBJECT:** Duty to Warn Potential Victims

REVISION DATE(S): 02/18

Patient Care Services Content Expert~~Department~~ Approval:	**~~10/17~~10/20**
Clinical Policies and Procedures Approval:	**~~10/17~~10/21**
Nursinge Leadership~~Executive Committee Approval~~:	**~~10/17~~11/21**
Division of Psychiatry:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/17~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval:	**~~02/18~~ n/a**
Board of Directors Approval:	**02/18**

A. **PURPOSE:**
1. To provide guidelines for the handling of threats of potential harm to an identified person.

B. **POLICY:**
1. A ~~therapist~~**Psychiatric Liaison (PL)/Social Worker** is responsible to warn, or take other appropriate action to protect, the foreseeable victim of a patient's violent tendencies, if a **(PL)/Social Worker** ~~psychotherapist~~ patient relationship exists, the **(PL)/Social Worker**~~psychotherapist~~ knows or should have known that the patient is dangerous, and there is a foreseeable victim of the patient's violent tendencies.
2. In carrying out this duty, the **(PL)/Social Worker** ~~therapist~~ may need to release confidential patient information.
   a. The California Courts held that in such situations, the justification for protecting the confidentiality of the patient information (e.g. to encourage patients to seek treatment and fully disclose information to their psychotherapist) is outweighed by the need to warn potential victims so that they can protect themselves.
   b. In addition, legislation was enacted to provide for the release of confidential information when a therapist believes that a patient presents a serious danger of violence to a reasonably foreseeable victim or victims **, or their property (property may be reported but it is not mandated)**.
3. The duty to warn arises not only when a patient expresses specific threats against an identifiable victim, but also when others report the threat to the treatment providers.
   a. If a family member or significant other reports such threats to the **(PL)/Social Worker**~~therapist~~, the **(PL)/Social Worker**~~therapist~~ is obligated to follow reporting procedures.
4. A **(PL)/Social Worker** ~~therapist~~ may be liable for injuries a third person suffers as a result of a patient's violent acts, if the **(PL)/Social Worker**~~therapist~~ fails to carry out his duty to appropriately evaluate the patient and identify his or her dangerous propensities.
5. In order to carry out the duty to warn, the **(PL)/Social Worker**~~therapist~~ must strike a careful balance between protecting the confidentiality of the patient's disclosures and protecting the potential victim.
   a. Initially, the **(PL)/Social Worker**~~therapist~~ should gather relevant information regarding the patient, including that pertaining to the patient's past treatment history.
   b. The **(PL)/Social Worker**~~therapist~~'s decision regarding whether it is likely that the patient will carry out his or her threats, or that the patient presents a danger to another person,

should be documented along with the information that led to the decision. This will provide important protection against claims that the **(PL)/Social Worker** ~~therapist~~ should not have released the information (if a warning is given) or that the **(PL)/Social Worker** ~~therapist~~ did not carry out his duty to warn the potential victim (if a warning was not given).

c. If a warning is given, the **(PL)/Social Worker** ~~therapist~~ should disclose only that information which is necessary to enable the potential victim to recognize the seriousness of the threat and to take proper precautions to protect him or herself. A general indication to a person that perhaps the person should avoid the patient may not be sufficient warning.

d. Also, depending upon the patient's therapeutic condition and possible reaction, it is advisable to inform the patient that the warning will be given.

6. Situations in which a **(PL)/Social Worker** ~~therapist~~ may have a duty to warn a potential victim usually involve difficult decisions. The treatment team, including the physician/Allied Health Professional (AHP), needs to be informed regarding any such reports. An ethical or legal consultation may also be obtained to guide the team with their decision.

C. **PROCEDURE:**

1. When a threat is made, the **(PL)/Social Worker** ~~therapist~~ must notify the police department in the city in which the threat occurred. The following information is conveyed:
   a. Patient name
   b. Patient address
   c. Patient date of birth
   d. Patient gender and race
   e. Patient physical description
   f. Patient social security number and driver's license number (if available)
2. The police department in the city in which the intended victim resides must also be notified.
   a. Report must include information stated above, as well as, the name of the intended victim and address, if known.
3. The **(PL)/Social Worker** ~~therapist~~ must make all reasonable attempts to notify the intended victim of the patient's threats (i.e. contacts or registered mail).
4. The Manager and physician/AHP are notified of any such occurrence and a Quality Review Report is filed.
5. Documentation of the threat and action taken is written in the medical record.

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

1. Administrative Policy: Incident Report-Quality Review Report (QRR) RL Solutions 396
2. Behavioral Health Services: Inpatient Unit Admission Criteria
3. Duty to Warn Letter – Sample

E. **REFERENCE(S):**

1. CA Civil Code, Section 43.92
2. CA Evidence Codes, 1010, 1024
3. CA Welfare & Institutions Code, Sections 5328, 8105 (c)
4. Ewing v Goldstein (2004) 120 Cal. App. 4th 807
5. Ewing v Northridge Hospital (2004) 120 Cal.App.4th 1289
6. HIPAA Privacy Regulations, 145 C.F.R. 164.512 (j)(l)(l)], Department Health & Human Services
7. Tarasoff v. Regents of the University of California (1976) 17 Cal. 3rd1425

Duty to Warn Letter – Sample

Tri-City Medical Center-Behavioral Health Unit
4002 Vista Way, Vista, CA 92056

To: Mr. Xxx
CC: Oceanside Police Dept.
3855 Mission Ave
Oceanside, CA 92054

CC: Oceanside Police Dept
3855 Mission Ave
Oceanside Ca 92054

April 13, 2010

Dear Mr. Xxx,

This letter is a written notice required by California law Civil Code 43.92 (commonly known as a "Tarasoff report") that mandates a psychotherapist has the "duty to protect" by making reasonable efforts to communicate with potential victims and to law enforcement, when in the course of performing work related functions a patient has communicated a "serious threat of physical violence against a reasonably identified victim or victims". This letter is to inform you that your student, (~~Princess~~_____) has made threats towards you (_____~~to harm you for giving her a failing grade in Biology~~) I recommend that you take the necessary precautions to protect yourself and anyone else that could be in possible danger due to this threat. In addition to notifying you, I have also notified Oceanside Police Department and spoke to **(**_____~~Officer Chalayne~~**)**, **(**_____~~Badge #1268~~**)** and reported this incident and was given incident **(**_____~~# 0900124874~~**)**. I have also contacted (add same info as above if you contacted another law enforcement agency here) to report the incident as you live in their jurisdiction. Please contact the respective police department if you have any questions regarding the police reports.

Respectfully,

Xxx xxx , LCSW, LCMFT

Tri-City Medical Center, BHU
760- 940-7396

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01 **SUBJECT: Interdisciplinary Plan of Care (IPOC)**

REVISION DATE(S): 06/03, 06/05, 01/08, 05/11, 05/12, 05/15, 07/18

Patient Care Services Content Expert~~Department~~ Approval:	~~02/18~~10/21
Clinical Policies & Procedures Committee Approval:	~~05/18~~10/21
Nursing Leadership~~Executive Council~~ Approval:	~~05/18~~11/21
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/18~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. PURPOSE:
1. To ensure an interdisciplinary plan of care (IPOC) i.e., plan of care:
   a. Is developed upon admission by a Registered Nurse (RN)
   b. Is maintained and updated
   c. Reflects the patient's goas and nursing care required to meet the patient's needs

B. DEFINITIONS:
1. IPOC – "a roadmap used to guide patient care so that all health care providers are moving toward the same patient goals".
2. Goals – "Broad statements of purpose that describe the overall aim of care. Goals may be short or long term".
3. Outcome – "a measurable behavior demonstrated by the patient responsive to nursing interventions with an identified timeframe to for the outcome to be reached by the patient". Outcomes are identified before nursing interventions are planned. After nursing interventions are implemented, nursing must evaluate if the outcomes were met in the time frame indicated for the patient. Outcomes are realistic, relevant, reevaluatedand revised for attainability as needed
~~A.~~4. Interventions –actions or activities undertaken to address a specific patient problem and to improve, maintain, or restore health or to prevent illness

~~A.~~C. POLICY:
1. An Interdisciplinary Plan of Care (IPOC) shall be initiated within eight (8) hours of a patient's arrival to an inpatient care area
~~1. An Interdisciplinary Plan of Care (IPOC) shall be initiated (electronically or paper per unit practice) within eight (8) hours of a patient's arrival to an inpatient care area.~~
2. The IPOC includes planning the patient's nursing care to meet the patient's needs and interventions toward meeting patient treatment goals.
3. The initial (admission) IPOC is based on assessing the patient's nursing care needs and not solely those needs related to the admitting diagnosis.
~~2. The IPOC shall include standards of care identified as appropriate based on the patient's diagnosis, medical condition, and/or need.~~
4. The IPOC shall have measurable outcomes with specific interventions **that assist to reach the identified outcomes.** ~~to meet the patient's inpatient and discharge needs~~.
~~1.~~5. **All outcomes will have an expected (target) ~~a~~ completion date ~~and time~~.**

a. The following factors shall be considered when developing and/or updating ~~the~~ IPOC**s**:
~~i. Disease Process/Physician's Order~~
i. Assessment findings:
~~ii.~~**1)** Biophysical
2) Psychosocial
3) Knowledge deficits
4) Safety
~~iii.~~**5) Spiritual and cultural**
~~iv. Spiritual/cultural~~
~~v. Functional~~
~~vi. Safety~~
~~vii. Knowledge Deficit~~
~~viii.~~**6)** Discharge Needs
a) Referrals to Interdisciplinary Departments
~~ix.~~**b) Assistance from family support persons**
~~i.~~**ii.** ~~Additional aspects obtained from the patient assessment~~
iii. Treatment goals

~~b. For any high risk factors, that specific IPOC(s) will be initiated upon admission to an inpatient care area.~~

~~2.~~**6.** The primary ~~Registered Nurse (~~RN**s**~~)~~ shall discuss **a summary of** the IPOC with the patient and their caregiver~~,~~**/ family support** ~~(if applicable)~~ **once a shift,** ~~every shift, and~~ **and** as **needed**~~the occasion arises~~ (PRN).

7. ~~The~~ IPOC**s** shall be **kept current by ongoing assessment of the patient's needs and of the patient's response to interventions, assessment of patient treatment goals, and updating or revising the patient's IPOC in response to assessments.**

~~3. reviewed and updated every shift, and as needed. The primary RN shall:~~
~~a. Consider the appropriateness of interventions not addressed within the last 48 hours, discontinue as needed.~~

~~3.~~**8.** When a patient is transferred to another nursing unit, the receiving RN shall review the existing **IPOCs** ~~plans fo~~**for**~~r~~ appropriateness and update or discontinue plans**, interventions and/or outcomes that are reached** ~~initiated on the transferring~~ as needed. The receiving RN shall initiate additional plans as needed based on the patient's transferring assessment.

~~B.~~D. REFERENCE(S):

1. Centers for Medicare and Medicaid Services (CMS). (2020, February 21). Sate Operations Manual Appendix A Survey Protocol, Regulations and Interpretive Guidelines for Hospitals. §482.23(b)(4).
2. The Joint Commission Handbook (2017), Provision of Care, Treatment and Services Standard
~~1.~~**3. Wisconsin Technical College System, (n.d.). Nursing fundamentals: 4.5 outcome identification. Retrieved from https://wtcs.pressbooks.pub/nursingfundamentals/chapter/4-5-outcome-identification**

Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**MEDICAL RECORD, MAKING CORRECTIONS TO DOCUMENTATION**
Purpose:	To maintain documented information for each patient that is accurate, timely, and legible.
~~Supportive Data~~	~~Patient Care Services Policy IX.I, Documentation in the Medical Record~~

A. **CORRECTIONS IN THE PAPER CHART:**

1. Corrections due to practitioner documentation error shall be lined through with a single line and "Error" written above the line and the practitioner's initials. The corrected entry shall be dated, timed, and verified with full signature and title.
2. Clarification of orders or corrected orders due to circumstances such as unacceptable abbreviations or inappropriate medication dosages shall be rewritten with "clarification of above order" documented with practitioner's full name and title.

B. **INCORRECT CHART OR INCORRECT ENCOUNTER:**

1. When errors are found in the electronic medical record, the practitioner is notified to correct the documentation.
2. If the practitioner who made the error is not available, the Clinical Manager, Administrative Supervisor or Director is notified to correct the chart.
3. ~~The incorrect form may be printed out from the Forms browser.~~ The documentation made in error is uncharted **(in-error notation)**. The reason for the error is then entered into the comment field. The information is then re-charted on the correct patient or encounter **electronically**~~by referencing the printed form~~.
4. Lab and Radiology Orders entered on wrong encounters/patients/physicians' order:
   a. A new order must be entered on the correct patient or encounter.
   b. Once the new order is placed and completed, the report from the wrong encounter or patient shall be placed with the new order.
   c. Charges associated with incorrect lab and radiology orders shall be credited.
   d. After the new order has been corrected, the report is in place, and charges have been reconciled, the incorrect order shall be cancelled.
   e. Order entry errors are tracked **electronically in Cerner**~~manually using the In Error Documentation form~~.
   f. **In the event a laboratory order entry error takes place and is not discovered same day, the error will appear on the Exception Report and will be reconciled by the Laboratory Billing Coordinator.** ~~Lab tests ordered on wrong patients shall be corrected, documented, and communicated per procedure "Detecting and Correcting Erroneous Lab Results" located in the Lab QA Manual.~~

C. **COMBINED MEDICAL RECORD NUMBERS:**

1. This is required when a patient has been assigned more than one medical record number (MRN). The Medical Records/Health Information department researches and resolves the duplicate MRN resulting in combining the losing MRN into the winning MRN. Both the Cerner system and the hard copy record are corrected to reflect the winning MRN. (The losing MRN is displayed in parenthesis.)
   a. The Imaging department will merge Picture Archive and Communication Systems (PACS) images to the winning MRN.

D. **REMOVING OR MOVING INCORRECT ENCOUNTERS:**

1. This is required when an encounter is added to the incorrect patient. The encounter needs to be moved from the incorrect patient to the correct patient's MRN.
   a. The Emergency Department (ED) registration area initiates the on-call move encounter process.
2. Allergy and diagnosis information is verified on both encounters and transferred to the correct

Department Review	Clinical Policies & Procedures	~~Patient Quality Care Committee~~Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/12, **06/21**	10/12, **10/21**	10/12, **11/21**	**n/a**	**n/a**	11/12, **11/21**	**11/21**	01/13, **n/a**	01/13

patient manually. When necessary, the additional step of combining encounters is completed.

E. **COMBINING ENCOUNTERS:**

1. This is required when two encounters have been created for the same episode of care. It is necessary to combine these into a single encounter.
2. Designated individuals (Registration and Medical Records/Health Information) combine the losing encounter into the winning encounter (the losing encounter is displayed in parenthesis).
3. Documentation in Cerner combines when the encounters are merged.
4. Individual departments are responsible for reconciling their orders and charges for combined encounters.

F. **CLINICAL NOTES:**

1. When documented in error or if additional information must be added, the clinician modifies the note, adds any corrections or changes in the addendum and enters the reason for the error.
2. If the note was made on the wrong patient or encounter, documentation is completed in the correct chart by entering the correct date and time of service.
3. The reason for the late entry shall be indicated.
4. Medical Records must be notified to error out any transcribed Clinical Note documents.

G. **PHYSICIAN CLINICAL NOTE:**

1. These are notes entered by the physician directly into Cerner.
2. If the document has been attached to the incorrect patient the physician is to contact Medical Records/Health Information department for the document to be moved to the correct encounter.

~~H. **CARE MANAGEMENT:**~~

~~1. Case Management or Social Services documentation created in Allscripts (and interfaced to Cerner) that is attached to the incorrect encounter will be identified and communicated to Medical Records/Health Information.~~

~~a. Document to be in Errored with identification of notification by Care Management and reason for the edit.~~

~~I.~~**H. POWERNOTE:**

1. Corrections due to practitioner documentation error in the computerized chart shall be completed by adding an addendum to the bottom of the Powernote. This addendum is added by modifying the note.
2. NOTE: Until the Powernote is signed; changes made by the physician are not considered corrections. The saved, unsigned report is not seen by anyone except the physician or scribe.
3. If the signed note was made on the wrong patient or encounter, Medical Records or the Physician will notify Information Technology (IT) to move the Powernote to the correct patient/encounter.
4. The IT Analyst will complete the documentation move to the correct patient/encounter and note the correction reason.

~~J.~~**I. POWERCHART:**

1. Corrections due to practitioner documentation error or late entry of additional information shall be marked "modified" to reflect the correction. Any modification to a form is tracked in the form history. The reason for the modification shall be noted in the comment field.
2. If a form was charted in error or charted on the wrong patient, the entire form shall be "Uncharted" with the reason given in the comment field. The information shall be re-charted on the correct patient/encounter. The system will red line through the form and list the form "In Error."

~~K.~~**J. PHARMACY:**

~~1. Medication order entry errors entered by the pharmacist and identified by the nurse shall be communicated to the pharmacist via the MAR Correction form. The pharmacist shall correct the error by modifying or replacing the original order.~~

~~2.~~1. Medication orders entered on the wrong patient or wrong encounter shall be voided and re-entered on the correct patient or encounter.

~~3.~~2. Any charges associated with any of the above medication order entry errors shall be credited and charged to the correct patient/encounter using the pharmacy charge/credit application.

~~4. All medication order entry errors shall be tracked using the MAR Correction form.~~

~~L.~~**K. SURGERY:**

1. Changes to the Operative Record shall be made as needed to maintain accuracy.
2. Existing entry shall be modified to make changes or additions to record.
3. Reason for change shall be noted in General Comments Section (i.e., "Corrected or Updated or Late or Revised Entry").
4. Beneath the words Corrected or Updated or Late or Revised Entry, the required change/modification/or new data entry shall be made.
5. The record shall be modified/saved (as indicated) and the record shall be re-finalized to add new data.

~~M.~~**L. MEDICAL RECORDS/HEALTH INFORMATION:**

1. Scanned Documents
   a. Operations Manger confirms document is posted to the incorrect patient or incorrect location within Clinical Notes.
      i. Document copied and posted to the correct encounter and/or folder
      ii. Scanned document In Errored with documented reason
   b. Transcribed Documents:
      i. Transcription Supervisor shall receive submissions from incorrect dictation in Powerchart forms, physicians, and other Cerner users.
      ii. Information is verified via:
      iii. Master Patient Index (MPI) research
      iv. Dictation notes from Physician/Physician Assistant (PA)/Resident
      v. Listening to dictation
      vi. Notations on incorrect dictation form
   c. Upon verification of an incorrect encounter, staff will search in Powerchart for the encounter with incorrect documentation. The document shall be selected and changed to "in error" under the clinical notes tab. The document shall be marked "in error document" and a comment may be added.
   d. Tracking document shall be updated with required information.

~~N.~~**M. IMAGING SERVICES/~~REDNET~~RADNET—DIAGNOSTIC REPORTS:**

1. Once the diagnostic report is finalized or signed by the radiologist, any changes shall result in the report being amended.
2. Amended Cerner reports are modified via the transcription application. When a finalized report is opened from this application, the report shall automatically assume an amended status.
3. Once the change has been made to the original report, it shall be placed in the radiologist queue. After the radiologist signs the report, an updated version will be electronically filed in Cerner. When this report is opened for review within Cerner, the amended portion of the report shall appear at the top, with the original report appearing at the bottom. The report shall also have a header entry of "Addendum" at the beginning of the report.
4. When printed, amended reports shall also contain a header that indicates the report has an addendum.
5. Once finalized, any amended reports will auto fax, if applicable.
6. Information regarding date of transcription and verification, and names of transcribers and physicians involved in the completion of the report shall be included in the report.

7. Audit trails shall exist with information regarding order, completion and verification of report.

~~O.~~N. CLINICAL LABORATORY:

1. Replacing the incorrect result with a correct result:
   a. In **Accession Result Entry (**ARE**),** ~~C~~**c**lick on Mode at the top of the screen, select Correction. The mode is indicated in the title bar, and the Perform and Verify buttons are replaced with a correct button.
   b. In the Accession box, enter the accession number for which you want to correct a result.
   c. Place the cursor on the result you want to correct.
   d. Right click and select "Convert Result" and change to the proper result type, such as Numeric.
   e. Enter the verified value and any other required documentation as a comment. Refer to the procedure for "Verification and Communication of Critical Values".
   f. Click on CORRECT to verify the result.
2. The technologist who corrects the reports is responsible for notifying the Department Supervisor as soon as possible by sending an e-mail with the following information:
   a. Accession number corrected
   b. An explanation of what happened, i.e. why the error occurred.
3. If the incorrect results are due to the wrong specimen, wrong sample labeled or wrong patient drawn, the results must be replaced with the result of ERROR since the incorrect result cannot be removed from Powerchart.
   a. Credit the incorrect result(s) using Charge Viewer.
   b. Enter ARE:
      i. Change the Mode to Correction
      ii. Enter the appropriate test site.
      iii. Enter the accession number.
      iv. For the each result to be corrected change the result type to FREETEXT then enter the text ERROR. Continue to enter ERROR for all the test results for the accession number. On the first corrected test enter an Order Comment that explains the reason for the correction.
      v. Examples of Order Comments:
         1) Wrong patient drawn
         2) Sample incorrectly labeled
         3) Contaminated Specimen
      vi. The remaining results must have the entry of ERROR without additional as long as the first tests result contained the comment. One of the results must have the reason comment attached. When complete, review the entries prior to correcting. All original results should have been replaced by the result ERROR. The first result should also have a reason commitment attached.

~~P.~~O. FETALINK:

1. Modifications and Deletions of Annotations must be made prior to Finalizing a Fetalink Episode.
2. To modify an annotation, complete the following steps.
   a. While viewing the waveform from a single patient view, double-click on a previous documented annotation.
   b. The annotation dialog displays. Either manually type in the new annotation or select one or multiple options from the Quick chart options.
   c. A "Revision History" tab is accessible within the "Annotations" dialog box that allows clinicians to see every edit that has been charted to an annotation. The "Revision History" tab dates and time stamps these changes as well as associated the clinician's user name to each annotation that has posted.
3. Deleting annotations made in errors, unselect the annotation options charged in error or delete the free text annotation and replace with free text '"In Error, Reason for uncharting."

4. Incorrect Patient Association
   a. After a period of time, whether that period of time is 5 minutes or 5 hours, the user notices the incorrect patient was selected, the user should note the Incorrect Patient Name, the device name, the room name and the approximate time of the episode and report it to their ~~Assistant~~ Nurse **Leader**~~Manager/ or relief c~~**C**harge ~~n~~**N**urse.
   b. The ~~Assistant~~ Nurse **Leader**~~Manager/ or relief c~~**C**harge ~~n~~**N**urse will utilize the Fetalink Management Tool to remove the incorrect Fetalink Episode from the patient's record.
   c. After the user has noted or reported the information above, finalize the episode by selecting Finalize and Disassociate in the Single Patient View.
   d. Once the Finalize and Disassociation process has been completed, the user must then retroactively associate the correct patient to the correct/current device.

~~Q.~~P. BEDSIDE MEDICAL DEVICE INTEGRATION (BMDI):

1. Modifications and Deletions of BMDI data can be made at any time during the Nurses shift.
2. To Modify BMDI data, complete the following steps:
   a. If the data has not been signed, clear the incorrect data by placing the cursor into the cell and click on the backspace key.
   b. Once data is cleared, enter the correct data into the field. Verify information is correct and sign documentation.
3. Deleting incorrect data already signed, complete the following steps:
   a. Right click into each cell, select either unchart or modify
   b. Provide a reason
   c. Enter correct data into cell
   d. Validate and sign documentation
4. Incorrect Patient Association to device
   a. After a period of time, whether that period of time is 5 minutes or 5 hours, the user notices the incorrect patient was selected, the user should note the Incorrect patient name, the device name and disassociate the patient from all devices, and report it to their ~~Assistant~~ Nurse **Leader**~~Manager~~**/Charge Nurse**.
   b. Reassociate the patient to the correct devices:
      i. Click on the BMDI ICON
      ii. Select the appropriate device and click Associate
      iii. Click Close

~~R.~~Q. POWER CHART ECG:

1. Power chart ECG changes via the computer
   a. The cardiologist will read unconfirmed ECG's and either note OK or note the appropriate changes on the unconfirmed ECB.
   b. Once the ECB is complete, the ECB technician will place the correct EKG in the MD computer box.
   c. The cardiologist will interpret the ECB typing their own interpretation in the interpretation section.
2. Power chart ECG changes via the mobile cart
   a. Turn machine on
   b. Turn know to directory and locate patient
   c. Locate patient name and select at top of screen
   d. Make changes to the current ECB and press OK when done

~~S.~~R. LATE ENTRY INTO THE MEDICAL RECORD:

1. When a pertinent entry was missed or not written in a timely manner, a late entry shall be used to record the information in the medical record.
2. If discovered before the end of the shift, the practitioner may make this entry without consulting a manager or director.

3. If the chart is still open, but the shift has ended and the staff member has since left the facility and returned, a Manager or Director shall be notified and any entry made shall be labeled "late entry."
4. If the medical record has been closed (four hours or greater after discharged) and a late entry is required, the **Nurse Leader**~~Clinical Manager~~ shall work with the employee required to make the late entry. (Tasks and orders are not accessible after discharge for completion. A Clinical Note must be used to document any corrections or additional information.)
5. Corrections to scanned documents must be completed in the Medical Records/Health Information department where a printed copy can be amended and labeled as a Late Entry. This document will then be scanned into the medical records as a new entry (previous entry remains).
6. Under any of the above situations the following guidelines shall be followed when making a late entry in the medical record:
    a. The practitioner directly responsible for the care/information being documented shall make the entry whenever possible.
    b. The new entry shall be identified as a "late entry" in the Clinical Note.
    c. The current date and time the entry is actually being made shall be noted. No attempt shall be made to make the entry look as if it were entered on the previous date or time.
    d. When correcting an omission, validate the source of the additional information as much as possible (for example, where the information to write the late entry was obtained)
    e. The late entry shall be documented as soon as possible.
    f. There is no time limit for writing a late entry, however, the sooner the entry is made, the more reliable the information becomes.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/05	**SUBJECT:** Minors Attempting to Leave Without a Parent/ Legal Guardian
REVISION DATE: 07/08, 05/11, 02/18	**POLICY NUMBER:** VI.K

Department Approval:	~~10/17~~08/21
Clinical Policies & Procedures Committee Approval:	~~10/17~~08/21
Nursing Leadership~~Executive Council~~ Approval:	~~10/17~~10/21
Medical Executive Committee Approval:	~~11/17~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **PURPOSE:**
1. Direction for healthcare providers at Tri-City Healthcare District (TCHD) when minors are leaving without being accompanied by a parent or legal guardian.

B. **DEFINITION(S):**
1. Minor: a person younger than eighteen (18) years of age, in the state of California **[Family Code Section 6500]**~~.~~.
2. Authorized individual: A parent, legal guardian or other person with the authority to consent to medical treatment for a minor ~~pursuant to California Hospital Association (CHA) Consent Manual (2017), Chapter 4~~.

C. **POLICY:**
1. A minor shall be discharged to an authorized individual.
2. If a minor is attempting to leave TCHD without an authorized adult present and the physician or Allied Health Professional (AHP) deems it is not in the best interest of the minor to be discharged, the following actions must be taken:
   a. Verbal discussion of the risks of a premature discharge.
   b. Clear instructions to remain on the unit/department.
   c. Notification of hospital security and law enforcement. If the minor becomes combative, appropriate actions to detain the minor shall ensue, keeping patient and staff safety at the forefront.
3. If a minor is attempting to leave the facility without an adult present and the physician or AHP releases the minor, the authorized adult shall be contacted to pick up the minor.
4. If the authorized adult is not available to pick-up the minor in a reasonable period of time, consult with the Risk Manager to determine if the minor can be released to one that is authorized by the parent or legal guardian.

D. **RELATED DOCUMENT(S):**
1. Patient Care Services: Consent for Minors Policy

E. **REFERENCE(S):**
1. CHA Consent Manual (201~~7~~**20**), Chapter 4

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

A. **RESPONSIBILITIES:**

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

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

~~1.~~ ~~A task will be triggered each shift to the nurse assigned to the patient on their unit.~~

~~2.~~ The primary Registered Nurse (RN) is required to complete the acuity on the patient each shift ~~or the task will be noted as overdue.~~
   a. There are care intensity and ADL indicators.
      i. The care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels.
      ii. The ADL indicator is defined by minimal, moderate and high.
      iii. Each care intensity and ADL indicator is unit specific based on the patient population and has a weight associated to it that assists in determining the acuity of the patient.

3. ~~The~~ Nursing Leadership or designee is responsible to verify that ~~all~~ acuities are completed each shift.

4. Each unit shall keep a record of the staffing assignments and acuity tool.

~~3.~~**5. A written staffing plan shall be developed by the administrator of nursing service or a designee, based on patient care needs determined by the patient classification system. The staffing plan shall be developed and implemented for each patient care unit and shall specify patient care requirements and the staffing levels for registered nurses and other licensed and unlicensed personnel.**

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

1. The coder will document on the Acuity Daily Report the Emergency Department census at 0700 and 1900. A daily Emergency Department (ED) Activity Log is generated at 0700 for the previous 24 hours which reflects the total patients seen, Patients Left Without Treatment, ICU admissions and hospital admissions in the last 24 hours. Emergency Severity Index (ESI) acuity levels are documented in Firstnet when patients arrive in Triage.

~~2.~~ The Labor and Delivery Nursing Leadership or designee will document on the Daily Staffing Sheet the Labor & Delivery census at 0700 and 1900. ~~Nursing Leadership or designee will fax this 24 hour retrospective report to staffing by 0900 for filing.~~

Department Review	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department / Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/12, 07/16, 04/20, **10/21**	12/12, 07/16, 04/20, **10/21**	12/12, 07/16, 05/20, **11/21**	n/a	n/a	4/12, n/a	05/20, **11/21**	04/13, 08/16, n/a	04/13, 08/16, 05/20

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

1. The purpose of this process is to ensure the consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) ~~powerform.~~ **Tool.**
2. Each shift the Charge Nurse or designee will complete an ~~A~~**a**cuity ~~V~~**v**alidation on patients within their department **and reviewed.**
3. This information will be monitored on a ~~monthly~~ **bi-annual** basis and reported as appropriate.
   - **a. Bi-annually, each unit leader shall review 5 charts for both day shift and night and validate the acuity tool based on nursing documentation and reported to nursing leadership.**
4. **The reliability of the patient classification system will be reviewed annually by a committee appointed by the Chief Nursing Officer to determine if the current acuity tool accurately measures patient care needs.**
   - **a. At least half of the committee members shall be registered nurses who provide direct patient care**
   - **b. If the committee review recommends adjustments to the patient classification system to ensure accuracy in measuring patient care needs, such adjustments will be implemented within 30 days of final determination.**
   - ~~a.~~**c. A process will be determined to ensure all interested staff may provide feedback on the patient classification system and/or the staffing plan.**

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

1. Women and Newborn Services NICU: Patient Classification (Acuity) in the NICU

F. REFERENCE:

1. **_§70053.2. Patient Classification System**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 12/11

SUBJECT: Point of Care (POC) New Test/Method Request and Implementation

REVISION DATE(S): 04/16, 02/19

Patient Care Services Content Expert Approval:	~~10/18~~10/20
Clinical Policies & Procedures Committee Approval:	~~11/18~~12/20
Nursinge Leadership~~Executive Committee~~ Approval:	~~11/18~~08/21
Department of Pathology Approval:	01/19
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~01/19~~11/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. To ensure that:
   a. POC testing meets the needs of the patients served, is performed correctly by non-laboratory staff, and is cost effective.
   b. POC testing is approved by the appropriate committees at a hospital level before implementation.
2. Devices, tests, and analytes available as POC testing are continually improving and expanding. However, POC testing is not appropriate for use in all situations. New test and method requests must be evaluated before implementation.

B. **POLICY:**

1. POC testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Medical Director.
2. Any patient testing, including testing that is performed outside of the clinical laboratory by non-laboratory personnel, must conform to state and federal regulations. The Product Standards Committee (PSC) reviews all requests for new testing. Once approved by the PSC, the Laboratory will establish standards for POC testing, evaluate POC devices or tests before implementation, and monitor all POC testing sites for compliance.
3. Requestors must complete and submit the form "Request for Approval of New POC Test/Method" to POC Coordinator (POCC) and/or Lab Leadership Team.
   a. The front of the form explains the extent and use of desired testing, and must be filled out in full by the requesting department.
   b. The back of the form evaluates the financial impact of testing. This can be completed with assistance from the POCC, but the requesting department must be fully aware of all costs involved.
4. Requestors must then submit to the Clinical Value Analysis Team according to current PSC policies. PSC reviews all requests for new POC testing taking into consideration the following aspects:
   a. Medical need for decreased turn around time
   b. Procedure complexity
   c. Regulatory compliance
   d. Ongoing competency

e. Cost

5. Following approval for consideration, the POCC and Lab Leadership Team assigns oversight to the appropriate personnel who will:
   a. Assess available technology for the requested test by contacting vendors.
   b. Evaluate and make recommendations to the Laboratory Leadership and Medical Director.
   c. Perform test method validation according to regulatory requirements and obtain approval by the Laboratory Medical Director.
   d. Create written policies/ procedures that are clear to users and meet all regulatory requirements.
   e. Establish quality control policy to be followed by testing personnel with regular review of data by responsible staff.
   f. Enroll in appropriate proficiency testing or establish alternative proficiency testing if needed.
   g. Ensure testing personnel are trained and demonstrate competency prior to performing patient testing.
   h. Request Lab Information System or Information System input, if needed.
   i. Communicate to physicians new test availability.
   j. The Laboratory Medical Director and POCC review and approve all data for test implementation prior to patient testing. The Lab Medical Director is involved in the selection of all equipment and supplies, in accordance with College of American Pathology (CAP) regulations.
6. CAP requirements for POC testing including but not limited to the following general items.
   a. Proficiency testing is performed at intervals determined by the subscribed survey, in a timely manner, as similar to patient testing as possible, by personnel who perform patient tests, and rotated among all testing personnel.
   b. Testing Personnel must adhere to manufacturer instructions and written procedure.
   c. Results are reported in the medical record. Critical Results are handled appropriately.
   d. Reagents are stored properly. New lots and shipments are evaluated appropriately before use.
   e. Equipment maintenance is performed and documented to meet manufacturer requirements.
   f. Personnel must be trained and competency assessed according to the Patient Care Services Procedure: Point of Care Testing Competency Assessment
   g. Quality Controls are performed and documented at required intervals.
7. Managers overseeing departments performing POC testing must complete the Request for Approval of New Point of Care Test/Method

C. **FORM(S):**
1. Request for Approval of New Point of Care Test/Method
2. Request for Clinical Product Review

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Procedure: Point of Care Testing Competency Assessment

E. **REFERENCE(S):**
1. College of American Pathology. CAP Accreditation Program. Point of Care Testing Checklist Tri-City Medical Center, CAP Number: 2317601. Version: 08.22.2018.
2. College of American Pathology. CAP Accreditation Program. Team Leader Assessment of Director and Quality Checklist Tri-City Medical Center, CAP Number: 2317601. Version: 08.22.2018.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/17 **SUBJECT:** Program Flexibility

REVISION DATE~~(S)~~: 07/17

Patient Care Services Content Expert~~Department~~ Approval:	**~~03/17~~03/21**
Clinical Policies and Procedures Approval:	**~~05/17~~10/21**
Nursinge Leadership ~~Executive Committee~~ Approval:	**~~05/17~~11/21**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/21**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **POLICY:**

1. Tri-City Healthcare District (TCHD) will maintain continuous compliance with the **special permit** ~~upplemental service~~ requirements **for program flexibility**
   a. **If TCHD is unable to maintain continuous compliance with all required standards, TCHD will request an exception i.e., program flexibility from the California Department of Public Health (CDPH) pursuant to Title 22 section 70363 and Health and Safety Code (HSC) section 1276.**
2. **Program flexibility requests shall be submitted to the California Department of Public Health using the appropriate Program Flexibility form (CDPH-5000 or CDPH-5000A).**
3. **All program flexibility requests must contain the following supportive evidence :**
   a. **The regulation for which the facility requests flexibility**
   b. **An explanation of the alternatives e.g., concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing, terms the program flexibility will be initiated etc.,**
   c. **Evidence demonstrating how the alternative concepts, methods, procedures, techniques, etc., meet the intent of the regulation**
   d. **A licensee, administrator, or authorized facility representative signature on all forms and/or requests**

~~1.~~**4. All approved program flexibility granted by CDPH will specify an expiration date and are subject to specific terms and conditions.**

~~a. If TCHD is unable to maintain continuous compliance with all required standards, TCHD will request an exception from the California Department of Public Health (CDPH) pursuant to Title 22 section 70307.~~

~~b. Such approval shall provide for the terms and conditions under which the exception is granted.~~

~~c. A written request plus supporting evidence shall be submitted by the applicant or licensee to CDPH.~~

~~d.~~**a.** ~~Any approval granted by CDPH shall be posted within TCHD.~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PUREWICK FEMALE URINARY INCONTINENCE MANAGEMENT**
Purpose:	To **identify**~~define~~ the appropriate procedure for initiation of urinary incontinence management through implementation of the **female urinary incontinence** ~~PureWick~~ system. To define the assessment, monitoring, and maintenance of urinary incontinence management with implementation of the PureWick system.
Supportive Data:	Reduces the need for inserting an indwelling urinary catheter for incontinent female patients and avoids the risk associated with catheter-associated urinary tract infections (CAUTI). Keeps patient's skin dry, avoids pressure ~~ulcers~~**injury**, contact dermatitis from urine, and the need for diapers
Equipment:	PureWick System/ **Female Urinary Incontinence system** Wall suction regulator Suction canister and liner Suction tubing Suction tubing connectors Incontinence pads, patient undergarments, mesh panties (optional) Hygiene supplies

~~A. **DEFINITION(S):**~~

~~1. Wick: Disposable, latex free flexible urine collection tube with a vacuum, with cloth material on one side and plastic or tape on the other side that is positioned between the labia and the bottom to collect urine. The wick is designed to connect to the suction regulator via suction tubing. The suction is set at **to a minimum of** 20-**40** mmHg to produce a mild vacuum inside of the wick. Wicks are capable of capturing 100% of urine.~~

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

1. Review the Elsevier Procedure : Urinary Catheter: External Female for detailed information on the following:

- **a. Purpose**
- **b. Assessment and Preparation**
- **c. Procedure for application and removal**
- **d. Monitoring and care**
- **e. Expected and unexpected outcomes**

~~**Always use the minimum amount of suction necessary.**~~

~~1. PureWick urine management system may be implemented for female patients with urinary incontinence 24 hours per day and the following:~~

- ~~a. Walking from bed to chair to a toilet is difficult or painful~~
- ~~b. Inability to retain urine~~
- ~~c. Post-surgical or procedure immobility~~
- ~~d. Accurate urine output measuring~~
- ~~e. Strict intake and output orders~~
- ~~f. Pressure ulcers~~**injury** ~~or contact dermatitis associated skin injuries related to urine~~
- ~~g. Urine sample, if a sample cannot be obtained from a clean catch~~

~~2. The PureWick system is contraindicated for the following:~~

- ~~a. Male patients~~
- ~~b. Patients with male genitalia~~
- ~~c. Patients with urinary retention~~
- ~~d. Uncooperative patient~~
  - ~~i. Uncooperative patients will remove wicks~~
- ~~e. Patient gets out of bed without supervision~~

Department Review	Clinical Policies and Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Infection Control Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/16,0 7/20, 10/21	01/17, 08/20, 10/21	02/17, 11/21		n/a	03/17, 11/21	11/21	04/17, n/a	04/17

~~f. Bowel incontinence with frequent episodes~~

~~3. Precautions for the use of the PureWick system include but are not limited to:~~
~~a. Skin irritation~~
~~b. Pressure from device~~
~~c. Patient discomfort~~

~~4. PureWick urine management system will be implemented by a Registered Nurse (RN); a physician order is not required. The RN is responsible for:~~
~~a. Identifying patients that will benefit from the use of a PureWick~~
~~b. Maintenance of PureWick.~~
~~c. Documentation in the medical record~~

~~5. Each wick may be used for a maximum of 12 hours.~~

~~6. Change the wick prior to the end of each shift, as needed (PRN) and if the following occurs: .~~
~~a. Indications for changing the wick~~
~~i. Patient comfort or request~~
~~ii. Skin irritation~~
~~iii. Frequency of urinations~~
~~iv. After each stool~~
~~Menstruating~~
~~v. **Always assess skin for compromise and perform pericare prior to placement of a new PureWick.**~~

~~7. Assessment~~
~~a. Assess the following at least twice per shift and PRN~~
~~i. Urine output, if urine is escaping the wick, refer to the Troubleshooting section below~~
~~ii. Patient's comfort~~
~~iii. Proper placement of the wick at least three times per shift and with position changes~~
~~iv. Presence of skin redness or irritation related to the wick location~~
~~v. Ensure patient does not insert the wick into the vagina, anal canal or other body cavities~~

~~8.~~**2.** Transport On and Off a Unit
a. Patients with PureWicks suction will be:
i. Disconnected from suction prior to transport by RNs and Advanced Care Technicians (ACTs)
ii. Reconnected to suction by RNs and ACTs when returning from test or procedures

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

~~1. Perform hand hygiene per Tri-City Healthcare District (TCHD) policies and procedures~~
~~2. Obtain a PureWick Urinary System~~
~~3. Explain procedure to patient~~
~~4. Set up suction per manufacturer's instructions~~
~~5. Set vacuum pressure i.e., suction to **at least** 20**-40** mmHg (low**est** setting **necessary**) continuous suction. Suction may be increased if required to a maximum of 60 mmHG. Do not exceed 60 mmHG~~
~~a. Ensure suction is working by closing and opening the suction tubing end with your thumb or by placing the suction tubing open end in the palm of your hand.~~
~~6. Perform hand hygiene and don new gloves.~~
~~7. Position patient on their back or side; place an incontinence pad under her buttocks to capture urine that escapes the wick.~~
~~8. Provide pericare **and assess skin integrity**~~
~~9. Remove wick from the package.~~
~~10. Peel the PureWick label from bag and wrap it around the suction tubing.~~
~~a. It will serve as a method of identifying the hose when replacing wicks.~~
~~11. Insert the plastic hose on the end of the wick into the connector on the suction tubing~~
~~12. Separate the **legs,** gluteus muscle and the labia. **Palpate pubic bone as anatomical marker.**~~

~~13. Hold the wick vertically with the connection to the suction tubing on top and the cloth surface facing the patient's perineum.~~
~~14. Gently place the wick snugly against the perineum, between the labia and patient's buttocks.~~
~~a. The cloth surface of the wick (white side) should be snugly positioned between the labia and close to the urethra.~~
~~b. The wick should touch the perineum between the anus and the pubic bone~~
~~i. Failure to properly place the wick will result in urine leakage~~
~~c. If the patient is lying still, the wick will typically stay in-position.~~
~~d. Assist patient with repositioning at least every 2 hours and PRN.~~
~~e. Mesh stretch panties or the patient's undergarments may be applied to hold the wick in place.~~
~~**Connect the PureWick to wall suction using standard suction tubing**~~
~~15. Ensure the hose connector is above the pubic bone~~
~~16. Verify the suction is functioning~~
~~17. Ensure there are no kinks in the suction tubing~~
~~18. Maintenance of Suction Canister~~
~~a. The suction will stop working when the suction canister is full~~
~~b. Change the suction canister when it is ¾ full.~~
~~i. The canister may be changed without removing the wick. Disconnect the suction tubing from the plastic connector attached to the wick and change suction canister per manufacture's recommendations.~~
~~c. Observe the amount of urine in the canister a minimum of 3 times daily.~~

~~D.~~B. OBTAINING A URINE SAMPLE WITH THE PUREWICK:

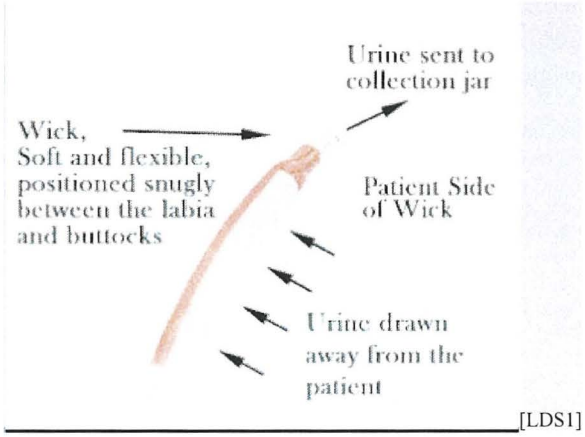
1. Set up suction
2. See Online Clinical Skills: Specimen Collection: Midstream (Clean-Voided) Urine
~~3. Female patient~~
~~a. Spread or have the patient spread the labia minora with the thumb and forefinger or forefinger and middle finger of the nondominant hand.~~
~~b. Use the dominant hand to cleanse the urethral area with antiseptic swabs moving from front (above the urethral orifice) to back (toward the anus).~~
~~c. Using a fresh swab each time, employ the front-to-back motion first with the left side, then the right side, and then down the center. Again using a fresh swab each time, repeat the process~~
~~d.~~**a.** While continuing to hold the labia apart,
   i. Apply a **female urinary incontinence device**~~PureWick~~ (do not connect ~~the PureWick~~ to suction) have the patient initiate a urine stream, discard the **female urinary incontinence device**~~PureWick~~
   ii. Apply a new **female incontinence device**~~PureWick~~, connect to suction and allow patient to void to collect a midstream specimen
   iii. After collecting the midstream specimen, disconnect the suction tubing from the suction canisters, close the lids on the liner, and remove the liner.
      1) If the **female incontinence device** ~~PureWick~~ is to remain in place, apply a new liner and connect the suction
      2) If the **female incontinence device** ~~PureWick~~ is no longer require remove and discard suction tubing.
   iv. Pour midstream specimen in a specimen container and label according to TCHD Specimen Labeling
   v. Transport specimen to lab ~~according~~ **and document the collection in the** ~~to TCHD policy~~
   ~~vi.~~ ~~Document~~ in the medical record ~~according to TCHD policy~~

~~E.~~C. TROUBLESHOOTING:

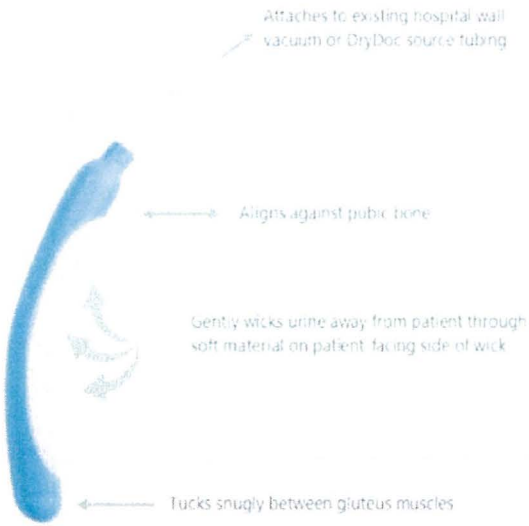
1. If a large amount of urine is escaping from the **gauze**~~wick~~, contributing factors include but are not limited to:

a. The **gauze**~~wick~~ is not correctly tucked between the labia and buttocks.
   i. The **gauze** ~~wick~~ must be snugly positioned between the labia with the bottom end between the buttocks.
   ii. Ensure the top of the wick reaches just above the pubic bone.
   iii. Change the **female external catheter i.e.,** PureWick
   iv. Apply mesh panties to assist with maintain**ing appropriate** ~~the PureWick's~~ position

b. No or low suction.
   i. Check suction settings and ensure the regulator is set **to** ~~at 24~~0 mmHg
   ii. Check for kinks in the tubing or sediments
   iii. Ensure the suction canister lid is firmly in place
   iv. Verify the suction regulator is functioning
   v. Ensure the suction tubing is connected- **female insentience device tubing**~~to the wick connector~~



~~vi.~~ [LDS1]



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

1. **Elsevier Urinary Catheter: External Female Procedure**
2. ~~1.~~ **Online** Clinical Skills ~~(Mosby's)~~: Specimen Collection: Midstream (Clean-Voided) Urine
3. ~~2.~~ Patient Care Services Policy: Specimen Labeling

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

1.
2. PureWick, Inc. (~~2016, April~~**2018, February**).Instructions for use ~~(in hospital settings)~~. **Retrieved from** ~~from~~ **https://www.bd.com/assets/documents/PDH/Initial/PF10741_BAW0319838.pdf**

~~1.~~**3.** ~~**https://www.crbard.com/CRBard/media/ProductAssets/BardMedicalDivision/PF10741/en-US/PF10741_BAW0319838.pdf**~~

~~2.~~**4.** PureWick, Inc. (n.d.). Successful incontinence management for women. Retrieved from http://www.purewick.com/

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Patient Care

ISSUE DATE:	**05/86**	**SUBJECT:**	**Reporting Suspected Child Abuse/Neglect**
REVISION DATE:	**08/94, 02/96, 01/97, 07/99, 04/02, 06/03, 12/05, 04/09, 06/11**	**POLICY NUMBER:**	**8610-308**

Department Approval:	~~04/17~~08/21
Clinical Policies and Procedures Approval:	~~05/17~~08/21
Nursinge Leadership~~Executive Council~~ Approval:	~~05/17~~10/21
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected child abuse and neglect cases.

B. **DEFINITIONS:**

1. Child – Person under the age of 18.
2. Mandated Reporter - Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, or licensed nurses.
3. Abuse or neglect – Intentional maltreatment of an individual that may cause injury, either physical or psychological. The following are various types of abuse:
   a. Mental Abuse – includes humiliation, harassment, and threats of punishment or deprivation.
   b. Physical Abuse – includes hitting, slapping, pinching ~~or~~,kicking **or mistreatment**. Also includes controlling behavior through unlawful corporal punishment.
   c. Sexual Abuse – **means**~~Includes~~ sexual assault and sexual exploitation.
   d. Emotional Damage – when a child is suffering serious emotional damage or is at a substantial risk of suffering serious emotional damage, evidenced by states of being or behavior, including but not limited to, severe anxiety, depression, withdrawal or untoward aggressive behavior toward self or others**, regressive behavior or new speech disorders**.
   e. Neglect – the negligent **treatment**~~failure~~ or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person **{Penal Code 11165.2}**.
      i. General Neglect - the negligent failure of a person having the care or custody of a child to provide adequate food,) clothing, shelter, medical care or supervision where no physical injury to the child has occurred.
      ii. Severe Neglect - the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed non organic failure to thrive. It also means those situations of neglect where the person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that the child's person or

health is endangered. **This includes intentional failure to provide adequate food, clothing, shelter and / or medical care.**

f. Willful cruelty or unjustifiable punishment - A situation where a person willfully harms or injures a child or causes or permits a child to suffer or inflicts unjustifiable physical pain or mental suffering upon the child or permits a child to be placed in a situation where the child's person or health is endangered.

g. Unlawful corporal punishment or injury - a situation where a person willfully inflicts upon a child cruel or inhuman corporal punishment or injury resulting in a traumatic condition.

h. Reasonable Suspicion – for purposes of this article, "reasonable suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect. "Reasonable suspicion" does not require certainty that child abuse or neglect has occurred nor does it require a specific medical indication of child abuse or neglect; any "reasonable suspicion" is sufficient. For purposes of this article, the pregnancy of a minor does not, in and of itself, constitute a basis for a reasonable suspicion of sexual abuse.

i. ~~Note:~~ Child abuse does not include a mutual affray between minors or an injury caused by a peace officer's reasonable and necessary force used while acting within the course and scope of the officer's employment as a peace officer. Affray is not defined in the law, but the dictionary defines it is a fight, quarrel or brawl.

C. **POLICY:**

1. ~~Under Sections 11166 of the~~ California Penal Code **§11166**~~,~~ mandated reporters who has knowledge of or observes a child in his/her professional capacity or within the scope of his/her employment whom he/she knows or reasonably suspects, has been the victim of child abuse or neglect, to report such suspected instances to the designated agency. The initial report must be made immediately, or as **soon as** practically possible, by telephone and followed up with a written report within thirty-six (36) hours **that is transmitted by facsimile (FAX) or electronically**. A mandated reporter may report suspected emotional damage under Section 11166.05 of the California Penal Code.
2. The following criteria may indicate a need for further assessment. Criteria may include the following:
   a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches).
   b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks).
   c. Poor hygiene, malnourishment.
   d. Fear of parent or caregiver, being withdrawn or tearful.
   e. Inappropriate responses to questions about a safe environment or being threatened at home.
   f. Home or institution in which child resides is unsuitable for the child because of abuse or neglect.
3. This law relates to any person under the age of 18 years whose home is an unfit place for him/her, by reason of neglect, cruelty, depravity or emotional abuse by ~~either parent~~**parent**, guardian or other person in whose custody or care he/she resides.
4. If a minor seeks treatment for pregnancy, an abortion, sexually transmitted disease or birth control assistance, a report is not indicated unless there is evidence or reasonable suspicion to believe that a sexual assault, sexual abuse, or other abuse or neglect has occurred. (Pregnancy in a mentally or physically impaired or mentally compromised child does raise a reasonable suspicion of child abuse).
5. If voluntary sexual activity exists between minors who are of disparate ages and one of the minors is under 14 years of age, or, one party is a minor and the other is over age 21, or, any relationship in which it appears that a minor is being manipulated or exploited, a report of child

abuse is required.

6. All cases of child abuse suspected **and actual must be reported** by any mandated reporter **as follows:**
   - **a. Notify the Child Abuse Hotline by telephone (1-858-560-2191 or 1-800-344-6000**
   - **b. Prepare and send a written report (SS 8572: Suspected Child Abuse Report) within 36 hours of receiving the information concerning the incident e.g., contacting the Hotline**
   - **c. Fax the completed SS 8372 or written report to the Hotline.**
   - **d.**
   - ~~6. must be reported in the following manner:~~
   - ~~a. Children Services 24 hour Child Abuse Hotline number: (1-800-344-6000).~~
   - ~~b.~~**e.** ~~Complete the SS 8572 suspected child abuse reporting form within 36 hours of a telephone report and f~~**F**orward **SS 8572** ~~it~~ to the hospital Social Services Department ~~to be mailed and a copy filed.~~
7. Use a FAX Report: Monday - Friday, 0800 to 1700 only. (Do not send an SS 8572 if the FAX Report has been sent).
8. ~~Use the Children's Services Child Abuse Hotline 1-800-344-6000 between 1700 and 0800, on weekends, and on holidays to make telephone reports. Complete the SS 8572 in addition to the phone call and forward the SS 8572 to the hospital's Social Services Department.~~
9. **8.** Upon reporting suspected child abuse, the county caseworker or child protective worker will instruct the hospital whether or not to place a 48 hour "hold" on said child. The court hold is usually placed as a means of providing protective custody and ensuring that the child will be given proper medical treatment. The "hold" shall be released within 48 hours, excluding non-judicial days, after the minor has been taken into custody, unless within said period of time a petition is filed with the Juvenile Court for a detention hearing. If a petition is filed with Juvenile Court, the child shall remain in custody until which time the "detention hearing" has transpired. At that time, the physician or District will act in accordance with court orders from said hearing.
10. **9.** The mandated reporter involved in evaluation, collection of facts and information, and reporting has the responsibility of ensuring such information is documented in writing in the medical chart in a comprehensive manner.
11. **10.** A mandated reporter shall inform the legal guardian of said "suspected" abused child of what actions have taken place, why they transpired, and what position the hospital must take in such situations as prescribed by law.
12. **11.** The Social Services Department at the hospital has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency as well as notification of the TCHD Compliance Officer. This applies whether seen in the Emergency Department or admitted to the Medical Center.
13. **12. TCMC** Social Services Department will be notified of all cases of suspected child abuse / **neglect** by one of the following methods:
   - a. Making a Social Services referral through the computer.
   - b. By telephone to the Social Services department or page to a specific Social Worker.
   - c. By completing an SS 8572 Child Abuse Reporting Form and forwarding it to the hospital Social Services Office.
   - d. By completing a Child Protective Service fax form and forwarding it to the hospital Social Services office.
14. **13.** The Clinical Social Worker shall serve as the communication link between the District and outside agencies regarding compliance with stated child abuse statutes and the regulations and procedures of the San Diego County Health and Human Services Agency, Children Services.
15. **14.** In the event that a child is to be discharged from the hospital while deemed in the custody of the Juvenile Court, the Clinical Social Worker or designee will coordinate such discharge by requiring proper identification from the person to whom the child is being discharged; and will request that court documentation of detention and custody be provided or mailed to the District as soon as possible.
16. **15.** Copies of all completed Child Protective Service fax forms and Child Abuse Reporting Forms (SS 8572) will be filed in the Social Services Department at the hospital.

~~17.~~**16.** Any problematic cases are reported to the Director/Manager of Social Services and Director of Legal Services/Risk Management for additional review.

~~18.~~**17.** Penal Code Section 11172 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.

~~19.~~**18.** When two or more mandated reporters have knowledge, or reasonably suspect, a reporting incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.

~~20.~~**19.** Any person who is not a mandated reporter who knows, or reasonably suspects, that a child has been the victim of abuse, may report that abuse. Such report may be coordinated through the Social Services Department.

D. **REFERENCES:**

1. California Hospital Association. (20~~17~~**20**). *California Hospital: Consent Manual*. CHA Publications: Sacramento.

2. California Penal Codes 11164-11174.3 of the *The Child Abuse and Neglect Reporting Act.*

~~1.~~**3.**

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Patient Care

ISSUE DATE:	**05/86**	**SUBJECT:**	**Reporting Suspected Dependent Adult/Elder Abuse/Neglect / Exploitation**
REVISION DATE:	**06/91, 09/94, 02/96, 01/97, 07/99, 10/00, 06/03, 12/05, 04/09, 06/11 07/17**	**POLICY NUMBER:**	**8610-309**

Department Approval:	~~04/17~~08/21
Clinical Policies and Procedures Committee Approval:	~~05/17~~08/21
Nursinge LeadershipExecutive Council Approval:	~~05/17~~10/21
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~11/21
Administration Approval ;	11/21
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. To provide guidelines for the management and reporting of suspected abuse/neglect of elders and dependent adults.

B. **DEFINITIONS:**

1. Abandonment:
   a. Desertion of willful forsaking of an elder or dependent adult by anyone having care of custody of that person under circumstances in which a reasonable person would continue to provide care and custody.
2. Abuse:
   a. means physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment resulting in harm, pain or mental suffering or deprivation by a care custodian of goods and services s that are necessary to avoid physical harm or mental suffering.
3. Dependent Adult:
   a. Anyone between the ages of 18 and 64 years who has physical or mental limitations or age-diminished physical or mental abilities which restrict that person's ability to carry out normal activities or to protect his/her rights including (but not limited to) persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age. This definition also includes any one between the ages of 18 and 64 who is admitted as an inpatient in an acute care hospital or other 24-hour health facility.
4. Elder:
   a. Any person 65 years of age or older.
5. Endangered Adult:
   a. Means a dependent or elder adult who is at immediate risk of serious injury or death, due to suspected abuse or neglect and who demonstrates the inability to take action to protect himself or herself from the consequences of remaining in that situation or condition
6. Financial Abuse:

a. **Theft, misuse of funds or property, extortion, duress, fraud.** ~~Occurs when a person or entity takes, secrets, appropriates, obtains, or retains (or assists another to do so) real or personal property of an elder or dependent adult for a wrongful use or with intent to defraud or both, or by undue influence~~

7. Exploitation:
   a. **Taking advantage of another for one's own advantage or benifit**An unjust or improper advantage or use of another person or their property for one's own profit or advantage (i.e., using a victim's financial means for another's gain).
8. Imminent Danger:
   a. Substantial probability that elder or dependent adult is in imminent or immediate risk of death or serious physical harm, through either his/her own action or inaction or as a result of the action or inaction of any other person.
9. Isolation:
   a. Acts to intentionally prevent**ing an individual from receiving mail, telephone calls or visitors.** an elder or dependent adult from receiving mail or phone calls.
   b. Telling a caller or prospective visitor that an elder or dependent adult is not present, does:
      i. False
      ii. Contrary to the express wishes of the elder or dependent adult, whether he or she is competent or not; and
      iii. Made for the purpose of preventing the elder or dependent adult from having contact with family, friends or concerned persons
   c. False imprisonment.
   d. Physical Restraint of an elder or dependent adult for the purpose of preventing him or her from meeting with visitors
10. Mandated Reporter:
   a. Professionals or individuals listed under Penal Code required to report by law. Such persons include, but are not limited to, health care providers such as physicians, surgeons, psychiatrists, psychologists, dentists, residents, interns, or licensed nurses.
11. Mental Suffering:
   a. Fear, agitation, confusion, severe depression or other forms of serious emotional distress brought about by threats, harassment, or other forms of intimidating behavior.
   b. False or misleading statements made with malicious intent to agitate, confuse, frighten or cause severe depression or serious emotional distress of the elder or dependent adult
12. Neglect:
   a. **Failure to provide food, clothing, shelter, or health care for an individual unders one's care when the means to do so are available.** ~~The negligent failure of a person having the care or custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise; or~~
   ~~b. The negligent failure of an elder or a dependent adult to exercise that degree of self-care that a reasonable person in a like position would exercise~~
   ~~c.~~**b.** Neglect includes:
      i. Failure to assist in personal hygiene, or in provision of food, clothing or shelter
      ii. Failure to provide medical care for physical and mental health needs (excludes the elder or dependent adult who voluntarily relies on treatment by spiritual means vs. medical treatment, when no other indicators of abuse exist)
      iii. Failure to protect from health and safety hazards
      iv. Failure to prevent malnutrition or dehydration
   ~~d.~~**c.** If a person cannot provide the above for oneself due to poor cognition functioning, mental limitation, substance abuse, or chronic poor health, this also constitutes neglect
13. Physical Abuse: means all of the following:
   a. Hitting, kicking, burning, and dragging, over or under medicating. Battery
   b. Assault with a deadly weapon or force likely to cause great bodily harm
   c. Unreasonable physical constraint, or prolonged or continual deprivation of food

or water

14. **Sexual Abuse:**
    a. **Unwanted sexual contact, sexual exploitation, forced viewing of pornography**

15. **Self-Neglect:**
    a. **Failure to provide food, clothing, shelter or health Hitting, kicking, burning, dragging, over or under medicating. Battery**
    b. **Assault with a deadly weapon or force likely to cause great bodily harm**
    c. **Unreasonable physical constraint, or prolonged or continual deprivation of food or water**
    ~~13.~~**d. care for oneself.**
    ~~a. Assault~~
    ~~b. Battery~~
    ~~c. Assault with a deadly weapon or force likely to cause great bodily harm~~
    ~~d. Unreasonable physical constraint, or prolonged or continual deprivation of food or water~~
    e. Sexual assault which means any of the following:
        i. Sexual battery
        ii. Rape
        iii. Rape in concert
        iv. Spousal rape
        v. Incest
        vi. Sodomy
        vii. Oral copulation
        viii. Sexual penetration
        ix. Lewd or lascivious act
    f. Use of physical or chemical restraint, or psychotropic medication under the following conditions
        i. For punishment
        ii. For a period significantly beyond that for which the restraint or medication is authorized by a physician's licensed in California who is providing medical care to the elder or dependent adult at the time the instructions are given
        iii. For any purpose not authorized by the physician

C. **POLICY:**

1. Sections 15600, et seq., of the California Welfare and Institutions Code requires that a mandated reporter who, in his/her professional capacity, or within the scope of his/her employment that has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he/she has experienced behavior, including the act or omission, constituting acts described above, shall report to an adult protective services agency or local law enforcement agency by telephone immediately or as soon as practicably possible, and by written report within two (2) ~~working~~ days.
2. The following may indicate a need for further assessment:
    a. Injuries inconsistent with what the patient reports to have happened (i.e., burns, welts, bites and scratches)
    b. Unusual patterns of injury (i.e., hairbrush, rope or belt marks)
    c. Poor hygiene, malnourishment
    d. Fear of parent or caregiver, being withdrawn or tearful
    e. Improper responses to questions such as, "Is anyone misusing your money, food, housing or not allowing you to obtain health care?"
    f. Inappropriate responses to questions about a safe environment or being threatened at home
3. The code also permits the reporting of suspected intimidation, cruel punishment, or other

treatment that endangers an elder or dependent adults' emotional wellbeing.

4. Instances do not have to be reported if a physician, registered nurse, or psychotherapist are unaware of independent evidence of incidents described in 1 above, and the patient has been diagnosed with a mental illness or dementia and mandated reporter does not believe abuse occurred.
5. Abuse of an elder or dependent adult is a criminal act.
6. Welfare and Institutions Code Section 15634 provides that no mandated reporter shall incur any civil or criminal liability as a result of making a report authorized by the law.
7. Any person who knowingly fails to report an instance of elder or dependent adult abuse is guilty of a misdemeanor.
8. The mandated reporter will complete an assessment and report the findings to the attending physician. If abuse is suspected, the mandated reporter will make a telephone report to the appropriate agency immediately or as soon as practically possible.
    a. If the alleged abuse occurred in a long-term care facility (Skilled Nursing Facility or Board & Care), the report must be made to the local ombudsman (1-800-640-4661; fax 858-694-2568) or the local law enforcement agency where the incident occurred.
    b. If the alleged abuse occurred anywhere else, the report must be made to the County Aging and Independence Services (AIS) at 800-510-2020.
    c. The mandated reporter will notify by phone, the adult abuse hotline (AIS) at 800-510-2020, or the ombudsman's office 1-800-640-4661 and will complete the elder abuse reporting form SOC 341.
9. The mandated reporter making the telephone report must complete a written report and mail it to the appropriate agency within two (2) ~~working~~ days of making the telephone report.
10. All completed SOC 341 forms need to be forwarded to the hospital Social Services Department for mailing and filing. Copies of all completed "Suspected Dependent Adult/Elder Abuse" forms (SOC 341) will be filed and maintained in the Social Services Department at TCHD.
11. The Social Services Department at TCHD has the primary responsibility for coordinating, tracking the reporting of suspected cases of abuse/neglect to the appropriate agency, as well as notification of TCHD Compliance Officer. This applies whether seen in the Emergency Department, or admitted to the Medical Center.
12. Social Services Department will be notified of all cases of suspected elder abuse/neglect by one of the following methods:
    a. Making a Social Service referral through the computer.
    b. By telephone to the Social Services department or page to a specific Social Worker.
    c. By completing an SOC 341 Elder Abuse Reporting Form and forwarding it to the hospital Social Services Office.
13. Detention of Endangered Adults - Welfare and Institutions Code Section 15703.05 allows a physician treating an adult, if he/she determines that adult is endangered, to delay the release until:
    a. A local law enforcement agency takes custody of the patient
    b. The responding agency determines the adult is not an endangered adult
    c. The responding agency takes other appropriate action to ensure the safety of the endangered adult (This law applies whether or not medical treatment is required)
14. If the patient was a victim of abuse, neglect or domestic violence (except child abuse or neglect), the patient must be promptly informed that a report has been or will be made unless:
    a. The health care provider believes, in the exercise of professional judgement, that the informing the patient would place him or her at risk of serious harm, or
    b. The health care provider would be informing a personal representative , and the provider reasonably believes the personal representative is responsible for the abuse, neglect or other injury and that informing the personal representative would not be in the best interests of the patient
    c. Verbal notification is sufficient. A report must be made even if the patient objects. The health care provider may suggest that the victim go to a protected environment due to the risk of retaliation after the report is made.

15. When appropriate, the Clinical Social Worker shall inform the patient and/or family of what actions have taken place, why they transpired, and what position the District must take in such situations as prescribed by law.
16. The Clinical Social Worker shall serve as liaison between the District and all outside agencies, in compliance with Elder/Dependent Adult Abuse statutes and the regulations and procedures of San Diego County Department of Social Services.
17. The Clinical Social Worker may continue to provide case management including discharge planning to a safe environment.
18. Any problematic cases are reported to the Director/Manager of Social Services and ~~the Director~~ of Risk Management for additional review.
19. When two or more mandated reporters have knowledge or reasonably suspect a reportable incident, they can agree that a single report can be made. This can be coordinated through the Social Services Department.
20. Any person who is not a mandated reporter who knows, or reasonably suspects, that an elder or dependent adult has been the victim of abuse, may report that abuse. Such reports may be coordinated through the Social Services Department.

D. **REFERENCE(S):**

1. Adult Protective Services (SRS).
2. California Hospital Association. (20~~17~~**2020**). *California Hospital: Consent Manual*. CHA Publications: Sacramento.
~~1.~~**3.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ~~Tdap (~~TETANUS, DIPHTHERIA & PERTUSSIS (TDAP) VACCINE ADMINISTRATION FOR ANTEPARTUM ~~OR& POSTPARTUM~~ OBSTETRIC PATIENTS AND EMPLOYEES

I. **POLICY:**

A. Function: To provide guidelines for administration of the Tdap vaccine to antepartum ~~and postpartum~~ women~~, and hospital employees~~.

1. Tdap vaccine will be offered to all inpatient antepartum patients with every pregnancy (unless already received in **the** current pregnancy)~~ and postpartum women who did not receive the vaccination during the pregnancy~~ **will receive Tdap only if they have never been vaccine with Tdap in the past (excluding a recent previous pregnancy),** and **if they** do not have a contraindication to **the** vaccination before discharge from the hospital.
2. The RN shall:
   a. Identify and provide Tdap vaccine to all inpatient antepartum ~~and postpartum~~ women meeting screening criteria.
      i. Tdap vaccine is contraindicated:
         1) In those with history of serious allergic reaction (anaphylaxis) to any component of the vaccine
         2) In those with history of encephalopathy (coma or prolonged seizure) within 7 days of receiving a vaccine with Pertussis.
      ii. Physician notification with a new order is required to proceed with immunization for the following risk factors:
         1) Moderate or severe acute illness with or without fever until the acute illness resolves.
         2) Guillain-Barré syndrome less than (<) 6 weeks after previous dose with tetanus toxoid containing vaccine
         3) Unstable neurologic condition (consult MD if patient has any neurologic condition for further advice)
         4) History of an Arthus reaction (i.e. a severe injection site reaction with hemorrhage or local necrosis typically developing 4 – 12 hours after vaccination) following a previous dose of a tetanus toxoid–containing and/or diphtheria toxoid–containing vaccine
      iii. Simultaneous vaccination of Tdap with M**easles** M**umps and** R**ubella, Rh immune globulin,** and Influenza vaccine is safe.
      iv. Tdap may be given in the 2nd or 3rd trimester of pregnancy and should be given **once** with every pregnancy. ~~If not given during the pregnancy the vaccination should be given postpartum prior to discharge~~ **~~if the vaccine was never received.~~**
      ~~iv.~~ **~~If Tdap was received earlier in the pregnancy, it does not need to be repeated. It is only needed once during the pregnancy.~~**
   b. ~~Make referrals for significant others, and household contacts of newborn infant to a nearby clinic affiliated with the Tdap vaccination or to their primary care provider for screening and if eligible to receive the Tdap vaccination.~~

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Department of OB/GYN	Pharmacy & Therapeutics	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 05/12, 01/15, 08/16	05/12, 02/15, 09/16, **05/20**	05/12, 02/15, 09/16, **06/20**	06/15, 12/16	05/12, 09/15, 02/17, **05/21**	11/12, 01/16, 04/17, **07/21**	11/12, 01/16, 04/17, **10/21**	**11/21**	02/16, 05/17, **n/a**	12/12, 02/16, 05/17

~~c. The Employee Health Clinic shall provide screening and vaccination of all health care providers/employees who have direct patient contact at Tri-City Medical Center.~~

B. Circumstances:
1. Setting: Tri-City Medical Center – Inpatient Antepartum~~ and Mother-Baby postpartum~~ care unit~~s~~:
2. Supervision: None required
3. Considerations for administration:
   a. Requires careful screening of patient's prenatal care or lack of prenatal care, availability of immunization record, ~~and~~ assessment of risk factors associated with exposure, and potential for development **~~with the previous vaccination~~** of Pertussis **(if it was developed with previous vaccination)**
   b. Reduces the risk of Pertussis exposure from **the mother**~~, postpartum women, significant others, and extended family members~~ to ~~their newly born infant.~~ **the newborn**
   c. Compliance with recommendation**s** from the California Department of Health, Centers for Infectious Disease to prevent infant deaths under 12 months due to Pertussis

II. **PROCEDURE:**
A. The RN shall:
1. Identify and document vaccination history regarding previous ~~Td and~~ Tdap vaccination while screening patient for eligibility for Tdap immunization ~~by going to Ad Hoc, WNS Maternal Forms, OB Immunization profile~~ **during the ~~documentation of the~~ admission process ~~in the electronic health record~~** for all inpatient antepartum~~, intrapartum patients and postpartum~~ patients ~~upon admission to the unit.~~
   a. **The ~~P~~p**atient is not eligible for vaccination if any of the risk factors below are identified:
      i. Previous severe allergic reactions (i.e. anaphylaxis) to any component of the vaccine.
      ii. History of coma or prolonged seizures occurring less than ~~(<)~~ 7 days **after** ~~of~~ administration of a pertussis vaccine (DTP, DTaP, Tdap) that was not attributable to any identifiable cause.
         1) Note: Family history of seizures is not a contraindication
      iii. Patient received and can verify administration of the Tdap vaccine **during** ~~in~~ this pregnancy ~~**or a history of previously receiving Tdap.**~~
         ~~1) A woman who did not get a dose of Tdap in pregnancy, should get a dose of Tdap postpartum prior to discharge.~~
      ~~iv. Physician order not to give vaccine at this time~~
   b. Physician notification with a new order is required to proceed with immunization for the following risk factors:
      i. Moderate or severe acute illness with or without fever until the acute illness resolves
      ii. Guillain-Barre syndrome less than ~~(<)~~ 6 weeks after previous dose with tetanus toxoid containing vaccine
      iii. Unstable neurologic condition ~~(consult MD if patient has any neurologic condition for further advice)~~
      iv. History of an Arthus reaction (i.e. a severe injection site reaction with hemorrhage or local necrosis typically developing 4 – 12 hours after vaccination) following a previous dose of a tetanus toxoid – containing and/or diphtheria toxoid – containing vaccine
2. **Administer ~~tetanus/diphtheria/pertussis (Tdap)~~ as per pharmacy dosing, preferable in the bicep muscle.**

III. **REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:**

A. Current **unencumbered** California RN license.
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annual**ly** ~~Skills Lab **procedural review and exam.**~~

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

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.

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

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Tdap Vaccine Administration for Antepartum ~~**or**and Postpartum~~ Obstetric Patients Standardized Procedure.

VI. **REFERENCES:**

A. The American College of Obstetricians and Gynecologists Committee. Update on Immunization and Pregnancy: Tetanus, Diptheria, and Pertussis Vaccination. Opinion Number ~~521~~ **718**, ~~March 2012~~ **September 2017 (Reaffirmed 2019)**
B. Center for Disease Control and Prevention, Morbidity and Mortality Weekly Report April 27, 2018 Recommendations and Reports, Vol. 67, No. 2
~~B.~~**C. Center for Disease Control**, ~~MMWR , February 22, 2013 / Vol. 62 / No. 7 Updated Recommendations for Use of Tetanus Toxoid, Reduced Diptheria Toxoid, and Acellular Pertussis Vaccine (Tdap) in Pregnant Women-Advisory Committee on Immunization Practices (ACIP), 2012.~~ **Vaccinating Pregnant Patients, June 29, 2017**
~~C. Centers for Disease Control and Prevention. Guidelines for Vaccinating Pregnant Women. March 2013 Reaffirmed 2015.~~
~~D. Forsyth, K., Plotkin, S., Tan, T., Wirsing von Konig, C.H. Strategies to Decrease Pertussis Transmission to Infants. *Pediatrics* 2015; 135;e1475 Retrieved August 26, 2016.~~
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Tri-City Medical Center
Allied Health Professional

Nurse Practitioner – Oncology
Standardized Procedures

Approvals

Oncology Division (Signature):	September 15~~,~~ 2021
Medicine Department (Signature):	September 15~~,~~ 2021
Interdisciplinary Practice Committee (Date):	~~April 11, 2017~~October 18, 2021
Medical Executive Committee (Date):	~~July 24, 2017~~November 22, 2021
Administration (Date):	November 30, 2021
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

C. Standardized procedures are maintained in the allied professional's file in the medical staff office.

1. All standardized procedures will be reviewed every two years, or as needed, and revised as indicated.
2. Changes made to the standardized procedures are reviewed by and approved by the Medical Director, the medical Department/Division and applicable Tri-City Medical Center (TCMC) Medical Staff committees and the Board of Directors.

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. SETTING

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

B. SCOPE OF NP PRACTICE (FUNCTIONS)

1. The Oncology NP will:
   a. Assume responsibility for the *Oncology* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.
   d. Obtain medical histories and perform overall health assessment for any presenting problem.
   e. Provide or ensure case management and coordination of treatment.

f. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.
g. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.
h. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.
i. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.
j. Formulate recommendations to improve patient outcomes.
k. Provide patient health education related to medications health issues.

III. MANAGEMENT OF CONTROLLED SUBSTANCES

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

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

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.
B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.
C. No physician shall provide concurrent supervision for more than four NPs.
D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.
E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.
1. Additional Supervision occurs as described below under "Quality Improvement."
F. Supervisor notification and consultation is obtained under the following circumstances:
1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. **QUALIFICATIONS - EDUCATION AND LICENSING**

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.

B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. **QUALITY IMPROVEMENT**

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

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

VII. **Practice Prerogatives**

A. As determined by the NP – Oncology Card.

Acknowledgement Statements:

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC.

As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

Nurse Practitioner Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date
Supervising Physician Signature	Date

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
EQUIPMENT MANAGEMENT

SUBJECT: Acquisition of Furniture and Furnishings **POLICY NUMBER: 5011**

ISSUE DATE: 11/87
REVIEW DATE~~(S)~~:
REVISION DATE~~(S)~~:01/97, 07/00, 05/03; 12/15

Department Approval ~~Date(s)~~:	~~09/15~~10/20
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~10/15~~11/21
~~**Medical Executive Committee Approval Dates(s):**~~	~~N/A~~
Administration Approval:	11/21
Professional Affairs Committee Approval ~~Date(s)~~:	~~11/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	12/15

A. **PURPOSE**

1. To establish policies and procedures for the procurement **of**~~r~~ furniture, furnishings and fixtures, (other than medical furniture) to meet the replacement and additional needs throughout Tri-City Healthcare District (TCHD).

B. **POLICY**

1. **Only fire safe materials will be allowed into the facility** ~~It is the policy of TCHD that~~ when acquiring furniture, furnishings, and related supplies.~~ that only fire safe materials will be allowed into the facility.~~
2. **The purchase of** ~~F~~**f**urnishings ~~in TCHD~~ will be determined **based on**~~from the standpoint of~~ utility, durability, maintaining cleanliness and therapeutic and aesthetic value of color and design.
3. Outside consultants and/or TCHD resources will be utilized for interior decorating or interior design services, when indicated.
4. ~~It is the policy of TCHD that a~~**A**ll furniture, curtains, draperies, carpeting, wastebaskets, shelving, and miscellaneous furnishings meet National Fire Protection Association (NFPA®) fire safety codes.

~~C.~~ ~~**RESPONSIBILITY:**~~

5. **All requests for new items will be requested through Supply Chain Management describing needs, justifications and specific locations. The request must have prior "C Suite" approval.**
6. Supply Chain **Management** is responsible for obtaining approvals and procuring all new furniture, furnishings, fixtures and related supplies.
   ~~1.~~**a. NFPA requirements and regulations will be followed for purchasing furniture or furnishings.**
7. ~~2.~~ Department **Directors or** Managers are responsible for the protection and safeguarding of furnishings assigned to their areas.
8. ~~3.~~ The Director of **Facilities** ~~Engineering~~ **or designee** is responsible for structural development on approved remodeling projects and for installation **or** /removal of fixtures permanently attached to structures.
4. ~~The Director of Safety/Environment of Care (EOC) is responsible for approving or disapproving requests in accordance with the NFPA.~~

~~D.~~C. PROCEDURE:

~~1. All requests for new items will be requested through Supply Chain Management describing needs, justifications and specific locations. The request must have prior "C Suite" approval.~~

~~2.~~1. ~~Supply Chain Management will forward all requests to the Director of Safety/EOC for approval or disapproval for compliance with NFPA fire safety codes~~.

~~3. To expedite the approval process, selected material may be approved in advance by the Director of Safety/EOC. Documentation to support prior approval will be retained by the Supply Chain Management.~~

~~E.~~D. FURNITURE AND FURNISHING ~~IMPLEMENTATION:~~

1. Interior furnishings consist of, but are not limited to; upholstered furniture, waste and trash receptacles, interior finishing such as wall, ceiling, and floor coverings, carpets and wallpaper, drapes, curtains and other textiles.
2. Upholstered Furniture: All furniture possessing a combustible capability must be certified or bear a statement or tag that it meets, or was tested under, the requirements of the National Fire Protection Association 260 or 261 Standard and California TB133 requirements. ~~These are the test methods for determining the resistance of upholstered furniture to ignition by smoldering cigarettes~~. This only applies to areas of the facility that lacks sprinklers. Areas with sprinklers are exempt per the Oceanside Fire Chief. Upholstered furniture paddings must maintain the flammability requirements of California Bureau of Home Furnishings Technical Bulletin 117 (TB 117) certification.
3. Draperies, Curtains and Similar Furnishings: Drapes, cubicle curtains, etc., (hanging fabrics or textiles) are to be flame resistant, and must have been tested to meet the requirements of the NFPA-701 "Standard Methods of Fire Tests for Flame Resistant Textiles and Films".
4. Waste and Trash Receptacles and Carts: Wastebaskets, trash and similar containers such as carts shall be of non-combustible or other approved materials as follows:
   a. No trash or garbage container (except those uses exclusively for transport) will be larger than 32 gallons.
5. Carpeting: All new carpeting purchased for installation TCHD facilities shall be Class I in accordance with NFPA Standard 253, "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source."
6. Fire Retardant Coatings: When articles used for interior finishing's have a fire retardant coating, users must ensure such materials retain their retardance under service conditions. ~~When in doubt, users shall contact the Director of Safety/EOC who will verify that the treatment complies with NFPA 703, "Standard for the Fire Retardant Impregnated Wood and Fire Retardant Coatings for Building Materials."~~
7. Highly Flammable Furnishings and **D**~~d~~ecorations:
   a. Furnishings or decorations of a highly flammable or explosive character are prohibited from being displayed or used in this facility.
   b. Textile materials having a napped, tufted, looped, woven, non-woven, or similar surface shall not be applied to walls or ceilings unless meeting requirements of proper testing for flame spread.
   c. Cellular or foamed plastic materials shall not be used as interior wall or ceiling finish.
8. Heat Producing Appliances: Equipment will be installed and maintained in accordance with their manufacturers' instructions, applicable NFPA Standard and testing laboratory acceptance criteria.
9. Supportive Documentation of Flammability Ratings:
   a. Documents or certifications indicating a product's flammability rating **shall** ~~are required to~~ be retained in an easily retrievable manner ~~to satisfy all regulatory agencies~~.
   b. ~~Due to the inordinate purchases of furniture, interior decorations, etc., by various services, all purchasers of such products will establish and maintain a documentation file for presentations to inspectors. This file must contain an accurate description of the products purchased, their location within the facility, and any documentation, certificates,~~

~~or manufacturer's literature referring to the product's conformance to the requirements of the fire retardation tests as specified~~.

~~F.~~E. REFERENCE(S):

1. National Fire Protection Association 260 or 261 Standard and California TB133
2. California Bureau of Home Furnishings Technical Bulletin 117 (TB 117)
3. NFPA - 701 "Standard Methods of Fire Tests for Flame Resistant Textiles and Films"
4. NFPA Standard 253, "Standard Method of Test for Critical Radiant Flux of Floor Covering Systems Using a Radiant Heat Energy Source"
5. NFPA 703, "Standard for the Fire Retardant Impregnated Wood and Fire Retardant Coatings for Building Materials."

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIAL MANAGEMENT

SUBJECT: Battery Management and Disposal **POLICY NUMBER: 6012**

ISSUE DATE: 3/98
REVISION DATE~~(S)~~: 6/00, 4/03, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**

1. To define the process of control and disposal of used batteries in compliance with State and Federal laws and regulations.

B. **POLICY:**

1. All batteries, including lead acid, gellcell, nicad, mercury carbon zinc, silver oxide, and lithium or alkaline are to be disposed of according to this policy. Batteries shall not be disposed in regular trash containers.
2. Standard Batteries:
   a. All used standard batteries will be stored in containers provided by Environment of Care/Safety Officer and held in the user department for pickup by Environmental Services.
   ~~b. Battery terminals must be covered with a piece of tape and kept in the separate compartments in battery storage container while waiting for pickup.~~
   ~~c. Battery storage containers can be ordered using the Work Order System in Affinity.~~
~~3. Specialty Batteries:~~
   ~~a. Engineering will insure collection and storage of all specialty batteries throughout the facility. These batteries include lead acid, gellcell, nicad, lithium, mercury, carbon zinc, and silver oxide.~~
   ~~b. Engineering will make proper identification of batteries, which require special disposal requirements.~~
~~4.~~**3.** Storage and Disposal:
   ~~a. Leaking batteries must be placed in double plastic bags/containers by Engineering and will require immediate disposal.~~
   ~~b.~~**a.** Central Storage for used batteries ~~in Compactors Compound~~ **is** maintained by **Environmental Services**~~Engineering~~.
      ~~i. Engineering will ensure that batteries are properly segregated for storage and pickup.~~
      ~~ii.~~**i.** **Environmental Services**~~Engineering~~ will contract/arrange with authorized battery handling company (ies) for the disposal of batteries.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
LIFE SAFETY MANAGEMENT

SUBJECT: ~~Code Red Policy and~~ Fire Plan (Code Red)

ISSUE DATE: 11/87
REVIEW DATE~~(S)~~: 11/90, 11/93, 11/97, 04/06, 06/12, 08/15
REVISION DATE~~(S)~~: 11/94, 03/00, 04/03, 10/11, 04/13, 10/15
03/19

Department Approval:	~~11/18~~10/21
Environmental Health & Safety Committee Approval:	~~11/18~~11/11
Administration Approval:	~~03/19~~11/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. PURPOSE:

1. **To identify the actions** Tri-City Healthcare District **(TCHCD)** ~~'s Code Red Policy~~ **shall**~~will~~ **implement** ~~insur~~**to** ~~e the~~ **ensure** protection of patients, **workforce members (WFM)** employees, visitors and property from fire, smoke and other products of combustion.
2. **To provide instructions on performing the following;**
   - a. **Identifying when to report a fire**
   - b. **Identifying when to initiate a fire alarm**
   - c. **Smoke and fire containment**
   - d. **Using a fire extinguisher**
   - e. **Assisting with relocating and evacuating patients**
   - ~~a.~~f. **Identify fire hazards**

B. DEFINITIONS:

1. Workforce Members – **Employees, medical staff, and Allied Health Professionals (AHP), volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD**~~P~~
2. RACE – **an standardize acronym for the actions to implement when a fire is identified**
   - a. **R: Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance**
   - b. **A: Alarm - activate the nearest fire alarm (pull station) and call PBX operators by dialing "66" and notify them of the "Code Red" fire. All off campus locations dial "911".**
   - c. **C: Contain - close all remaining doors.**
   - d. **E: Extinguish - extinguish the fire if it can be done without endangering yourself or others.**
3. PASS – an acronym used to provide instructions for using a fire extinguisher
   - a. **P: PULL the pin**
   - b. **A: AIM the nozzle at the base of the fire**
   - c. **S: SQUEEZE the handle**
   - d. **S: SWEEP back and forth across the base of the fire**
4. **Evacuation Plans – Evacuation plans that identify evacuation routes and the location of alarms and firefighting equipment. The plans are posted in all departments, units, and throughout the facility.**

~~B.~~C. POLICY:

1. **WFM will be provided education to use the following acronyms RACE and PASS to assist with remembering the following:**
2. **Supervisors are responsible for showing new employees the location of extinguishers and alarm pull stations during department orientation**
3. **-The Code Red policy will be reviewed by all WFM~~staff~~ during orientation.** ~~Aspects~~
4. **Fire safety will be reviewed annually using a ~~computer based~~computer-based learning module (CBL). The following topics will be reviewed:**
   a. **Actions to implement in the event of a fire**
   b. **How to initiate a fire pull alarm stations**
   c. **Instructions to identify the fire pull alarm stations, location of fire extinguishers, and evacuation map on their assigned departments**

~~**Staff will be provided education to use the following acronyms RACE and PASS to assist with remembering the following:**~~

5. **AHP, Volunteers, Medical Staff, students, and non TCHD personnel do not have a defined role in the fire response plan and should remain in their current location at the time a fire alarm sounds and render assistance under the direction of the department leadership team as needed.**

~~All employees will be familiar with Tri-City Healthcare District's Fire Policy, and when applicable, the Department Specific Fire Policy for the area in which they work. All staff must know what to do in case of a fire, how to initiate an alarm, the location of the fire extinguishers and alarm pull stations in his or her department, and the operation of the fire extinguishers~~.

~~a. Employees must be familiar with the acronym RACE:~~
~~i. R: Rescue - remove anyone from immediate danger, closing fire and room doors and calling out for assistance.~~
~~ii. A: Alarm - activate the nearest fire alarm (pull station) and call PBX operators by dialing "66" and notify them of the "Code Red" fire. All off campus locations dial "911".~~
~~iii. C: Contain - close all remaining doors.~~
~~iv. E: Extinguish - extinguish the fire if it can be done without endangering yourself or others.~~

~~b. Supervisors are responsible for showing new employees the location of extinguishers and alarm pull stations during department orientation.~~ . ~~Remember the acronym **PASS** for extinguisher use:~~

~~i. P: PULL the pin~~
~~ii. A: AIM the nozzle at the base of the fire~~
~~iii. S: SQUEEZE the handle~~
~~iv. S: SWEEP back and forth across the base of the fire~~

~~C.~~D. PROCEDURE:

1. When a **fire or smoke is observed, staff will notify the public broadcast exchange (PBX) via telephone and if possible activate a fire pull alarm.** ~~Fire Alarm Sounds:~~
   a. The **PBX** ~~hospital~~ operator will announce **using the** ~~on~~ the overhead page system "Code Red" **~~and the~~and the location of the code red three times.** ~~and give location of the fire. Do Not call the operator to obtain information about the fire~~.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these **WFM**~~staff members~~ are to stop their work and go immediately to the area indicated by the overhead page system.
   d. **An**~~The Senior~~ Engineer **Leader** will take immediate charge of the Fire Response Team. In his or her absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.
   e. Patients are not to be evacuated from floors without the order of the Incident

Commander or designee. If it is apparent to the Department Director/or designee **an**~~that~~ evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.

f. Engineering will clear the fire alarm after the fire is secured.

g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.

h. The ~~H~~**h**ospital P**ublic Broadcast Exchange (P**BX**)** Operator will announce on the overhead page system **"**Code Red All Clear" when fire is secure.

2. Code Red **(Implementing a Code Red** in **Your Work** ~~Your~~ Area**)**:

~~a. Avoid Panic; The greatest danger in most fires is panic. Do not alarm patients by excited motions. Never shout "Fire!" Patients look to you for protection. Appear calm and move with assurance.~~

~~b.~~**a.** Remove patients and other persons from immediate danger.

~~c.~~**b.** Go to the nearest fire alarm pull station and pull the handle to activate the alarm.

~~d.~~**c.** Dial "66" to report "Code Red." **Provide your** ~~Give~~ location, size, extent **and location** of fire, and material burning, if known. **Affiliated** ~~Facilities off~~ campus dial "911".

d. Extinguish fire if ~~possible - if~~ it is safe.~~,~~ **U**~~u~~se a fire extinguisher to attempt to bring fire under control **using the** ~~.~~**acronyms RACE and PASS – See addendum A**

~~e.~~**i.** If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.

~~f.~~**e.** Check for smoke and flames in other rooms then close all doors.

~~g.~~**f.** Stand by to assist as needed.

3. Fire in Patient's Room:

a. Patient's bed in flames:

i. Remove the patient from bed to a safe place such as another bed, chair or hallway.

~~a.~~**ii.** Depress the nurse call button in the bathroom for immediate assistance. Do not take a smoldering bed out of the room.

~~b.~~**iii.** Close the patient's room door once the patient is out.

~~c.~~**iv.** Activate the fire alarm pull station nearest to the fire.

~~d.~~**v.** Call PBX Operator, dial "66". **Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".**~~Give exact location of the fire, including the room number.~~

4. Area Not Evacuated **Secondary to the Condition of the Fire**~~Under Fire Conditions~~:

a. Provide maximum protection:

i. Instruct people to stay in their rooms with the door closed.

ii. Reassure patients of their safety.

iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.

b. If safe to do so one **WFM**~~employee~~ must remain in the corridor to assist fire department upon their arrival.

5. Evacuation

~~5.~~**a.** ~~:~~ Always use stairs, never the elevator, during a fire.

~~a.~~**i.** If evacuation is ordered for an area, the following are methods to be used:

~~i.~~**1)** Blanket Carry

~~ii.~~**2)** Two Person Carry

~~b.~~**ii.** Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after **an evacuation** ~~that~~**is completed.**

~~c.~~**iii.** Remove Medical Records if possible.

~~d.~~**iv.** **Review the evacuation plans to identify** ~~Evacuation plans are posted throughout the facility. They include~~ **the most appropriate** evacuation route.~~s and the location of alarms and firefighting equipment~~.

6. ~~Be Alert For~~ Fire Hazards:
   a. Never prop open fire doors.
   b. Hallways must be kept clear at all times.
   c. Never place flammable liquids or oxygen near an ignition source.
   d. Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
   e. ~~Good housekeeping is the best guarantee against fire. Do all you can to maintain order and cleanliness in the interest of fire protection. Make it a habit to watch for fire hazards~~.
   f. Do not ~~allow~~ stored items to obstruct sprinkler heads**, maintain an** ~~.(~~18" minimum clearance **from the items and the sprinkler heads**)
   g. If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.
7. Duties of Personnel
   a. **Review**~~Be completely familiar with~~ the Fire Safety Program**, evacuation routes,** and your responsibilities **identified policies and procedures**
   b. Participate in all fire drills and practice sessions as required.
   c. ~~Learn~~**Study** the fire alarm code and how to report a fire - Dial "66". **Affiliated** ~~All off~~ campus locations dial "911".
   d. **Identify** ~~Learn~~ the locations of and how to operate the fire alarm pull stations and fire extinguishers.
   e. ~~Be acquainted with panic control and evacuation procedures~~.
   f. Observe the "No Smoking" rules.
   g. Never store flammable liquids in your desk or cabinet.
   h. Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
   i. Properly dispose of waste or rags used with cleaning solvents **per manufacturer's instructions**.
   j. Do not use portable heating units.
      i. These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering,
      ~~j.~~**ii.** ~~-~~No portable heaters are allowed in patient care areas.
   k. California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.
      i. If necessary, fire response will be coordinated via CDCR staff for custody patients' evacuation.
   l. Switchboard personnel:
      i. If the fire is in the area of the PBX office **follow**~~you would follow~~ the steps outlined in the general instructions section.
      ii. If the fire is not threatening the PBX office ~~you would~~ initiate the steps below:
         1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, ~~you will~~ immediately:
            a) Notify the Fire Department, giving the address and location of the fire in the hospital.
            b) Notify all personnel through the use of the public address system. Use the following code:
               i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.
         2) Prepare the **s**~~S~~witchboard for emergency operations only, restricting calls.
         3) Notify:
            a) ~~-~~**Safety Leader**~~Manager of Safety/EOC~~
            b) Administrator On-call
            c) Administrative Supervisor on duty
            d) Security ~~-~~Supervisor or Lead

e) Director of Engineering
f) Emergency Department **Clinical Leader** ~~Charge Nurse~~
g) Other key personnel, as needed

4) **Implement**~~Carry out~~ administrative orders as directed.
5) If PBX system is inoperative, use the RED phones system or cell phones.

~~m. Practitioners, Allied Health Professionals, Volunteers & Non Staff Personnel:~~

~~i. Tri-City Healthcare District believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff/Allied Health Professionals and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.~~

E. FIRE HAZARDS:

1. Hazards that WFM shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:

a. Careless Smoking – Observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes and vapor devices).

b. Exit Ways - Do not obstruct aisles, doorways, fire escapes or allow their use as storage places.

c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container.

i. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.

d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.

e. Flammable Liquids - (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.

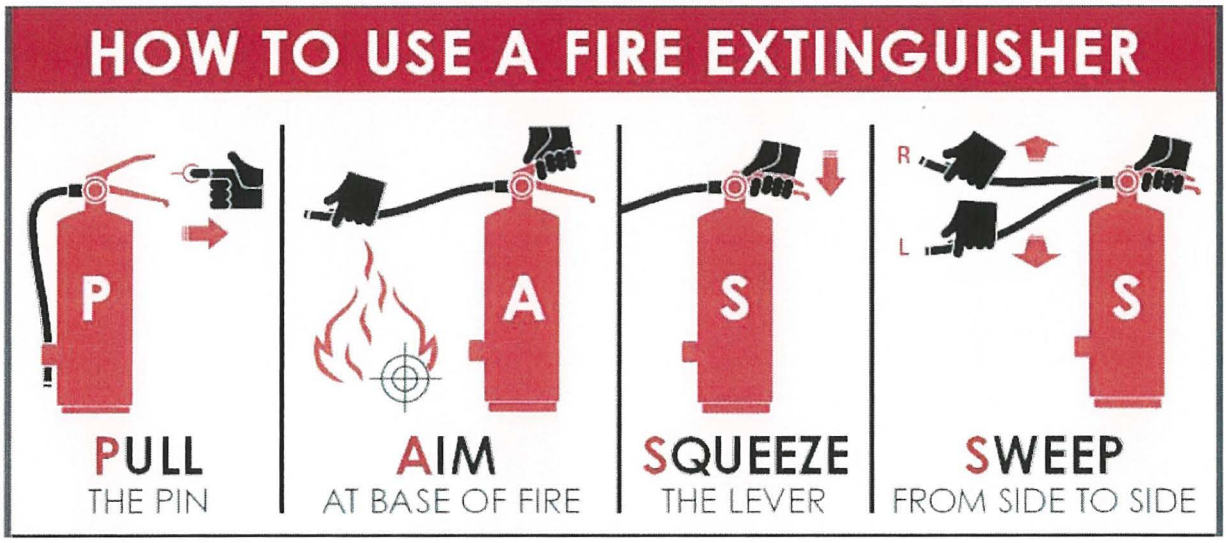
f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.

h. **Electric Heaters - These units, particularly the portable type, are not permitted anywhere on the hospital premises unless approved by Engineering. No portable heaters are allowed in patient care areas.**

i. **Heat generating devices or substances such as candles, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker. Persons who do not comply with these directions will be subject to the disciplinary process.**

Addendum A



What is the Fire Plan?

- Rescue anyone in danger and close the door on your way out
- Alarm – pull the pull-station and dial 66

- Contain the fire by closing other doors in the area
- Extinguish the fire if you can. Evacuate if necessary

How is a fire extinguisher used?

- Pull the pin
- Aim at the base of the fire
- Squeeze the handle
- Sweep from side to side

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
SAFETY MANAGEMENT

SUBJECT: Disposing of Recalled Products **POLICY NUMBER: 1030**

ISSUE DATE: 11/87
REVISION DATE(S): 1/97, 7/00, 05/15~~, 09/2021~~

Department Approval ~~Date(s)~~:	**~~04/15~~10/20**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~04/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. PURPOSE

1. **To prevent staff from attempting to use of defective and/or recalled products**
2. **To maintain the health and safety of Tri-City Health Care District (THCD) workforce members, medical staff, patients and visitors.**

~~A.~~B. POLICY

1. **The following procedure will be implemented when disposing recalled products:**
   - **a.** ~~Isolate all recalled products~~**Isolate products** awaiting disposition in a secure area of the department.
   - **b.** Label the recalled product(s) "Do Not Use"~~ to prevent them from being used~~.
   - **c.** Notify Risk Management and **Biomedical Department** ~~Supply Chain management~~ for directions on disposal.
   - ~~Notify Bio-Med Dept. for directions of disposal for recalled / non-functioning medical equipment.~~

~~1. It is the policy of Tri-City Healthcare District to prevent the use of defective/recalled products to maintain the health and safety of employees, medical staff, patients and visitors. The following procedure will be followed when disposing of a recalled product~~

- a. Isolate all recalled products awaiting disposition in a secure area of the department.
- ~~b.~~**a.** Label the recalled products "Do Not Use" to prevent them from being used.
- **a.** Notify Risk Management and Supply Chain management for directions on disposal.
- ~~c.~~**a. Notify Bio-Med Dept. for directions of disposal for recalled / non-functioning medical equipment.**

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

SUBJECT: Environmental Health And Safety Committee Charter

POLICY NUMBER: 1001

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 1/97, 7/00, 05/15

Department Approval ~~Date(s)~~:	**~~04/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~04/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE**

1. The purpose of the Environmental Health and Safety Committee (EHSC) **includes the following:**

a. ~~is to s~~**S**erve as a communication center for various departments and individuals who are responsible for the environment.

b. ~~The individuals on the committee are expected to help d~~**D**evelop, implement, evaluate, and maintain the organization-wide safety programs

~~1.~~**c.** ~~and to r~~**R**eview policies and procedures **and** ~~. The EHSC also reviews the~~ **the** results of semiannual emergency preparedness drills or the implementation of the emergency preparedness program during actual emergencies.

B. **SCOPE ~~OF AUTHORITY~~:**

1. The EHSC is empowered to provide a safe, functional, and effective environment for patients, **workforce members (WFM)** ~~staff members~~, and other individuals in the hospital.

~~1.~~**2.** The ~~Hospital~~ Safety Officer **or designee** will review all Environment of Care Management Plans **for their effectiveness and** ~~for: Scope, Objectives, Performance and effectiveness. . An~~ **submit an** Executive Summary report ~~will be submitted~~ at the end of the fiscal year to the EHSC Committee.

C. **FUNCTION:**

1. Ensure~~s~~ **all**~~that the~~ newly constructed and existing environments of care are designed and maintained to comply with the Life Safety Code.
2. Develop~~s~~ written policies and procedures to enhance safety and cleanliness within the **Tri-City** Medical Center **(TCMC)** and its grounds.
3. Provide~~s~~ reports to the~~–~~ Board of Directors, Administration, Medical and Nursing ~~Staff~~ and all pertinent departments and services.
4. **TCMC**~~Hospital~~ safety policies and department specific safety policies are reviewed **per hospital policy (at lease every three years and** as frequently as necessary.~~, but at least every three years~~.
5. Maintain~~s~~ ongoing hazard surveillance programs including response to product safety recalls.
6. Oversee~~s~~ the planning and execution of disaster and fire drills. **E**~~I~~nsures drills are conducted according to The Joint Commission, Local, State, and Federal requirements.
7. Review~~s~~ summary reports of accidents or injuries to patients, visitors, or **WFM**~~employees atthe meeting. I~~**i**dentifies risks and makes recommendations **as required**.
8. Oversee~~s~~ safety orientation and continuing education of employees in collaboration with the Education Department.

9. Periodically inspects **TCMC's**~~Medical Center~~ premises for assuring compliance with safety policies.
10. Oversees~~e~~ maintenance of a current reference library of pertinent documents and publications dealing with facets of hospital safety.

D. **MEMBERSHIP:**

1. The EHSC ~~M~~**m**embership **shall**~~will~~ include all levels of hospital management and employees who have a primary responsibility for the safety, health, and well-being of patients, visitors, and hospital staff.

2. ~~The c~~**C**ore membership **shall**~~will~~ include, but is not limited to, representation from **the following:**

- **a.** ~~-~~Administration
- **b.** ~~,-~~Facilities
- **c.** ~~,-~~Laboratory~~,~~
- **d.** Risk Management
- **e.** ~~,-~~Employee Health
- **f.** ~~,-~~Food **and Nutrition** Services
- **g.** ~~,-~~Nursing
- **h.** ~~,-~~Environmental **Services (EVS)**~~Services~~
- ~~1.~~**i.** ~~and~~ Infection **Prevention**~~Control~~.

3. Attendance:

- **a. Membership Implies A Commitment To Attend All Meetings Or Send A Representative If Unable To Attend.**

4. Meeting Date And Time:

- **a. The Committee Will Meet Quarterly Or More Often At The Direction Of The Safety Officer/ Designee.**

~~E.~~**5.** Officers:

- **a.** The Safety Officer **Or ~~-~~Designee** Is Appointed By Administration For An Indefinite Term.
- ~~1.~~**b.** The Safety Officer **Or Designee** Has The Authority To Intervene Whenever Conditions Exist That Poses An Immediate Threat To Life, Health, Or Threaten Damage To Equipment Or Buildings. .

6. Sub-Committees:

- **a. Sub-committees or task force shall be established as needed.** ~~The Disaster Preparedness Committee and the Radiation Safety Committee are sub-committees of the EHSC~~

~~F.~~**E. DECISION MAKING**

1. Decisions will be made by consensus of members present.

~~G.~~**A. SUB-COMMITTEES:**

1. The Disaster Preparedness Committee and the Radiation Safety Committee are sub-committees of the EHSC

~~H.~~**F. REPORTING MECHANISM:**

1. Reports will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) and ~~to~~ the Board of Directors.

~~I. ATTENDANCE:~~

~~1. Membership implies a commitment to attend all meetings or send a representative if unable to attend.~~

~~J. MEETING DATE AND TIME:~~

~~1.~~**2.** ~~The EHSC meets quarterly or more often as the direction of the Safety Officer.~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
LIFE SAFETY MANAGEMENT

SUBJECT: Exit Doors

ISSUE DATE: ~~NEW~~10/15
REVIEW DATE~~(S)~~:
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~08/15~~10/21
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~09/15~~11/21
~~**Medical Executive Committee Approval Dates(s):**~~	~~n/a~~
Administration Approval:	11/21
Professional Affairs Committee Approval ~~Date(s)~~:	~~10/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	10/15

A. **POLICY:**

1. It is the policy of the Tri City Healthcare District (TCHD) to ensure ~~that~~ all designated exit doors throughout the organization and off site buildings are free from obstruction**, clutter, and equipment per regulations.**
2. **All designated exit doors are** ~~and~~ clear for access by patients, staff or visitors~~.~~ **in the event of an** ~~in an~~ emergency.~~ situation.~~
3. **Exit doors are to be fully functional and capable of opening to complete width.**

~~1.~~**4.** All exit door vision panels (windows) will be maintained free from decorations, mirrors, hangings, or any other type of obstruction.

5. Exit access corridors will maintain a minimum width of 44 inches or 36 inches where serving an occupant load of less than 50 occupants
6. **All exit stair doors and designated exit doors leading to outside the facility will be kept free from obstructions and all panic bars will be maintained in working order**
7. **Exit (egress) doors should not be locked in a way that restricts passage to safety for patients, visitors, vendors, and staff.**
8. **Exit access doors and exit doors shall be free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit.**

~~2.~~**9.** **Signs reading "No Exit" are posted on any door, passage, or stairway that is neither and exit nor an access to an exit.**

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

10. All designated exit doors **and** ~~(including~~ stairwells~~)~~ will not be locked at any time in the path of egress. **Exceptions, doors locked for specific reasons such as but not limited to the following:**

- **a. Restricting access to medication rooms or storage areas with hazardous materials i.e., hazardous materials**
- **b. Protecting patients in restricted areas such as the Neonatal Intensive Care Unit (NICU)**

~~1.~~

~~2.~~**11.** ~~All s~~**S**tairwells will not contain any items ~~(with the exception of evacu-chairs)~~ or be utilized for storag**ing items such as equipment** ~~e a~~**a**t any time. **Exceptions, evacuation chairs may be stored in stairwells.**

12. ~~All exit stair doors and designated exit doors leading to outside the facility will be kept free from obstructions and all panic bars will be maintained in working order.~~ ~~The~~

~~3.~~**13.** ~~exit doors are to be fully functional and capable of opening to complete width.~~

~~4.~~**14.** All exit door vision panels (windows) will be maintained free from decorations, mirrors, hangings, or any other type of obstruction.

~~5.~~**15.** Exit access corridors will maintain a minimum width of 44 inches or 36 inches where serving an occupant load of less than 50 occupants.

~~6.~~**16.** Egress pathways outside of all exit doors will remain clear to the public way.

17. **All** ~~It is the duty of all~~ TCHD **workforce** ~~staff~~ members **are responsible for ensuring** ~~to ensure~~ designated exit doors, corridors and stairwells are kept free from obstructions which may hamper the safe exit of any staff, patients or visitors from the facility.

18. ~~If any~~ **SsWorkforce**~~taff~~ member**s** observ**ing**~~es an~~ obstruction**s** prohibiting a safe exit, **should**~~they are to~~ immediately remove ~~it~~ **the obstruction** or contact the department **leader**~~supervisor~~ for assistance.

~~7.~~**19.**

Tri-City Medical Cer
Oceanside, California

DELETE – incorporated into Environment of Care Policy: Fire Plan (Code Red)

Environment of Care Man
Life Safety Management

SUBJECT: Fire Safety Hazards

ISSUE DATE: 10/15
REVIEW DATE(S):
REVISION DATE(S): 01/17

Department Approval:	~~06/16~~10/21
Environmental Health and Safety Committee Approval:	~~06/16~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~01/17~~ n/a
Board of Directors Approval:	01/17

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

~~1. Hazards that personnel shall recognize and correct, or cause to be corrected, or prevent from existing, are as follows:~~

~~a. Careless Smoking - Be careful to observe all "No Smoking" rules and regulations. This includes any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes & vapor devices).~~

~~b. Exit Ways - Do not permit the obstruction of aisles, doorways, fire escapes or allow their use as storage places.~~

~~c. Combustible Waste - All combustible waste shall be placed in all metal containers with tight fitting covers; so that any fire occurring will be kept entirely within the container. When materials capable of spontaneous ignition are stored, they shall be kept in separate containers until safely disposed.~~

~~d. Fire Doors - The proper operation of fire doors is necessary to protect or isolate one section of the building from another, thus providing protection to other areas and persons within the building. Keep all fire doors properly closed, except those equipped to close automatically. Fire doors wedged or propped open are of no value in preventing the spread of fire.~~

~~e. Flammable Liquids - (Such as acetone, alcohol, benzene, and ether) Limit the amount on hand to a minimum working supply. If possible, keep in metal container. Where safety cabinets or storage rooms are available, keep these materials in them and maintain the door to such storage in the closed position. No smoking, open flame or sparking device shall be allowed around flammable liquids or compressed gas. Oxygen and nitrous oxide shall not be stored with flammable gases, such as cyclopropane and ethylene, or with flammable liquids.~~

~~f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.~~

~~g. Acids - All concentrated or corrosive acids must be handled with extreme care. Avoid storing these materials on high shelves, or in locations where they are likely to be spilled or the containers broken. Organic acids and inorganic acids shall not be stored together. Any spillage shall be immediately diluted or neutralized and cleaned up.~~

~~h. Electric Heaters - These units, particularly the portable type, are not permitted anywhere~~

on the hospital premises unless approved by Engineering. No portable heaters are allowed in patient care areas.

i. Heat generating devices or substances such as candles, hot plates, electric blankets, heating pads, propane fueled devices, strand lights and oil lamps are not appropriate for the hospital environment and are not allowed on hospital property. Toasters, toaster ovens, microwaves and coffee machines are allowed in break rooms/offices with the approval of the Safety Officer or Director of Facilities. Devices must have an Engineering Electrical Safety sticker. Persons who do not comply with these directions will be subject to the disciplinary process.

B. **AFFECTED AREAS/PERSONNEL:**

1. Governing Board; Medical Staff; All Hospital Employees; Volunteers; Vendors

C. **REFERENCE(S):**

1. The Joint Commission
2. NFPA
3. CA State Fire Marshall

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIAL MANAGEMENT

SUBJECT: Handling & Use of Gas Cylinders **POLICY NUMBER: 6010**

ISSUE DATE: 10/94
REVISION DATE~~(S)~~: 5/97, 7/00, 4/03, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date~~(s):	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**

1. The purpose of this policy is to define safe process for the handling and use of compressed gas cylinders.

B. **POLICY:**

1. Only personnel trained in proper handling of cylinders, cylinder trucks, cylinder supports and cylinder valve protection caps will be permitted to use or transport such equipment.
   a. All cylinders will be transported on a proper cylinder truck or cart, constructed for the intended purpose, self-supporting, and provided with appropriate chains or stays to retain cylinders in place.
2. Gas cylinder valve protection caps will be secured tightly in place unless the cylinder is connected for use.
3. Cylinders will be stored in accordance with all applicable National Fire Protection Association (NFPA) standards. Partial and full cylinders will be separated.
4. Portable liquid oxygen reservoirs ***will not*** be stored in a tightly closed space such as a closet.
5. When small size (A, B, C, D, or E) cylinders are in use, they will be attached to a cylinder stand or to therapy apparatus of sufficient size to render the entire assembly stable.
6. Cylinders will not be dropped, dragged, rolled or picked up by the valve cap.
7. Free standing cylinders will be properly chained or supported in a proper cylinder stand or cart. They will not be chained to portable or movable apparatus such as beds and oxygen tents, or supported by radiators, steam pipes and heat ducts.
8. Very cold cylinders will be handled with care to avoid injury.
9. Cylinders will not be handled with hands, gloves or other materials contaminated with oil or grease.
10. Contents of cylinders will be identified by reading the label prior to use. Labels will not be defaced, altered, or removed. Cylinders without labels will not be used.
11. Cylinders will be tagged to reflect their capacity: **FULL**, **IN USE**, **EMPTY.** Cylinders not appropriately tagged will be considered in use. Exception to the tagging rule is "Walk-About" style E-cylinders where the cylinders have permanent regulators and are always fully pressurized. Assessment of gas contents is accomplished by looking at the pressure gauge (any E-cylinder with the gas gauge needle in the red section on the dial is considered empty).
12. Empty cylinders will be handled as if they were full.
13. Mixing or transferring of compressed gas from one cylinder to another is prohibited.
14. Gas cylinder valves will be opened and connected in accordance with steps below:
    a. Make certain that apparatus and cylinder valve connections and cylinder wrenches are free of foreign materials.
    b. Turn the cylinder valve outlet away from personnel. Stand to the side-not in front or in back. Before connecting the apparatus to the cylinder valve, momentarily open the

cylinder valve to eliminate dust.

c. Make connections of apparatus to cylinder valve. Tighten connection nut securely with appropriate wrench.
d. Release the low pressure adjustment screw of the regulator completely.
e. ***Slowly*** open the cylinder valve to full open position.
f. ***Slowly*** turn in the low pressure adjustment screw on the regulator until the proper working pressure is obtained.
g. Open the valve to the utilization apparatus.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
HAZARDOUS MATERIAL MANAGEMENT

SUBJECT: Hazardous Material and Waste Management and Communication Plan

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 09/94, 07/97, 09/00, 04/03, 12/10, 05/15, 01/17, 03/19

Department Approval:	**~~11/18~~ ~~04/2020~~10/21**
Environmental Health & Safety Committee Approval:	**~~11/18~~11/21**
Administration Approval:	**~~03/19~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

B. **DEFINITIONS ~~OF HAZARDOUS MATERIALS~~:**

1. **Hazardous materials:** ~~Those~~ materials ~~that~~ by their nature are a potential threat to the health and safety of persons coming into contact with them. **Examples of hazardous materials include but are not limited to the following:**
   a. Corrosives - having a pH less than or equal to 2 or greater than or equal to 12.5 and liquids that corrode steel at a rate of greater than .25 inch per year.
   b. Toxics (EP Toxicity) - a waste whose constitutes have a tendency to leach or migrate when disposed of in an improperly designed landfill; able to cause illness, death or restrict awareness enough to present a danger.
   c. Flammable liquids (ignitable) - flammable gases, oxidizers, liquids with a flash point of less than 140F, and solids that ignite spontaneously through absorption of moisture or friction.
   d. Reactive (Explosives) - substances that are unstable and readily undergo violent change, react violently with water, form potentially explosive mixtures with water, capable of detonation when exposed to a strong initiating source, generate significant quantities of toxic gas when exposed to water or in the case of cyanide or sulfide bearing waste, pH conditions between 2 and 12.5.
   e. Pharmaceutical **W**~~w~~aste and Expired Medications — Expired or unusable parenteral **or** /oral liquids; dextrose/saline **intravenous (IV)**~~I.V. admixtures/ss~~solutions containing;~~:~~ antibiotics, multivitamins, dopamine, dobutamine, electrolytes epinephrine, epi-cal, heparin, insulin, lidocaine, lorazepam, magnesium sulfate, meperidine, midazolam, morphine, nitroglycerin, norepinephrine, oxytocin, theophylline,~~TPN~~; Maalox, Mylanta, alcohol containing liquids with less than 24% alcohol.
   ~~e.~~**f.** Expired Unusable Pharmaceuticals: Intact expired or unus**ed**~~able~~ medications.

C. **PURPOSE**

1. The purpose of the management plan is to define how hazardous materials and waste are identified, labeled, handled, whose responsibility they are, how training and communication is managed, and how monitoring occurs.

D. **POLICY**

1. Tri-City Healthcare District **(TCHD)** is committed to providing a safe and healthy environment for all employees, medical staff, patients and visitors by establishing ongoing mechanisms for controlling and monitoring the use of hazardous materials and waste in compliance with State and Federal regulations.
2. Right to Know Law

   a. ~~Employees and~~ **Iinstructional signs informing employees of their rights under the law are posted. C**~~c~~ontractors are to be provided with information about the known and suspected health hazards that may result from working with Hazardous and Infectious Materials~~. W~~**w**hile performing duties at T**CHD.**~~ri-City Healthcare District facilities, employees and contractors shall be informed so they can make a more knowledgeable and reasoned decision with respect to any associated personal health hazards~~.

   b. General Orientation: New employees will be informed of "Right to Know Law" ~~during the Safety portion of~~ Employee Orientation.
      i. Employees have the right to refuse to work with a hazardous substance if they have not been provided with Safety Data Sheet information.
      ii. Employees, former employees, or applicants may not be terminated or discriminated against in any way for exercising any rights they are given under the law.

   c. ~~Instructional signs informing employees of their rights under the law are posted~~. Department Specific **Initial** -Orientation: ~~At the time of initial assignment, all e~~**E**mployees will receive training on any chemical which is known to be present in the workplace in such a manner that employees may be exposed under normal conditions of use or in a foreseeable emergency. If an employee is not ordinarily in a position to be exposed to hazardous chemicals, **they**~~he or she~~ need not be trained.

   d. Contracting for Outside Services:
      i. Departments that obtain outside services through contracts or service agreements will **ensure**~~insure that the~~ contractor**s are**~~has been~~ informed of all hazardous materials to which their employees may be exposed. The department will insure that the contracted employee has completed the Non-Tri-Healthcare District Employee Orientation Program.

E. **GUIDELINES**:

1. Method of Identification of Hazardous Material:
   a. Material is identified as hazardous by evaluation produced by ~~M~~**m**anufacturer, information disseminated from a reliable source, or by professional knowledge and experience.
   b. Directors **or hospital designated leader** ~~**of the following**~~ of Engineering, Surgery, Nutrition, Laboratory, Pharmacy, and ~~EVS~~**Environmental Services**, will submit a list of substances determined to be hazardous by this policy to the Safety **Leader**~~Officer/**hospital appointed personnel**~~ **or designee**~~.~~
      ~~b.~~**i.** ~~This~~**The** list will be updated as new products determined to be hazardous are introduced to the department.
   c. Labels are required on all hazardous substances to identify the hazardous material(s) contained therein and to provide warning about the type of hazard and the type of precautions required. This includes all containers with toxic substances in a concentration greater than or equal to 1% of the total composition, or 0.1% if carcinogens; unless specifically exempted.
2. Safety Data Sheets (SDS~~) 3 E Company Fax on Demand~~:
   a. Request an SDS **using the internet or TCMC's intranet link** when assistance is needed with medical emergencies, chemical spills, and employee ~~**using the internet**~~

~~**or TCMC's intranet link.**~~

i. Emergency Request – Immediate to 15 minutes: Poisoning, chemical exposure, chemical spill, human or environmental contamination, fire.

ii. Immediate to 30 minutes: Regulatory Agency Request **e.g., Occupational Safety and Health Administration** (OSHA), **Environmental Protection Agency** (EPA), The Joint Commission **(TJC)**~~)~~.

iii. Immediate to 3 hours: Employee request (non-emergency)

iv. Standard Request – Immediate to 24 hours: Customer Request, Contractor Request.

v. Mail Request – Rush: mailed within 24 hours – Standard: mailed within 3 business days: Request of 10 or more Safety Data Sheets.

~~b. To initiate SDS request follow the following procedure:~~

~~i. Call Toll Free: 1-800-451-8346 or 760-602-8703, to request up to nine SDS.~~

~~ii. Fax request to (760-602-8888 for orders and numbers on SDS of SDS sheets~~

~~iii. DO NOT FAX EMERGENCY SDS REQUESTS – CALL IMMEDIATELY~~

~~c.~~**b.** To request a SDS **contact the Environmental Services Supervisor or Facilities Director.** ~~complete the attached request form then call, fax or mail to 3 E Company. Provide as much of the following information as possible:~~

~~i. Product name.~~

~~ii. Manufacturer name.~~

~~iii. Product number.~~

~~iv. UPC Code (if available).~~

~~v.~~**c.** ~~Be specific when request is for a product. Separate SDS are maintained for products that have even very minor differences from others (e.g. colors, aerosol vs. pourable, concentrated vs. ready – to use).~~

3. Employee Training:

a. Department ~~directors~~ **leaders** are responsible for providing training to employees on hazardous materials in their work area at the time of their initial ~~assignment~~**orientation** ~~/ or reassignment~~ and when a new hazard is introduced into their work area.

~~a.~~**b.** All employees must complete the Annual Computer Based Learning (CBL~~'~~s) modules which include a section on Hazardous Materials/Global Harmonization/Right-to-know training. The CBL **course content includes but is not limited to e**~~instructions include~~ the following ~~items~~:

i. Employee rights under the law.

ii. Explanation of the (SDS)

iii. Explanation of the labeling system and pictograms

iv. Explanation of methods used to identify hazards and how to detect the presence of toxic substances in the work place, and routes of entry into the body.

v. Safety and control devices to include personal protection.

vi. Location of hazardous substance list.

vii. Emergency procedures for spill control.

viii. Review of blood-borne diseases and potential for transmission.

ix. Types of protective equipment and proper use.

x. Situations requiring use of protective equipment.

xi. Review of concept of standard precautions as it applies to the **workforce members**~~employees~~ specific work practices.

xii. Review of methods to determine and designate infectious waste and linen along with instructions for proper disposal.

xiii. Training in proper handling of needles and sharps along with proper disposal

xiv. Training in completion of Employee Health Injury Report to indicate exposure to potential infectious agents.

xv. Department ~~D~~**d**irectors will ensure that all employees annually complete the C**BL**~~omputer Based Learning~~ module on Hazardous Materials. .

4. Hazardous Chemical Waste & Infectious Medical Waste Disposal
   a. General Disposal Guidelines:
      i. Disposal methods must comply with all federal, state and local regulations. Flammable materials are not to be disposed of into the drainage system.
      ii. Wear appropriate protective equipment (~~i.e.~~**i.e.,** gloves, safety glasses, lab coat and respirator where applicable).
      iii. Date must be filled in on the substance's hazardous material storage label upon final use or disposal. All Chemical Waste will **be** placed into the Chemical Waste Storage Shed for final disposal.
      iv. All empty discarded containers will be disposed of according to the manufacturer instructions and/or in accordance with Federal, State and local regulations.
      v. T**CHD**~~ri-City Healthcare District~~ is contracted with an outside company for the disposal of hazardous materials and waste in accordance with local, State and Federal regulations.
      vi. Medical Infectious Waste will be placed into the RED Bio-Hazardous Container or Sharp Container and collected by the EVS Department and placed into the Bio-Hazardous Waste Storage shed until collected by the Waste Disposal Vendor final disposal (See Infection Control Manual).
      vii. Waste Pharmaceuticals – Refer to AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions.
   b. Monitoring:
      i. Waste Gas Levels (Surgical Suites):
      ii. Waste gas levels in surgical areas are to be tested at least annually.
      iii. Testing is to be conducted by an independent testing company contracted by T**CHD-**~~ri-City Healthcare District~~.
      iv. Results of such testing are to be kept on file by the respective departments.
      v. Results of the annual testing should be posted along with the maximum permitted levels of the gases tested for employee review.
      vi. In the event levels exceed permitted levels, the Engineering Department and the Environment of Care/Safety Officer shall be notified in order that corrective measures can be taken.
   c. Airflow Testing:
      i. Airflow and air changing systems will be monitored and tested by the Engineering Department on an as needed basis. All new equipment is to be certified at the time of installation.
      ii. Areas using or storing hazardous materials must have adequate ventilation in order to comply with room air change and flow standards as governed by the California Building Codes.
      iii. Fume hoods should be utilized when using volatile or gaseous-forming hazardous materials to **ensure**~~insure that~~ gas levels remain at safe levels and do not affect air quality, fume hoods should remain running at all times.
   d. Radiation
      i. All monitoring of radiation levels will be conducted according to departmental policies per State regulations by the Radiation Safety Officer.
   e. Formaldehyde Testing
      i. Air monitoring for formaldehyde will be conducted annually. Methods will be in accordance with OSHA regulations and will be of two (2) types: 1) Personal and 2) Area.
      ii. Engineering controls will be utilized to reduce airborne concentrations whenever feasible.
      iii. Employees working with solutions of 1% or more formaldehyde will

utilize protective equipment as follows:
1) Safety Glasses.
2) Gloves.
3) Disposable chemical resistant Lab coats.

f. Work Test Area:
i. Work areas suspected of containing airborne hazardous materials will be evaluated and tested immediately by Engineering Department and or the ~~Environment of Care/~~Safety **Leader**~~Officer/ hospital appointed personnel.~~**designee**
ii. Levels exceeding permitted safe limits will be reported to the Safety Officer/**hospital appointed personnel**.
iii. A consultation with Administration, ~~EOC/~~Safety Officer/**hospital appointed personnel**~~-~~and the Director of the department involved will be made to determine whether or not work can continue in the affected area or to determine steps to be taken to **ensure**~~insure~~ employee safety.

g. Employee Monitoring and Medical Testing:
i. Appropriate medical testing will be conducted to determine the effects of the exposure and in order that an effective diagnosis and proper treatment can be conducted.
ii. Testing will be done under the supervision of a licensed qualified physician.

h. Storage and Transportation:
i. A Flammable Storage Cabinet will be provided for flammable materials in order to prevent the spreading of fire.
ii. ~~Further, f~~**F**lammable liquids will be stored away from flammable gases. ~~Thus~~
~~i.~~**1)** ~~,i~~In the event of fire the possibility of explosion is reduced and containment is readily achieved.
~~ii.~~**iii.** All openings will be controlled with approved self-closing fire doors.
iv. Every inside storeroom will have a mechanical exhaust system that provides at least six complete air changes per hour.
~~iii.~~**1)** The Hazardous Material Storage Building has a switch that controls the ventilation system as well as the lights.
~~iv.~~**v.** Cylinders will be stored at least 20 feet from flammable and combustible liquids and other ignitable.
~~v.~~**vi.** Cylinders will be stored separately (rooms) from flammable material
~~vi.~~**vii.** Hazardous wastes/materials will not be stored with nonhazardous waste in order to prevent accidental contamination.
1) Incompatible materials will be stored away from each other.
~~vii.~~**2) No hazardous material will be transported to and stored in areas other than work or storage areas**
viii. Materials will be transported in approved safety containers or in their original shipping packages.
ix. ~~No hazardous material will be transported to and stored in areas other than work or storage areas~~.
x. Materials will be transported in amounts comparable to regulated daily or weekly limits.
xi. Materials will not be transported and then stored in unapproved areas or in an unsafe manner.
xii. All materials packaged and shipped for outside disposal must comply with Department of Transportation (DOT) regulations.
xiii. Daily limits will be stored in approved safety cabinets.

i. Emergency Response Procedures:
i. Various hazardous chemicals are used throughout the hospital which could pose a threat of danger if a moderate or major spill should occur.
~~i.~~**ii.** The following procedure is outlined in the event that such a chemical spill occurs

within the hospital environment. All personnel will be familiar with the proper procedure for handling these events to minimize the risk towards patients, visitors and staff members.

1) Areas of concern:
   a) Laboratory - Large variety of chemicals.
   b) Pharmacy - Large variety of chemicals.
   c) Materials Management - Cleaning supplies and hospital chemical supplies.
   d) Environmental Services - Cleaning supplies and solvents.
   e) Radiology Radioactive material.
   f) Food and Nutrition - Degreasers and cleaning supplies.
   g) Respiratory –Disinfectants.
   h) Facilities Management - Large variety of chemicals.
   i) Sterile Processing Department – Disinfectants.
   j) Surgical Services – Tissue Fixative.

j. Chemical Spills:
   i. Immediately alert personnel in area.
   ii. Dial "66" and ~~tell~~ **inform Public Broadcast Exchange (P**BX**)** Operator that there is a chemical spill and the location.
   iii. The PBX Operator will alert: The **Safety Leader/designee**~~**Officer/hospital appointed personnel** Environment of Care/Safety Officer,~~ Manager of Environmental Services **(EVS)** or Lead EVS, ~~Manager of~~ Security ~~or Lead Officer~~, and Engineering.
   iv. Evacuate and seal off areas from a safe distance; if flammable are involved, eliminate ignition source if possible. Allow no one to enter area until Environmental Services, Security, and the **Safety Leader/designee** ~~**Officer/hospital appointed personnel** Environment of Care/Safety Officer~~ has been notified and arrives on scene.
   v. **Review the** ~~Contact 3 E Company 1-800-451-8346 for~~ Safety Data Sheet (SDS) information on how to handle the spill and what type of Personal Protective Equipment is needed. 3 E Company will fax the information within minutes to the closest fax machine number provided. Employees will need to know the name of the chemical to tell the 3 E Company operator.
   vi. If at this time an evacuation is necessary the Hospital Evacuation Procedure will be implemented. The **Safety Officer/hospital appointed personnel** ~~Environment of Care/Safety Officer~~ will consult with Management and area personnel as to proper containment, identification, and disposal procedure as prescribed by the EPA or other written instructions that provide measures that are approved by law or ordinance.
   vii. Notification of the fire department will depend on the type of the spill and the potential danger involved.
   viii. If a minor spill of flammable, corrosives, toxics or reactive occurs and there is no immediate danger to employee(s) then:
      1) Properly trained employees may clean-up the spill using approved spill kits/supplies/equipment that meet or exceed the PPE requirements listed on the SDS notice.
      2) Contact ~~Environmental Services (~~EVS~~)~~ who will contain the spill, and clean the chemical ~~up~~ per SDS guidelines.
      3) All collected chemicals must be handle**d**~~s~~ per hazardous waste requirements and placed in an appropriate container, then labeled with the chemical name and other hazardous waste properties.
      4) Contact the **Safety Leader/designee** ~~**Officer/hospital appointed personnel** Environment of Care/Safety Officer~~ with any questions.

k. Treatment of Contaminated Area:

i. Wash area immediately.
ii. Clothing contamination: Take item of clothing off immediately to prevent soaking through and contaminating skin. This includes all clothing affected.
iii. First Aid:
1) If skin/eye/mouth area(s) have been contaminated, flush affected area with large amounts of water for at least 15 minutes.
2) Do not try to neutralize.
a) Go to the Emergency Department immediately after flushing affected area.

F. ~~-~~**GOALS/OBJECTIVE FOR FY202119**

1. Provide training to all applicable Pharmacy, Engineering and Lab ~~em~~**em**ployees on how to properly respond to a chemical spill. Measurement will be number of applicable employees/number of employees receiving the spill management training. Goal is 100% of applicable employees.
2. Update and complete department specific hazardous material lists for all TCHD areas.
3. ~~Incorporate a First Responders hazardous material spill team to respond to larger than normal type spills within the hospital.~~

G. **REFERENCE)S):**

1. ~~AP&P # 276 Handling of Pharmaceutical Waste, Expired Medications & Expired IV Solutions~~
1. **TCMC Waste Disposal Guidelines.**

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIALS MANAGEMENT

SUBJECT: Hazardous Materials Management **POLICY NUMBER: 6009**

ISSUE DATE: 10/94
REVISION DATE~~(S)~~: 5/94, 7/00, 4/03, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**
1. To ensure that departmental personnel are prepared to properly respond to the spill of a hazardous material.

B. **POLICY:**
1. EVS personnel will clean blood borne pathogen spills.
2. The following equipment will be used by the Environmental Services (EVS) department to clean-up large blood spills:
   a. Absorbents
   b. Face shields
   c. Plastic bags and containers
   d. Head covers (for use in the case of splashes or drops). impervious shoe covers/gowns
   e. More elaborate equipment may be required for certain emergencies and would be obtained from other departments.

C. **GUIDELINES:**
1. In the case of a ~~C~~**c**hemical ~~S~~**s**pill, the Safety Data Sheet for that material should be quickly obtained and proper procedure followed.
   a. Hazardous Drug – review the Patient Care Services (PCS) Procedure: Hazardous Drug ~~procedure~~
      i. Review the Tri-City Hospital District Hazardous Drug List
   b. Laboratory Spills - review Laboratory Procedure: Laboratory Spills ~~procedure~~
      i. Review the Laboratory Spill Chart
   c. Chemotherapy Spills – Review the PCS Procedure: Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents and Body Fluids~~, Accidental Exposure to Radioactive Body Fluids policy~~
   ~~a.~~**d.** In general the response should be as follows:
      i. If the spill is over 500 mL the Safety Officer or designee will contact the hazardous waste disposal vendor to respond to clean up the spill.
      ~~i.~~**ii.** If the vendor is not available the Private Branch Exchange (PBX) operator will notify the Oceanside Fire Department~~.~~ and request assistance.
      ~~ii.~~**iii.** Evacuate the personnel in the area.
      ~~iii.~~**iv.** Put absorbent material (paper-towel) on the spill if the product is in liquid form (and if this can be done safely).
      ~~iv.~~**v.** Notify the Environmental Services Supervisor and the ~~Environment of Care (EOC)~~/Safety Officer**/designee**.
      ~~b.~~**vi.** E**VS**~~nvironmental Service~~ personnel will contact the ~~EOC/~~Safety Officer**/designee** if the chemical spill is over 500 mL.

2. Formaldehyde Spills
   a. Laboratory and Surgical Services employees are instructed to clean up small quantity spills associated with Formaldehyde.
3. Radioactive Material Spills
   a. The Radiation Safety Officer (RSO) will be notified and will clean-up all ~~R~~**r**adioactive ~~S~~**s**pills.

D. RELATED DOCUMENT(S):

1. **Laboratory Procedure: Laboratory Spills**
2. **PCS Procedure: Hazardous Drug**
3. **PCS Procedure: Chemotherapy Exposure, Spills, and Handling of Linens Contaminated with Chemotherapeutic Agents and Body Fluids**
~~a.~~**4. Hazardous Drugs List**

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIAL MANAGEMENT

SUBJECT: Hazardous Waste & Material-Ordering, Receiving and Storage

POLICY NUMBER: 6004

ISSUE DATE: 10/94
REVISION DATE~~(S)~~: 5-97, 7/00, 4/03, 4/05, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**

1. To ensure ~~that~~ hazardous materials are ordered, received, handled and stored in a safe and an expeditious manner preventing injury to patients or personnel.

B. **POLICY:**

1. **Regularly ordered** ~~All~~ hazardous materials ~~which are regularly ordered and~~ **that are** stocked within the hospital are ~~set~~ **recorded** ~~up~~ in the purchasing and inventory system.
2. All hazardous materials are received into the department by appropriate personnel, ~~and~~ stored in a supply closet or chemical storage cabinet, **and**. ~~They are properly~~ labeled with a description of the hazard they represent.
   a. Since storage space may be limited, acid and alkali products may be stored together if they are suitably separated.
3. Par levels have been established for these hazardous chemicals, and purchases are made upon these levels.
4. Storage areas are kept under lock and key until they are needed. The following are the approved Hazardous Materials Storage areas:
   a. All Environmental Services (EVS) Storage Closets
   b. Laboratory Area
   c. Waste Storage Area
   d. Morgue
   e. Engineering
   f. Sterile Processing Department
   g. Surgical Services
   h. Biomedical
5. The storage areas for hazardous chemicals are cleaned and organized routinely.
6. Hazardous waste storage and processing areas will be free of clutter and effectively separate from patient care, food preparation and serving areas.

C. **PROCEDURE:**

1. It will be the responsibility of the user department to notify Supply Chain that it is a hazardous material they wish to order.
   a. User departments will be responsible for notifying Supply Chain of any hazardous item, which has not been denoted as such.
2. **The receiving** ~~It will be the responsibility of receiving~~ personnel ~~to~~ **is responsible for** monitor**ing** the labeling and packaging of all materials, which have been denoted as hazardous on the purchase order.

a. These materials must have labeling which explicitly states:
   i. Identity of the hazardous chemical
   ii. Appropriate warning signs
   iii. Name and address of the chemical company
b. Any deficiencies will be reported to the ~~Environment of Care/~~Safety Officer/**designee**~~.~~
c. The vendor/manufacturer will be notified of any deficiency and corrective action will be requested.
d. Receiving personnel **are**~~will be~~ responsible for obtaining and affixing appropriate labeling when not provided by the manufacturer.

3. Inventory levels of all hazardous materials will be routinely reviewed for appropriateness as a part of the overall inventory management program ~~of the Healthcare District~~.
4. Receiving personnel will be knowledgeable of all hazardous materials coming across the receiving dock and ~~will assure~~ **ensure**~~that~~ they are handled and transported appropriately.
5. A warning label will be placed on the shelf or in the storage area in the warehouse where hazardous materials are **stored**~~kept~~.

Tri-City Medical Center
Oceanside, California

Environment Of Care
Hazardous Material Management

SUBJECT: Hazardous Waste & Materials Responsibilities

POLICY NUMBER: 6003

ISSUE DATE: 10/94
REVISION DATE~~(S)~~: 3/97, 7/00, 4/03, 11/10, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**

1. To designate responsibility in each department to provide information about hazardous waste and materials in the workplace to maintain the safety of all employees, medical staff, patients and visitors of the Healthcare District.

B. **POLICY:**

1. The Healthcare District will provide a safe and healthy environment for all employees, medical staff, patients and visitors.

~~1.~~**2. Education will be provided to newly hired staff and all other required staff annually on Hazardous Communication/Global Harmonization / Right-to-Know Legislation**

~~C. **GUIDELINES**~~**PROCEDURES:**

~~1.~~**3.** Environment of Care/Safety Officer/Designee **will** :

a. ~~Will obtain and disseminate information regarding Hazardous Communication/Global Harmonization/ Right-to-Know Legislation~~.

b. ~~Will c~~**C**oordinate action plans for compliance with other members of the Environmental Health and Safety Committee (EHSC).

c. ~~Will request~~ **Obtains** hazardous chemical inventories **for high use departments i.e.,** ~~those departments that have been identified as high use~~ departments: Facilities, Environmental Services (EVS), **Food and Nutrition**~~Dietary~~, ~~Lab~~**Laboratory**, Sterile Processing Department (SPD), Surg**ical Services**~~ery~~

d. ~~Will c~~**C**oordinate with the Employee Health and Education Departments to provide training programs and continuing education for new and existing employees.

e. ~~Will o~~**Reviews**~~btain copies of all~~ hazardous materials and waste ~~related RL Solutions~~ Incident Reports ~~for review by the EHSC.~~

f. ~~Will m~~**M**aintain**s** a copy of **currently regulatory standards and guidelines**:

~~i. The list of hazardous chemicals for identified department.~~

~~ii. Occupational Safety and Health Administration (OSHA) Standards and Interpretations.~~

~~iii. Part 1910. Occupational Safety Health Studies. Subpart C- General Safety and Health Provisions.~~

~~iv. 1910.20- Access to Employee exposure and medical.~~

~~g. Environment of Care/Safety Officer/designee will include a general statement in the hospital orientation to all new personnel regarding exposure to hazardous chemicals and explain that detailed orientation will follow in individual departments.~~

~~h. Notice of employee rights will be posted in Human Resources, and Employee Health Services.~~

~~2.~~**4.** Department Directors/**d**~~D~~Designee **shall identify** ~~will review area with supervisors to develop a composite~~ **a** list of all chemicals currently being used and store**d within their departments**.
- a. ~~Will s~~**S**ubmit a hazardous materials inventory list to the Safety Officer**/designee**.
- b. ~~Will r~~**Identify** ~~eview operations with supervisors to determine~~ **unit/department positions** ~~jobs~~ which ~~will require Hazard~~**requiring Hazard** Communication Training **and ensure the staff complete the required training.**~~.~~
- c. ~~Will arrange for training of all involved employees in coordination with a hospital-wide training program~~.
- d. ~~Will n~~**N**otify the Environment of Care/Safety Officer of any change affecting hazardous materials being used.
- e. Maintain copies of Safety Data Sheets and Chemical Inventory.
- f. Provide information to outside contractors:
  - i. Before the work begins, department directors will inform outside contractors and their personnel about the potential hazards to which they may be exposed at the work site and protective measures to prevent exposures.
  - ii. The following should be made available when requested:
    - 1) Chemical inventory for the area(s) in which they will be working.
    - 2) Access to appropriate Safety Data Sheets.
    - 3) Any additional safety information for contractors to utilize in training their personnel.

~~3.~~**5.** Supply Chain **or EVS** ~~**shall**~~~~will~~ assist **d**~~D~~epartment Directors/~~D~~**d**esignees in obtaining Safety Data Sheets on all hazardous materials used **within their** ~~in their areas~~**departments**.
- a. ~~Will e~~**E**nsure ~~that~~ supplier's samples include Safety Data Sheets for the use of operating personnel in evaluating the product.
- b. ~~Will i~~**I**dentify suppliers who fail to cooperate in providing Safety Data Sheets and report this information to the appropriate person.
- c. ~~Will follow~~ **Implement** ~~established~~ safe practices for receiving hazardous substances that include the following provisions:
  - i. Ensure Safety Data Sheets are received with initial shipment of a hazardous material.
  - ii. Ensure labels are affixed to containers.
  - iii. Store hazardous materials in designated locations.
  - **iv.** Use prescribed personal protective equipment when handling hazardous material.

6. Employees identifying a ~~Reporting~~ hazardous waste or hazmat incidents and/ or exposure shall report the incidents and/or exposure immediately to their director/manager/supervisor/designee. Directors or designee will ensure the incident is reported to the ~~will be completed by the employee discovered the spill, the manager or director of the area,~~ Safety Officer/designee ~~and Director of~~ Risk Management.
- **a. All hazardous material and waste spill or exposures must be reported~~, even if no bodily harm or property loss resulted,~~ utilizing the RL Solutions ~~QRR~~ reporting system.**
- **b. Directors / designees shall follow the hospital policy for investigating and reporting incidents. ~~The discovering employee is responsible for completing the report online immediately following the event~~.**
- **c. ~~The manager or director responsible for reviewing the report and performaing an investigation as needed within 3 business days.~~**
- d. **The ~~Director of~~ Safety Officer /Designee ~~/EOC i~~s responsible for the final review of ~~the~~ spills and the** ~~The Director of Safety/EOC is responsible for~~ tracking, trending,~~ and~~ analyzing **incidents** ~~the records of spills and will report the information, results~~ **reporting findings** ~~and investigations~~ quarterly to the EHSC.
- **e. ~~, and t~~The Director of Employee Health is responsible for final review of the exposures.**
- ~~i.~~**f. The Director of Safety/EOC is responsible for tracking, trending and analyzing the**

records of spills and will report the information, results and investigations quarterly to the EHSC.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
LIFE SAFETY MANAGEMENT

SUBJECT: Life Safety Management Plan

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 03/00, 04/06, 04/09, 04/13, 05/12, 06/15, 12/17, 03/19

Department Approval:	~~11/18~~11/21
Environmental Health & Safety Committee Approval:	~~11/18~~11/21
Administration Approval:	~~03/19~~11/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. **EXECUTIVE SUMMARY:**

1. Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the **workforce**~~employees~~ and medical staff who use and manage it, and to others who enter the environment.

~~1.~~**2.** The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD.

3. The Management Plan for Life Safety describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities.

~~2.~~**4.** The management plan and the Life Safety Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

~~3.~~**5.** The program is applied to the Medical Center and **affiliated** ~~all offsite~~ clinics and care facilities of TCHD. The Life Safety Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD.

B. **PRINCIPLES:**

1. All buildings of TCHD housing patient care services must be designed, operated, and maintained to comply with the **current**~~2012~~ edition of the National Fire Protection Association (NFPA) Life Safety Code, and the **current**~~2012 E~~**e**dition of the NFPA Health Care Facilities Code.
2. All fire alarm, detection, and extinguishing systems and equipment must be maintained to comply with applicable codes and standards.
3. All **workforce members (WFM)** ~~staff~~ must be educated and trained to respond effectively to fire, smoke, or other products of combustion to minimize the potential of loss of life or property in the event of a fire.
4. Appropriate temporary administrative and engineering controls must be designed, implemented, and maintained whenever existing deficiencies or conditions created by construction activities significantly reduce the level of life safety in any area where patients are cared for or treated.

C. **OBJECTIVES:**

1. Design and construct all spaces intended for housing patient care and treatment services to meet national, state, and local building and fire codes.
2. Conduct required fire drills in all buildings ~~of TCHD~~ housing patient care services.
3. Calibrate, inspect, maintain, and test fire alarm, detection, and suppression systems in accordance with codes and regulations.
4. Inspect and maintain all buildings housing patient care services to **ensure**~~assure~~ compliance with the applicable requirements of the **current** ~~2012~~ edition**s** of the NFPA Life Safety Code and ~~the 2012 Edition of~~ NFPA Health Care Facilities Code.
5. **Provide education to** ~~Train~~ **the WFM**~~all staff~~, volunteers, and members of the medical staff to respond effectively to fires.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Engineering or ~~D~~**d**esignee assures that an appropriate maintenance program is implemented. The Director of Engineering or **d**~~D~~esignee also collaborates with the Safety **Leader**~~Officer~~ to develop reports of Life Safety Management performance for presentation to the Environmental Health and Safety Committee **(EHSC)** on a quarterly basis. The reports summarize organizational experience, performance management and improvement activities, and other fire safety issues.
2. The facilities management technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of fire safety equipment in a timely manner.;~~ In addition, the~~ technicians and service company **WFM**~~staff perform~~ **complete** necessary repairs.
3. **WFMs**~~Individual staff members~~ are responsible for being familiar with the risks inherent in their work,~~ and~~ present in their work environment**, and**~~. They are also responsible for~~ implementing ~~the~~ appropriate organizational, departmental, and ~~job related~~**job-related** procedures and controls required to minimize the potential of adverse outcomes of care and workplace **incidents**~~accidents~~.
4. The Board ~~of Directors of TCHD~~ receives regular reports of the activities of the Life Safety Management program from the E**HSC**~~nvironmental Health and Safety Committee~~. The Board of Directors reviews the reports and, as appropriate, communicates concerns about identified issues back to the Director of Engineering or ~~D~~**d**esignee and appropriate clinical **WFM**~~staff~~. The Board collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Life Safety Management program.
5. The CEO or designee ~~of TCHD~~ receives regular reports of the activities of the Life Safety Management program. The CEO or designee collaborates with the Director of Engineering or ~~D~~**d**esignee and other appropriate staff to address fire safety issues and concerns.

E. **ELEMENTS OF THE LIFE SAFETY MANAGEMENT PLAN:**

1. Life Safety Management Plan ~~(FS.EC.01.01.01 EP6)~~
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of TCHD experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property ~~(FS.EC.02.02.01 EP1)~~
   a. The Director of Engineering or **d**~~D~~esignee and Safety **Leader**~~Officer~~ are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Engineer**ing** or ~~Designee~~ **designee** and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to **en**~~as~~sure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of

Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Engineer or ~~D~~**d**esignee assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer or ~~D~~**d**esignee permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services~~. of TCHD.~~

c. Management
   i. The Director of Engineer or ~~D~~**d**esignee oversees the design, implementation, and documentation of processes designed to assure optimal performance and continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.
   ii. The Director of Engineer or ~~D~~**d**esignee is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process
   i. The Safety **Leader**~~Officer~~ is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of TCHD. The current fire response plan is based on the remov**ale** from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.
   ii. The emergency number "66" is to be dialed to report a fire.
   iii. The unattached buildings located on the Medical Center campus will dial "66" to report a fire.
   iv. All buildings off the main Medical Center campus will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds ~~(FS.EC.02.03.01 EP2 & EC.02.01.03 EP1)~~
   a. TCHD has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (~~ie: cigarettes~~**i.e., cigarettes**, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.
   b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.
   c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.
4. The hospital maintains free and unobstructed access to all exits ~~(FS.EC.02.03.01 EP4)~~
   a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds**/tours** activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety **Leader**~~Officer~~, and the E**HSC**~~nvironmental Health and Safety Committee~~.
5. The hospital has a written fire response plan ~~(FS.EC.02.03.01 EP9-10)~~
   a. The Safety **Leader**~~Officer~~ is responsible for coordinating the implementation of the fire response plan. **The**~~All~~ **WFM**~~staff is~~**are** oriented**:**
      i. ~~-~~to the RACE response model and effective use of portable fire extinguishers.
      ~~a.~~**ii.** ~~In addition, all staff are oriented t~~**t**o the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.
   b. The department and area specific fire response plans include information about:

i. The roles of all **WFM**~~employees~~, medical staff, volunteers, contract staff and students near the point of fire origin.
ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.
1) Note: TCHD believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the area as needs arise.
iii. Operation of the fire alarm system.
iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

6. Fire Drills ~~(FS.EC.02.03.03 EP1 – 5)~~
a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.

7. Inspection, Testing, and Maintenance of Fire Safety Systems ~~(FS.EC.02.03.05 EP1 – 20)~~
a. The Director of Engineering or ~~D~~**d**esignee works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the N**FPA**~~ational Fire Protection Association~~ or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes.
~~a.~~**b.** The hospital conducts monthly evaluations of ~~nuclear powered~~**nuclear-powered** exit signs and verified for expiration dates and replaced accordingly.
~~b.~~**c.** ~~When d~~**d**eficiencies are ~~identified, they are~~ corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Manager/**Supervisor or designee** evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security **Leader**~~Officer~~.

8. Life Safety Management ~~(LS.EC.01.01.01 EP1 – 3)~~
a. The Director of Engineering or ~~D~~**d**esignee is responsible for maintaining the Statement of Conditions. The Director of Engineering or ~~D~~**d**esignee prepares a quarterly report of the rate of completion of any Plan for Improvement for the **EHSC**~~Environmental Safety Committee~~. If any items will not be completed within the established timeframe ~~plus The Joint Commission allowed six month grace period,~~ the Director of Engineering or ~~D~~**d**esignee is responsible for preparing a letter to the ~~appropriate~~ Joint Commission ~~staff~~ requesting an extension of the timeframe or a change of the method of correction.

9. Management of Fire Safety Risks ~~(LS.01.02.01 EP1 – 14)~~
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
   b. The Director of Engineering or ~~D~~**d**esignee and Safety **Leader**~~Officer~~ are responsible for implementation of the ILSMP~~. The implementation~~ may include training, installation of engineering controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
   c. The Director of Engineering or ~~D~~**d**esignee and Safety **Leader**~~Officer~~ are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety **Leader**~~Officer~~ and/or the Director of Engineering or ~~D~~**d**esignee take appropriate action to resolve the deficiencies.
   d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented~~.~~ **and** ~~The documentation is~~ presented to the E**HSC**~~nvironmental Health & Safety Committee~~ as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.
10. The hospital monitors conditions in the environment ~~(EC.04.01.01 EP1 – EC.04.01.01 EP11)~~
   a. The ~~Director of~~ Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety **Leader**~~Officer~~ works with the ~~Director of~~ Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, **WFM**~~staff member~~ incidents, and property damage related to environmental conditions.
   b. Incident reports **(RLs)** are completed by a witness or the **WFM**~~staff member~~ to whom a patient or visitor incident is reported. The completed reports are forwarded to ~~the Director of~~ Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
   c. In addition, ~~the Director of~~ Risk Management and the Safety **Leader**~~Officer~~ collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the E**HSC**~~nvironmental Health and Safety Committee~~ and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety **Leader**~~Officer~~ provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
   d. The Safety **Leader**~~Officer~~ coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD. **Appropriate representatives from hospital administration, clinical services, and support services, and department managers are consulted to analyze safety and environmental issues and to develop recommendations for addressing the identified risks**
   ~~e. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the seven management of the environment of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.~~
   ~~f.~~**e.** The E**HSC**~~nvironmental Health and Safety Committee~~ and the P**SC**~~atient Safety Committee~~ are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care

management programs.

~~g.~~**f.** The Safety **Leader**~~Officer~~ prepares a quarterly report to the leadership of TCHD **that**. ~~The quarterly report~~ summarizes key issues **and recommendations** reported to the ~~C~~**c**ommittee.~~s and the recommendations of them~~.

~~h.~~**g.** The quarterly report ~~is~~ also ~~used to~~ communicate**s** information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. Semi-annual **EOC activity** reports are provided to the Board of Directors.~~ related to the EC activities~~.

11. **Annually (approximately** ~~E~~**e**very twelve months**)** the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. ~~(EC.04.01.01 EP15)~~
    a. The Safety Officer coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources **that**~~. The sources~~ include aggregate analysis of environmental rounds and incident reports;~~,~~ findings of external reviews or assessments by regulators;~~,~~ accrediting bodies, insurers, and consultants:~~,~~ minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the E**HSC**~~nvironmental Health and Safety Committee~~ by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal ~~year.~~**year, as well as,** ~~Each report includes~~ an action plan to address identified weaknesses.
    c. ~~In addition, t~~**T**he annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security **Leaders**~~Officer~~.
    d. The E**HSC**~~nvironmental Health and Safety Committee~~ reviews and approves the annual reports. Actions and recommendations of the **c**~~C~~ommittee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, ~~The~~ Board of Directors, the P**SC**~~atient Safety Committee~~, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues ~~(EC.04.01.03 EP1 – 3)~~
    a. The E**HSC**~~nvironmental Health and Safety Committee~~ receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified,~~;~~ the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.

13. Improving the Environment ~~(EC.04.01.05 EP1 – 3)~~
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with E**HSC**~~nvironmental Health and Safety Committee~~ recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The E**HSC**~~nvironmental Health and Safety Committee~~ works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of

improvement.

b. The E**HSC**~~nvironmental Health and Safety Committee~~ also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient safety leadership.

14. Orientation and Ongoing Education and Training ~~(LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – 3)~~

a. Orientation and training addressing subjects of the environment of care is provided to each **WFM**~~employee~~, volunteer, and to each new medical staff member at the time of their employment or appointment.

b. ~~In addition, all c~~**C**urrent **WFMs**~~employees~~ complete an annual review of life safety via a C**omputer Base Learning (C**BL**)** module and documented in the Netlearning system.

c. The Human Resources **(HS)** Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program **per TCHD policies and procedures.**. ~~New staff members are required to attend the general NEO program within 30 days of their date of employment. The Human Resources Department maintains attendance records for each new staff member completing the general orientation program.~~

d. ~~New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the procedures and controls in place to minimize or eliminate them during routine daily operations~~.

e. The Safety **Leader**~~Officer~~ collaborates with the ~~Environment of Care~~ managers, ~~department heads, the Director of~~ Regulatory ~~Compliance a~~**a**~~nd~~ Infection Control, the P**SO**~~atient Safety Officer~~ and others as appropriate to develop content materials for general and ~~job related~~**job-related** orientation and continuing education programs.

~~e.~~**i.** The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.

f. The Safety **Leader**~~Officer~~ gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how ~~job related~~**job-related** risks are to be managed or eliminated as part of daily work. ~~In addition~~ t**T**he Safety **Leader**~~Officer~~ evaluates the degree to which **WFMs**~~staff members~~ understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

g. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the E**HSC**~~nvironmental Health and Safety Committee~~. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **ANNUAL GOALS/OBJECTIVES FOR 2021~~19~~**

1. ~~-~~Continue working with staff to **ena**ssure **education is provided**~~they have a good working knowledge o~~**onf** the expectations of their roles during a Life Safety emergency situation.
2. **Ensure**~~Insure that RedHawk~~ Life Safety continues to inspect fire systems in accordance with all ~~R~~regulatory **compliance**~~Agencies~~ and **identify plans to** correct~~s~~ deficiencies with **identified** ~~in mandated~~ time lines.
3. Continue working with department **WFM**~~staff~~, with maintaining specific clearance spacing for fire extinguishers, pull-down stations and electrical panels, for compliance and safety purposes.
4. Continue to work with **WFM**~~staff~~ and contractors in regards to both pre and post activities during construction phases that are necessary to maintain the safety of staff, patients and visitors to the facility.

G. **REFERENCE(S):**

1. The Joint Commission **(TJC). (2021). Accreditation Requirements.** ~~/NFPA Life Safety Book~~

~~for Health Care Organizations (2013)~~

2. The 2012 Edition NFPA 101 Life Safety Code
3. The 2012 Edition NFPA 99 Health Care Facilities Code

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
EQUIPMENT MANAGEMENT

SUBJECT: Medical Equipment Management Plan

ISSUE DATE: 10/94
REVIEW DATE~~(S)~~: 03/97, 07/00, 05/03, 05/08
REVISION DATE~~(S)~~: 03/97, 07/00, 05/03, 05/08, 06/15, 01/17, 03/19

Department Approval:	**~~11/18~~ ~~04/2020~~10/21**
Environmental Health & Safety Committee Approval:	**~~11/18~~11/21**
Administration Approval:	**~~03/19~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **SCOPE:**

1. The Medical Equipment Management Program is designed to assure proper selection, of the appropriate medical equipment to support a safe patient care and treatment environment.

2. ~~T~~he Program**:**

a. ~~will~~ **ensures** ~~assure~~ effective preparation of staff responsible for the use, maintenance, and repair of the equipment, and manage risks associated with the use of medical equipment technology**.**

~~1.~~**b.** ~~Finally, the Program i~~**I**s designed to assure continual availability of safe, effective equipment through a program of planned maintenance, timely repair, ongoing education and training, and evaluation of all events that **may**~~could~~ have an adverse impact on the safety of patients or staff as applied to the building and services provided at ~~Tri-City Healthcare District~~**TCHD (TCHD)**.

~~2.~~**c.** ~~The program i~~**I**s applied to **TCHD** ~~Tri-City Healthcare District~~**TCHD** ~~medical center~~ and offsite care locations.

~~1.~~**3.** The Medical Equipment Management Plan describes the processes ~~it~~ implement**eds** ~~s~~ to manage the effective, safe, and reliable operation of medical equipment as well as provide a safe environment for patients, staff members, visitors, and other individuals in the hospital. Directly or indirectly, the ~~Medical Equipment Management P~~**p**lan involves every person in the hospital who uses, maintains, or is associated with medical equipment.

B. **FUNDAMENTALS (RISKS):**

1. The sophistication and complexity of medical equipment continues to expand. Selecting new medical equipment technology requires research and a team approach.
2. Patient care providers need information to develop an understanding of medical equipment limitations, safe operating conditions, safe work practices, and emergency clinical interventions during failures.
3. Medical equipment may injure patients or adversely affect care decisions if not properly maintained.

C. **OBJECTIVES:**

1. The ~~O~~**o**bjectives for the Medical Equipment Program are developed from information gathered during risk assessment activities, annual evaluation of the previous year's program, performance measures, and environmental tours.

~~1.~~**2.** ~~The~~ **plan's ob**~~Ob~~jectives **include the following:**~~for this Plan are~~:

a. To increase training, both formal and informal, for all resident technicians.
b. Develop departmental rounds to ensure medical equipment safety within the facility.
c. Keep the medical equipment inventory current and accurate.
d. Minimize risks to patients, users, and the environment.
e. Maintain the highest level of availability of medical equipment to clinical users.
f. Reduce the need for premature replacement of equipment.
g. Comply with applicable laws, regulations, standards, and codes.
h. Continually seek opportunities for quality improvement and cost reduction.
i. Reduce unnecessary workload that does not produce positive impact of care delivery.

D. **ORGANIZATION and& RESPONSIBILITY:**

1. The Hospital Governing Board receives regular reports of the activities of the Medical Equipment Management Program from the Environmental Health and Safety Committee **(EHSC)**. **Reports are**~~They~~ review**ed** ~~the reports and, as appropriate,~~**to** communicate concerns about identified issues~~,~~ and regulatory compliance. They provide support to facilitate the ongoing activities of the Medical Equipment **Management** Program.
2. The Chief Operating Officer (COO) **/ designee** receives regular reports of the current status of the Medical Equipment program through the E**HSC** ~~nvironmental Health & Safety Committee~~. The COO **/ designee** reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the medical staff, nursing, ~~Clinical~~ Engineering, and other appropriate staff.
3. The ~~Manager of~~ Clinical- Engineering **leaders** with COO support assures that the Medical Equipment Program is implemented in all key clinical areas. The program manages a variety of activities, including tracking of rental or leased equipment, warranty repairs, and contract services. The Program also assists in the management of the activities of specialty service contractors providing services to other departments, such as radiology, laboratory, respiratory care, and surgery and anesthesia.
4. The Manager of Clinical Engineering implements the in-house medical equipment maintenance program and tracks maintenance provided by original equipment manufacturers, and other contractors who provide maintenance and repair services for specific items of equipment.
5. Department **leaders**~~heads~~ **ensure** ~~orient~~ new staff **are oriented** to their department and, as appropriate, specific uses of medical equipment. When requested, the ~~Clinical~~ Engineering Technicians provides assistance.
6. Individual staff members are responsible for learning and following job and task specific procedures for safe medical equipment operation.

E. **PERFORMANCE ACTIVITIES:**

1. The performance measurement process is one part of the evaluation of the effectiveness of the Medical Equipment Program. Performance measures have been established to measure important aspect of the Medical Equipment Program.
2. The following fundamental performance indicators will be monitored:
   a. S**cheduled** M**aintenance (SM)** -completion rate benchmark is 95% or greater.
   b. Repair completion rate within 30-days benchmark is 85% or greater.
   c. Critical/High Risk Equip SM Mthly Completion rate is 100%.
   d. Use Error Percentages
   e. Could not Duplicate Percentages per year
   f. Equipment found without PM Safety Sticker <1%
3. As they occur**:**
   a. Safe Medical Device Act of 1990 (SMDA)
   b. Incident investigations
   c. Device recalls and alerts

F. **PROCESSES FOR MANAGING MEDICAL EQUIPMENT:**

1. The hospital plans activities to minimize risks in the environment of care ~~– EC.01.01.01 EP7~~

a. The hospital has a written plan for managing medical equipment. The organization develops and maintains the Medical Equipment Management Plan to effectively manage the medical equipment risks of the staff, visitors, and patients at T**CHD**~~ri-City Healthcare District~~.

2. The hospital manages safety and security risks~~ - EC.02.01.01 EP11~~
   a. The hospital responds to product notices and recalls. ~~The Manager of Clinical~~ Engineering responds and acts on medical equipment notices and recalls. Any notices or recalls (OEM voluntary or FDA) which are affected on any devices or equipment in the facility will be acted on immediately and reported to the EHSC meeting. The Department **leadership**~~Director~~ (owner of the equipment) and Risk Manager will be notified of the notice or recall and action taken. The notice or recall will be annotated on the EHSC medical equipment report until the issue is resolved. This will also be discussed at the EHSC meeting to all members.
3. The hospital manages medical equipment risks~~ - EC.02.04.01 EP1~~
   a. The hospital solicits input from individuals who operate and service equipment when it selects and acquires medical equipment. **TCHD**~~Tri-City Healthcare District~~**TCHD** utilizes a ~~capital~~ committee to select and assure the proper equipment is selected. **Examples of committee participation include but is not limited to the following:** ~~The Capital Committee[PFR1] is made up of (at a minimum) Information Technology, Clinical~~ Engineering, Nursing, Facility Management, Finance and Materials Management.
4. The hospital manages medical equipment risks ~~- EC.02.04.01 EP2~~
   a. The hospital maintains a written inventory of all medical equipment. **TCHD**~~Tri-City Healthcare District~~ maintains an electronic and written inventory of all medical equipment. This includes all Critical/High Risk equipment. ~~The Manager of Clinical~~ Engineering evaluates new types of equipment before initial use to determine whether to include this equipment in the inventory.
   b. Written criteria are used to identify risks associated with medical equipment. The risks include, equipment function, physical risks associated with use, and equipment incident history as it relates to patient safety. The risks identified are used to assist in determining the strategies for maintenance, testing, and inspection of medical equipment. In addition, the identified risks are used to guide the development of training and education programs for staff that use or maintain equipment.
   c. Equipment requiring a program of planned maintenance is listed as part of a maintenance inventory. The list includes equipment maintained by in-house staff as well as equipment maintained by vendors.
5. The hospital manages medical equipment risks ~~- EC.02.04.01 EP3~~
   a. The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.
      i. Note: High-risk medical equipment includes life-support equipment. ~~The Manager of Clinical~~ Engineering **leadership** identifies the activities used for maintaining, inspecting, and testing all of the medical equipment in the inventory used for the diagnosis, care, treatment, and monitoring of patients thus assuring safety and maximum useful life. The determination of the appropriate activity is made as part of the initial evaluation of equipment. Critical/High Risk equipment is identified and scheduled according to manufacturer recommendations. They are **electronically** tracked~~. using IDesk.~~
   b. Potential activities selected to ensure reliable performance include:
      i. Predictive maintenance based on manufacturer's recommendation.
      ii. Reliability-centered maintenance based on equipment history.
      iii. Interval-based inspections based on specified intervals between tests, inspections, or maintenance activity.
   c. T**CHD**~~ri-City Healthcare District's Clinical~~ Engineering Department follows manufacturer's recommendations for predictive (scheduled) maintenance including

frequency and task (or the activity that requires MORE frequent inspections). Any changes of maintenance strategy and specific tasks shall be based on the experience accumulated locally or elsewhere, upon approval of the Environment of Care/Safety Committee or appropriate hospital authority.

6. The hospital manages medical equipment risks ~~- EC.02.04.01 EP4~~
   a. The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers' recommendations or with strategies of an alternative equipment maintenance (AEM) program. ~~The Manager of Clinical~~ Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with ~~M~~**m**anufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.
   b. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. ~~The Manager of Clinical~~ Engineering manages the work order generation and completion process via **electronic system**~~!Desk~~. The ~~Clinical~~ Engineering Technicians perform assigned work orders and review prior to filing. Work done by outside contractors is tracked to assure the work is completed in accordance with the terms of a contract.
   c. In addition, other departments manage performance testing and daily user maintenance of sterilizers.
7. The hospital manages medical equipment risks ~~- EC.02.04.01 EP5~~
   a. The hospital's activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers' recommendations:
      i. Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturer recommendations, or otherwise establishes more stringent maintenance requirements.
      ii. Medical laser devices.
      iii. Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes).
      iv. New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies Note: Maintenance history includes any of the following documented evidence:
         1) Records provided by the hospital's contractors.
         2) Information made public by nationally recognized sources.
         3) Records of the hospital's experience over time.
   b. The Manager of ~~Clinical~~ Engineering identifies the frequencies for inspecting, testing, and maintaining medical equipment on the inventory in accordance with Manufacturers' recommendations. The frequency of scheduled (planned) maintenance is determined based on manufacturer recommendations, and can be more often based on risk levels, and current hospital experience. The frequency of maintenance is determined at the time of initial evaluation of the medical equipment.
   c. A work order is used to manage the work for each scheduled maintenance event. Work orders are issued for maintenance performed by in-house staff and by contractors. ~~The Manager of Clinical~~ Engineering manages the work order generation and completion process via **an electronic system**~~!Desk~~.
8. The hospital manages medical equipment risks - ~~EC.02.04.01 EP6~~
   a. A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:

i. How the equipment is used, including the seriousness and prevalence of harm during normal use.
ii. Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm.
iii. Availability of alternative or back-up equipment in the event the equipment fails or malfunctions.
iv. Incident history of identical or similar equipment.
v. Maintenance requirements of the equipment.

b. ~~The Manager of Clinical~~ Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.

c. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.

d. Each department leader maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.

e. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.

9. The hospital manages medical equipment risks ~~- EC.02.04.01 EP7~~

a. The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program. The Manager of ~~Clinical~~ Engineering will bring any alternative equipment maintenance programs to the Environmental Health & Safety Committee for approval before using the alternative measures. There are no alternative maintenance programs currently being used.

10. The hospital manages medical equipment risks ~~- EC.02.04.01 EP8~~

a. The hospital monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

b. The Risk Manager is**:**

i. -responsible for monitoring and reporting all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

ii. ~~The Risk Manager c~~**c**ollect**ings** information about potentially reportable events through the incident reporting and investigation process.

~~a.~~**iii.** ~~The Risk Manager and appropriate clinical staff c~~**C**onduct**ing** investigations of medical equipment incidents to determine if the incident is reportable under criteria established by the Food and Drug Administration. ~~Clinical~~ Engineering will help in the investigation only when instructed by Risk Management.

iv. ~~The Risk Manager~~ **Using**~~uses~~ the Sentinel Event Process to investigate and document reportable incidents.

v. **Reporting**~~The Risk Manager reports for~~ **to** the **EHSC**~~Environmental Health & Safety Committee~~ on those incidents determined to be reportable.

~~b.~~**vi.** ~~The Risk Manager is also r~~**R**esponsible for completing all reports and handling other communications with medical equipment manufacturers and the **Food and Drug Administration (**FDA**)** required by the Safe Medical Devices Act.

~~a.~~**c.** Appropriate changes in processes and training are made through the performance improvement process. The changes are communicated to all appropriate staff.

11. The hospital manages medical equipment risks ~~- EC.02.04.01 EP9~~
    a. The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment. The Manager of ~~Clinical~~ Engineering assists in the development of written procedures that are followed when medical equipment fails. These procedures include emergency clinical interventions and the location and use of backup medical equipment. The leader of each department that uses Critical/High Risk medical equipment develops and trains staff about the specific emergency procedures to be used in the event of failure or malfunction of equipment whose failure could cause death or irreversible harm to the patient dependent on such equipment.
    b. These emergency response procedures provide clear, specific instructions for staff responding to an emergency and provide information about notifying appropriate administrative staff of the emergency, actions required to protect patients from harm, contacts for spare equipment or repair services, and contacts to obtain additional staff to manage the emergency.
    c. Each department head maintains copies of applicable emergency procedures in accessible locations in their departments. Departmental staff receives orientation and ongoing education and training about the emergency procedures.
    d. Each department Director/Manager reviews the department specific medical equipment emergency procedures annually.
12. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP1~~
    a. Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. ~~(See also EC.02.04.01, EP 2).~~ The ~~Clinical~~ Engineering staff will test all medical equipment on the inventory before initial usage and perform safety, operational, and functional checks. The inventory includes, equipment owned by ~~Tri-City Healthcare District~~**TCHD**, leased, and rented from vendors. These inspection, testing and maintenance documents are maintained in the ~~Clinical~~ Engineering Department for review. The Manager of ~~Clinical~~ Engineering manages the program of scheduled inspection and maintenance.
13. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP2~~
    a. The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. ~~(See also EC.02.04.01, EPs 3 and 4; PC.02.01.11, EP 2).~~ The Manager of ~~Clinical~~ Engineering assures that scheduled testing (inspects, tests and maintains) of all Critical/High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 100%, the Manager of ~~Clinical~~ Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing, and maintenance documents are maintained in the ~~Clinical~~ Engineering Department for review.
14. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP3~~
    a. The hospital inspects, tests, and maintains non–high-risk equipment identified on the medical equipment inventory. These activities are documented. The Manager of ~~Clinical~~ Engineering assures that scheduled testing (inspects, tests and maintains) of all Non Critical/Non High Risk equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the Environmental Health & Safety Committee. If the monthly rate of completion falls below 95%, the Manager of ~~Clinical~~ Engineering will present an analysis to determine the cause of the problem and make recommendations for addressing it. These inspection, testing and maintenance documents are maintained in the ~~Clinical~~ Engineering Department for review.
15. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP4~~
    a. The hospital conducts performance testing of and maintains all sterilizers. These

activities are documented. The Manager of ~~Clinical~~ Engineering is responsible for the maintenance and documentation of maintenance of all types of sterilizers used at ~~Tri-City Healthcare District~~**TCHD**. Maintenance documentation to include SMs are maintained in **electronic system** ~~I~~Desk (the ~~Clinical~~ Engineering Medical Equipment Database) and filed into the equipment file for review.

b. Records of load testing (performance) and regular user maintenance are maintained by Sterile Processing Department (SPD) and Perioperative Services Department, respectively.

16. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP5~~
    a. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented. The Manager of ~~Clinical~~ Engineering is responsible for managing the service and maintenance of the dialysis units performed by Fresenius. The service maintenance records are also entered into **the electronic system**~~I~~Desk the ~~Clinical~~ Engineering shop medical equipment database and filed into the equipment file for review.
    b. Engineering is responsible for managing the chemical and biological testing of water used in hemodialysis at ~~Tri-City Healthcare District~~**TCHD** by Fresenius. The program of maintenance includes, regular cleaning and disinfection of all dialysis equipment, and testing for compliance with biological and chemical standards for the dialysis water supply. Documentation of the testing and maintenance activities is maintained in the Dialysis storage room for review.
17. The hospital inspects, tests, and maintains medical equipment ~~- EC.02.04.03 EP14~~
    a. Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The dates of these activities are documented. The Manager of ~~Clinical~~ Engineering assures that scheduled inspecting, testing, and calibrating (for the service and Scheduled Maintenance) of the Nuclear Medicine Camera and related equipment is performed in a timely manner at least annually. The service maintenance records are also entered into I-Desk the ~~Clinical~~ Engineering shop medical equipment database and filed into the equipment file for review.
18. The hospital collects information to monitor conditions in the environment. ~~EC.04.01.01 EP1~~
    a. The hospital establishes a process~~(es)~~ for continually monitoring, internally reporting, and investigating the following:
        i. Medical or laboratory equipment management problems, failures, and use errors
            1) Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.
            2) Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process. Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by ~~Clinical~~ Engineering on the EHSC report. All use errors will have in-service education and follow-up.
19. The hospital collects information to monitor conditions in the environment~~. EC.04.01.01 EP10~~
    a. Based on its process ~~(es),~~ the hospital reports and investigates the following: Medical/laboratory equipment management problems, failures, and use errors. (See also ~~EC.04.01.03, EP 1)~~ Medical/Laboratory equipment management problems, failures, and use errors will be reported to the EHSC by ~~Clinical~~ Engineering on the EHSC report.
20. The hospital collects information to monitor conditions in the environment. ~~EC.04.01.01 EP12~~
    a. The hospital conducts environmental tours every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. ~~(See also EC.04.01.03, EP 1).Clinical~~ Engineering participates on the multi-disciplinary team which conducts environmental

safety tours every 6-months in patient care areas and annually in non-patient care areas at ~~Tri-City Healthcare District~~**TCHD** .

21. The hospital collects information to monitor conditions in the environment ~~- EC.04.01.01 EP15~~
    a. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness. On an annual basis, Manager of ~~Clinical~~ Engineering evaluates the objectives, scope, performance, and effectiveness of the Plan to manage the medical equipment risks to the staff, visitors, and patients at ~~Tri-City Healthcare District~~**TCHD**. The basis for the evaluation will include but not be limited to the medical equipment performance standards and the EHSC Committee reports on medical equipment issues (supported from IDesk). The goal of the annual evaluation is to continually improve processes and outcomes to improve the patient experience.
22. The hospital addresses N**ational Patient Safety Goal**~~PSG.06.01.01 -~~ Improve the safety of clinical alarm systems. ~~(EP 1-3~~ are completed) ~~(EP 4-5 will be accomplished in 2015)~~
    a. ~~EP 1 -~~ Leaders establish alarm safety as a hospital priority.
    ~~c.~~ ~~EP 2 -~~ Prepare an annual inventory of alarms used in the hospital and identify the default alarm settings. ~~(For more information, refer to Standard EC.02.04.01)~~
    b. ~~EP 3 -~~ Based on the annual inventory, identify the most important alarms to manage.
    c. ~~EP 4 -~~ Establish policies and procedures for managing the alarms identified ~~in EP 3~~ above that at a minimum address the following:
        i. Whether specific alarms are needed or unnecessarily contribute to safety concerns.
        ii. When alarms can be disabled.
        iii. When alarm parameters can be changed.
        iv. Who in the organization has the authority to make decisions about disabling alarms and changing alarm parameters.
        v. Monitoring and responding to alarms.
        vi. Checking individual alarms for accurate settings, proper operation, and detectability.
    d. ~~EP 5 -~~ Educate staff about alarm policies and procedures.

G. **INFECTION CONTROL**

1. ~~Clinical~~ Engineering staff will observe the hospitals infection-control policies and procedures, including current CDC hand hygiene guidelines, in order to minimize the risk of cross-contamination to patients and clinicians. In addition, ~~Clinical~~ Engineering employees are required to follow the blood borne pathogens exposure control plan (including training, universal precautions, engineering and safe work practices, personal protective equipment usage, and post-exposure evaluation and follow-up) developed by ~~Aramark~~ **TRIMEDX** Healthcare Technologies as required by O**ccupation** S**afety** H**ealth** A**dministration (OSHA)** per 29 CFR 1910.1030.

H. **PATIENT INFORMATION PRIVACY (HIPAA):**

1. As a service provider, ~~Clinical~~ Engineering staff do not use or disclose protected health information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 – HIPAA, specifically the Standards for Privacy of Individually Identifiable Health Information. Any disclosure of protected health information to ~~Clinical~~ Engineering staff that occurs in the performance of their duties (such as what may occur while repairing a piece of medical equipment) is limited in nature, occurs as a by-product of the maintenance duties, and cannot be reasonably prevented. Such disclosures are incidental and permitted by the HIPAA Privacy Rule (45 CFR 164.502(a)(1)).
2. On the other hand, ~~Clinical~~ Engineering staff shall follow policies and procedures established by client to protect PHI, including attending required training and assisting clients in identifying privacy risks and practicing risk reduction measures. Specifically, the Technology Managers and ~~Clinical~~ **Engineering** staff is instructed to:

a. Assist in identifying and recommending preventive measures for PHI theft risks for medical devices that are exposed to non-authorized employees, patients and visitors.
b. Work with the Information Technology department to remove all PHI from equipment that is sent out for repair or disposal.
c. Not use or disclose any information (oral, transmitted, or recorded in any form or medium) that relates to the health (past, present, or future) of or provision of healthcare to an individual.

I. **EMERGENCY PREPAREDNESS AND MANAGEMENT:**

1. ~~Clinical~~ Engineering staff will observe the client's emergency preparedness and management policies and procedures in order to provide care to the population served by the client in the case of local, regional, and national emergencies.

J. **GOALS AND OJECTIVES FOR FY ~~19~~21:**

1. **Identify and respond to equipment hazard and recall notices in a timely manner.**
2. **Review and Update as required the Medical Equipment Management Plan annually.**
3. **Complete annual equipment preventative maintenance according to manufacture guidelines, goal 100% compliance.**

~~3. Assess the entire inventory of medical scales throughout the organization for the ability to locked-down the scale to Kilograms only (not able to readout in pounds). Scales where the ability to lockdown is not an option will have a visual reminder sticker added to the front of the device to alert care providers of the risk and to ensure that kilograms are always used for patient safety. Measurement will be the total number of hospital scales/number of scales locked-down to Kg. only and/or labeled with the warning to use Kg. only.~~

~~4. Increase use of DEFECTIVE stickers on medical devices in need of repairs, by creating a schedule of rounding of all departments and providing on-the-spot education to management and frontline staff. Measurement will be to have 90% or greater of medical devices in need of repair to have the proper use of a defective sticker when sent down to Bio-Med.~~

K. **ENTERNAL LINKS:**

1. **Equipment Management Plan: Engineering Manual, Section 4**
2. **2021 TCMC 2021 Medial Equipment Management Plan**

~~5.~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
SAFETY MANAGEMENT

SUBJECT: Patient Age Related Hazards **POLICY NUMBER: 1021**

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 5/96, 1/97, 7/00, 05/15

Department Approval ~~Date(s)~~:	**~~04/15~~10/21**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~04/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **POLICY**
1. In order to ensure a safe environment for patients of all ages, the following procedures **shall be** ~~will be~~ followed by the affected departments~~.~~

B. **Adult Patient – All Ages**
1. **Fall Risk Hazards**
   a. **The following procedures provide detailed education and instructions to assist with decreasing patients' risk for falls**
      i. **Fall Risk Procedure and Score Tool**
         1) **Screen all patients and implement safety measures as outlined in the procedure**
      ii. **Fall Prevention Procedure – Elsevier Clinical Skills**
2. **Fire, Electrical, Radiation and Chemical Hazards**
   a. **Review the following Elsevier Clinical Skills**
      i. **Fire, Electrical, Radiation, and Chemical Safety**
3. **Safety Hazards – General Guidelines**
   a. **Areas used to provide patient care i.e., rooms, bays, shall be clear of clutter with clear egress**
   b. **Egress locations shall be free patient care and staff equipment i.e., equipment, supplies and work stations on wheels (WOWs) are stored as to allow patients and staff from moving freely within halls, corridors, and within their patient care areas i.e., rooms, bay.**
   c. ~~Floors are to be kept clean and dry~~.
   d. **Lighting should be adequate to meet patient's needs**
   e. **Bed handrails shall be in the proper position per manufacturer's recommendations for patient safety i.e., upper side rails up (this excludes specialty beds)**
   f. **Grab bars are available in showers and halls**

C. **NEWBORN PATIENT:**
~~B.~~1. **Review Women and Newborn Services (WNS) Standards of Patient Care Adults: Standards of Care: Patient Safety**

D. **NEONATAL PATIENT**:
1. **Review the Standards of Care _ Neonatal Intensive Care Unit – Patient Safety**

E. **PEDIATRIC PATIENT**:

1. **Review Environment (Pediatric) Tri-City Hospital District (TCHD) intranet Elsevier Procedures ~~GUIDELINES~~**

~~C.~~

~~1. Pediatric Patients~~

~~a. Side rails are to remain up on all beds used for pediatric patients. Padded restraints may be used if called for by the physician in charge.~~

~~b. Pillows should be firm and offer support. Light plastic wrappings are never permitted on sheets and pillows.~~

~~c. Children receiving heat treatments of any kind are to be kept under close supervision.~~

~~d. Baby scales will be placed on a table top when in use to prevent the infant from falling to the floor.~~

~~e. No child is to be left unsupervised while he or she is eating.~~

~~f. Small candies and toys are not to be accessible to a small child lest he or she chokes or inserts them into a body orifice.~~

~~g. When a small child has finished eating, the feeding equipment will be removed and the child be returned to his or her crib immediately.~~

~~h. Toys should be suitable for the age and condition of the child. Children should not be given any toys made of glass or having sharp edges, flaking paint, or parts that can be detached and swallowed.~~

~~i. All cleaning supplies will be kept in locked cabinets when not in use.~~

2. ~~Elderly Patients~~:

a. ~~Patient rooms and halls should be kept clear of furniture or equipment that may lead to falls.~~ Floors are to be kept clean and dry.

~~b. Lighting should be adequate and without a glare.~~

~~c. Beds will remain in the lowest possible position and the call button will be within easy reach.~~

~~d. Handrails must be available in showers and baths.~~

~~e. Patients and family should be instructed in safety measures and rationale to prevent injury.~~

~~f. Instruct patient and family to call for assistance before getting out of bed if at risk for falls. Advise patients to:~~

~~i. Ask for help when needed.~~

~~ii. Rise slowly and keep necessary items within reach.~~

~~iii. Use wheelchairs, canes and walkers properly.~~

~~iv. Use handrails if needed.~~

~~v. Wear non-skid footwear when walking[JEH].~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SAFETY MANAGEMENT

SUBJECT: Providing a Safe Environment

ISSUE DATE: 12/15
REVIEW DATE~~(S)~~:
REVISION DATE~~(S)~~: 12/15

Department Approval ~~Date(s)~~:	**~~09/15~~10/20**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~10/15~~11/21**
~~Medical Executive Committee Approval Dates(s):~~	**~~N/A~~**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~11/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**12/15**

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

1. **To** ~~It is the policy of the Tri-City Healthcare District (TCHD)~~ to develop and implement plans, programs, ~~and~~/**or** ~~processes~~ **that**~~which will~~ promote a safe and functional environment.

2. **To institute a series of initiatives to reduce the risk of system failure**

3. **To ensure staff knowledge relative to emergency procedures to be taken in the event of a failure.**

~~1.~~**4.** **To implement programs that include, but are not limited to, risk assessments, preventive maintenance and testing, environmental tours and staff education.**

B. **POLICY~~ROCEDURES~~:**

~~1. To accomplish this objective, the facility has instituted a series of initiatives to reduce the risk of system failure and also to ensure staff knowledge relative to emergency procedures to be taken in the event of a failure.~~

1. **The** ~~Specifically,~~ programs **will be developed for specific areas/locations**

2. **The programs ensure** ~~are in place that~~ include, but are not limited to, ~~risk assessments, preventive maintenance and testing, environmental tours and staff education. The~~ **the** following: ~~are specific areas reviewed:~~

   a. Interior spaces ~~shall~~ meet the needs of the patient population, ~~and~~ are safe and suitable to the care, treatment, and services provided.

   b. ~~For p~~**P**atients **requiring care** ~~who remain in the care of the hospital ff~~or more than 30 days **in departments**, such as the Acute Rehabilitation Unit (ARU) and Behavioral Health Unit (BHU).

      i. Space has been provided for recreation and social interactions

      ii. Outside areas **are** suitable to patient's age, physical or mental **needs / diagnosis**~~conditions~~

   c. Storage space **is** ~~has been~~ provided to meet ~~the~~ patient**s**'~~s~~ needs.

   d. Lighting is suitable for care, treatment, and services and the specific activities being conducted.

   e. Ventilation provides for acceptable levels of temperature and humidity

   f. Areas used by patients are clean, sanitary, and free of offensive odors.

   g. Emergency access provision is provided to all locked and occupied spaces.

   h. Furnishing and equipment are maintained **according to regulatory requirements**~~to be safe and in good repair.~~

   i. **The Safety Officer / designee reviews:**

i. **The** ~~The~~ status of the environment ~~will be reviewed~~ during ~~the~~ ~~E~~**e**nvironmental **t**~~T~~ours. ~~process and reviewed by the Director of Safety/Environment of Care (EOC).~~

~~i.~~**ii.** **Environmental tours findings and**~~Deficiencies and~~ corrective actions **and** ~~will be reviewed by the Director of Safety/EOC and r~~eport**sed** **the findings** to the Environmental Health and Safety Committee (EHSC)~~. as appropriate~~.

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIAL MANAGEMENT

SUBJECT: Radioactive Contaminated Waste Handling and~~t~~ Storage Area **POLICY NUMBER: 6011**

ISSUE DATE: 7/93
REVISION DATE~~(S)~~: 7/96, 7/97, 7/00, 4/03, 05/15

Department Approval ~~Date(s)~~:	**~~03/15~~10/21**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~05/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE:**

1. In order to ensure ~~that~~ waste material generated by Tri-City Healthcare District **(TCHD)** does not contain any radioactive contamination, all biohazard and medical waste will be screened with scintillation detectors before ~~placing~~ **the containers are placed in the designated areas for** ~~into the containers to be~~ picked up by a certified waste management company.

B. **POLICY:**

1. Biohazardous (Red Bag) Waste:
   a. Appropriate protective equipment, i.e., disposable surgical mask with wraparound splash guard visor, plastic aprons, and gloves, must be worn by all Environmental Service **(EVS)** personnel when handling biohazardous waste to be screened for radioactivity and **when placing the waste** ~~then placed~~ into the storage units. ~~Any c~~**C**ontaminated disposable equipment must be placed in the **appropriate** containers before closing and locking the storage unit.
   b. All E**VS**~~nvironmental Services (EVS)~~ personnel must pass the biohazardous waste (red) bags over the radiation detection monitor located in the waste handling area before placing the red bags into a biohazard barrel for disposal.
   c. Personnel **MUST** allow the bag to rest on the detector for 10 seconds in order for the detector to be activated.
   d. If **NO ALARM** is produced, personnel may proceed to place the red bag into the waste storage barrel.
   e. If an **ALARM** is generated, the EVS employee must contact their supervisor immediately.
   f. The supervisor will unlock the storage area #1 or #2 and secure the red bag in the storage locker**, post a**~~. The~~ radioactivity placard.~~ must be posted~~ **and contact the Radiation Safety Officer (RSO)/designee**~~.~~
   g. **The**~~As soon as possible, the~~ **RSO**~~Radiation Safety Officer (RSO),~~ Nuclear Medicine technologist, or radiation safety designee will take measurements of the barrels in holding using the hand-held survey meter and attempt to determine the source of the radioactivity. When the material has decayed to background level it must be handled as biohazard medical waste for disposal.
2. Medical (Solid) Waste:
   a. All EVS personnel must**:**
      ~~a.~~**i.** ~~-~~position the wagon used to transport the bags of trash to the compactor area on the platform next to the compactor door between the two scintillation detectors for monitoring before disposal.
      ii. ~~Personnel must~~ verify that there is power to the monitoring system.

~~b.~~**iii.** ~~Personnel **MUST** allow~~ the wagon to reside **on the monitoring system**~~there~~ for a minimum of 10 seconds in order for the detector to be activated.

~~c.~~**b.** If **NO ALARM** is produced, personnel may proceed to remove the bags from the wagon and place them in the compactor.

~~d.~~**c.** If an **ALARM** is generated, personnel must contact their supervisor immediately.

d. The EVS supervisor **will**~~must~~ log the date, time, and route of the pickup that triggered the alarm.

~~e.~~**i.** The~~is~~ information will be monitored for trends and problems.

e. The EVS personnel **shall**~~must~~ take the wagon to the biohazard trailers and must individually check the bags in the wagon for radioactivity utilizing the scintillation detectors at the biohazard processing area. (see Procedure A) The bags, which are radioactive, must be isolated from the other **bags**~~s~~.

f. ~~-~~The supervisor will unlock the liquid waste safety storage area #1 or #2 and the radioactive bag(s) **will be**~~must be~~ secured until decayed to background. The radioactivity placard must be posted. ~~-T~~**T**he remainder of the waste ~~must~~ **will** be monitored again at the compactor before disposal to ensure no other radioactive contamination.

3. Discipline:

a. **ANY** observed occurrences of improper handling of waste**,** including failure to follow protocol, deliberate disregard for safety precautions, or tampering with the monitoring system will result in disciplinary action in accordance with AP # 424, Coaching and Counseling for Work Performance Improvement.

4. Imaging Services Department ~~Only~~

a. Monitoring Equipment~~-~~The radiation detection monitors are Ludlum model 3530 Medical Waste Radiation Detection Monitor.

i. Background at Tri-City Healthcare District is approximately 10-20 uR/hr.

ii. The red light/alarm trigger will be set to activate at approximately two times background or no more than 50 uR/hr.

b. The hand-held survey meter is a Victoreen Thyac V digital count rate and survey meter (190) with a scintillation detector model 489-50. This will be used to monitor trash in the storage area.

i. background at Tri-City Healthcare District is approximately 10-20 uR/hr

c. Any reading greater than 50 ur/hr must be held for further decay.

Tri-City Medical Center
Oceanside, California

Environment of Care Manual
Hazardous Material Management

DELETE – combine with Environment of Care Policy: Hazardous Waste and Materials Responsibilities

SUBJECT: Reporting Hazmat Incidents

ISSUE DATE: 10/15
REVIEW DATE(S):
REVISION DATE(S): 10/15

Department Approval Date(s):	~~09/15~~10/21
Environmental Health and Safety Committee Approval Dates(s):	~~09/15~~11/21
Medical Executive Committee Approval Dates(s):	n/a
Administration Approval:	11/21
Professional Affairs Committee Approval Date(s):	~~10/15~~ n/a
Board of Directors Approval Date(s):	10/15

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

~~1. It is the policy of Tri City Healthcare District to implement processes for reporting and investigating hazardous materials and waste spills and exposures.~~

~~B. **RESPONSIBLE PARTIES:**~~

~~1. Employee that discovers the spill~~
~~2. Manager or Director of the area~~
~~3. Director of Safety/ Environment of Care (EOC)~~
~~4. Director of Risk Management~~
~~5. The Director of Safety/EOC will maintain and document information concerning hazardous materials and waste spills and the Director of Employee Health will maintain information and documentation on hazardous material and waste exposures within Tri City Healthcare District owned or operated facilities.~~

~~C. **PROCEDURES:**~~

~~1. All hazardous material and waste spill or exposures must be reported, even if no bodily harm or property loss resulted, utilizing the RL Solutions QRR reporting system~~
~~2. The discovering employee is responsible for completing the report online immediately following the event.~~
~~3. The manager or director is responsible for reviewing the report and performing an investigation as needed within three business days.~~
~~4. The Director of Safety/EOC is responsible for final review of the spills and the Director of Employee Health is responsible for final review of the exposures.~~
~~5. The Director of Safety/EOC is responsible for tracking, trending and analyzing the records of spills~~
~~6. The Director of Safety/EOC will report the information, tracking and trending, and results of investigations for spills and exposures quarterly to the Environmental Health and Safety Committee.~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SAFETY MANAGEMENT

SUBJECT: Environment of Care Tours and Risk Assessment ~~Policy~~

ISSUE DATE: 11/87 **POLICY NUMBER: 1040**
REVIEW DATE~~(S)~~: 01/90, 01/94, 06/08, 09/15
REVISION DATE~~(S)~~: 01/97, 07/00, 04/03, 10/05, 06/11, 10/15

Department Approval Date~~(s)~~:	**~~09/15~~10/21**
Environmental Health and Safety Committee Approval Date~~(s)~~:	**~~09/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval Date~~(s)~~:	**~~10/15~~ n/a**
Board of Directors Approval Date~~(s)~~:	**10/15**

A. **PURPOSE:**
1. **To define the process for identifying and minimizing environment of care (EOC) risk within Tri-City Healthcare District (TCHD).**
2. **Describes the actions required to initiate and conduct an initial risk assessment and the actions required to re-evaluate a risk assessment as part of the annual evaluation of the EC programs**

~~A. POLICY:~~
~~1. It is the policy of the Tri-City Healthcare District to conduct a Risk Assessment of the healthcare environment to evaluate potential and existing hazards and recommend and implement protective measures associated with various tasks performed in each area of the hospital, off-site facilities and campus grounds.~~

B. **DEFINITION:~~PURPOSE:~~**
1. ~~The~~ **R**~~r~~isk **A**assessment – **A systematic approach that involves the proactive evaluation potential and actual environmental risk to a facility, patients, visitors, business associates and workforce members (WFM).**~~is used to evaluate the impact of the environment of care on the ability of the organization to perform clinical and business activities. The impact may include disruption of normal functions or injury to individuals~~.

C. **POLICY~~RESPONSIBILITY~~:**
1. The ~~Director of~~ Safety ~~/EOC~~ Officer **or designee** ~~is~~ responsib**ilities include but are not limited to**~~le for~~ managing the risk assessment process. The responsibilities include:
   a. Participating in the selection of **environment of care team** ~~Risk Assessment Team~~ members.
   b. Scheduling area **environment of care tours**~~assessments~~
   c. ~~Managing the documentation of the~~**Ensuring** -risk assessment ~~process~~**findings are documented**
   ~~c.~~**d. Reviewing and reporting risk assessment findings in the appropriate TCHD committees**

~~D.~~ **~~PRACTICE:~~**
2. Risk Assessments
   ~~1.~~**a.** A risk assessment of all existing programs will be conducted as part of the evaluation of the EC programs.
   ~~2.~~**b.** The risk assessment **findings** will be reviewed periodically or as deemed necessary.
   ~~3.~~**c.** A risk assessment of all new services and of all areas undergoing major renovation, alteration, or conversion will be conducted prior to occupancy and/or use.

~~4.~~**d.** The risk assessment findings will be used to identify protective measures necessary for ensuring personnel / occupant safety and serve as a data source for confirmation during Hazard Surveillance/EOC tours.

~~5.~~**e.** The risk assessment will be submitted to the Environmental Health **and**~~&~~ Safety Committee (EHSC) for review, updates and **modifications**~~changes~~.

f. An initial risk assessment is required whenever a new building is constructed, the purchase of an exsiting building, or when an area undergoes significant renovation or change of use.

g. Risk assessment will also be conducted when widespread risk are identified during environmental tours and as needed.

h. Each department or area requiring an initial risk assessment will be evaluated using an appropriate risk assessment tool. ~~(~~**S**~~s~~**see the sample**~~example~~ **Risk Assessment Tool.**~~)~~**).**

i. The evaluator completes the identified risk tool and scores the risk based on the directions for using the risk tool

j. When scoring, the reviewer will consider information obtained through a physical tour of the facility, regulatory inspections, historical incident reports, accident and injury statistics, previous safety committee minutes, hazard surveillance reports, interviews with department heads & staff members, as well as the current best demonstrated practices

k. The completed risk assessment, including the sections on the form for recommended protective measures required including but not limited to, training, personal protective equipment, policies/procedures, and comments and changes will be presented to the EHCSC for review and approval.

i. Should any situations that constitute immediate danger be discovered during the course of the risk assessment process, they will be reported immediately to the Director of Safety or designee and the appropriate department manager for appropriate corrective action and resolution

~~E. **PURPOSE:**~~

~~1. This procedure describes the actions required to initiate and conduct an initial risk assessment and the actions required to re-evaluate a risk assessment as part of the annual evaluation of the EC programs.~~

3. ENVIORNMENT OF CARE TOURS (EOC Walk-Through Rounds)~~INITIAL RISK ASSESSMENT~~:

a. The Safety Officer or designee will ensure that the ongoing hospital-wide EOC tours program to collect and evaluate the information regarding hazards and safety practices covers each hospital building's department or service, interior or exterior

b. The Environmental Health and Safety Committee (EHSC) members/or designee will survey clinical patient care areas at least bi-annually e.g., at least twice per calendar year and non-clinical care areas at least annually e.g., at least once per calendar year.

c. The survey of clinical and non-clinical areas is completed by the EOC leadership members which will include but is not limited to: Administration, Nursing, Environmental Services, Bio-Med, Facilities, Risk Management, Infection Control, Regulatory Compliance and the Safety Officer or designee

d. Results of inspections will be forwarded to the (EHSC) for discussion and action plans as needed.

i. Inspection reports submitted to the EHSC will contain a summary report of the findings from EOC tours rounding Walk-through Inspection Sheet.

ii. Problems identified during the EOC tours will be reported through the TAMIS System or direct e-mails to the appropriate department leader (Engineering, Environmental Services (EVS), or Biomedical) if repairs are required .

iii. **Issues that cannot be resolved at the time of inspection or through a Work Order, will be communicated to the Department Director via the EHSC.**

iv. **EOC rounding questionnaires will be entered into the Verge data system and forwarded to the EHSC for review.**

v. **The results of the Verge data will be reported to the EHSC for trending and identification of the department specific educational needs.**

~~F.~~

~~1. An initial risk assessment is required . for all areas not having had a risk assessment conducted within the last 3 years.~~

~~a. An initial risk assessment is required whenever a new building is constructed, the organization purchases an existing building, or an area undergoes significant renovation or conversion of use.~~

~~2. Each department or area requiring an initial risk assessment is evaluated using an appropriate risk assessment form(s). *(See Risk Assessment Tool)*~~

~~3.~~**4.** ~~The evaluator completes the .form by identifying the risks related to the environment and the activities conducted in the area. Each risk is scored using the numerical values:1-5 rating scale or color coded scale included in the form.~~

a. ~~To determine the appropriate score for each identified risk, the reviewer will consider information obtained through a physical tour of the facility, regulatory inspections, historical incident reports, accident & injury statistics, previous safety committee minutes, hazard surveillance reports, interviews with department heads & staff members, as well as the current best demonstrated practices~~.

~~4.~~**5.** ~~The Director of Safety/EOC Officer is responsible for identifying an appropriate Risk Assessment Team and scheduling the evaluation of the affected areas~~.

~~5. The completed risk assessment, including the sections on the form for recommended protective measures required including but not limited to, training, personal protective equipment, policies/procedures, and comments and changes will be presented to the EHCSC for review and approval.~~

~~a. Should any situations that constitute immediate danger be discovered during the course of the risk assessment process, they will be reported immediately to the Director of Safety/EOC Officer and the appropriate department manager for appropriate corrective action and resolution.~~

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

1. Risk Assessment Scoring Grid
2. Risk Assessment Tool

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

1. The Joint Commission. **(2021). The Joint Commission Hospital Manual E-Dition**: ~~EC 02.01.01 EP 1&3~~

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Risk Assessment
Scorning Examples

Scoring (color-coded)	Criteria
5 (pink)	A high-risk area with possible life threatening or disabling consequences, as well as some history of associated incidents with serious injury.
4 (violet)	A high or significant risk area with possible life threatening or disabling consequences and no history of associated incidents with serious injury.
3 (yellow)	A moderate risk of minor injury or inconvenience to patients, visitors, or staff.
2 (green)	A minimal risk of minor injury or inconvenience to patients, visitors, or staff.
1 (blue)	Virtually no risk of injury or inconvenience to any one.

Tri-City Medical Center
(Title of Risk Assessment)
Risk Assessment

Date:	
Describe the Issue:	
Those involved in the discussion:	***(Team must include at least 3 individuals but not more than 10)*** **1.** **2.** **3.** **4.**

Place Arguments in support of the issue—why things should remain the same.		**Place Arguments against the issue—why things should change**

Based on the current state determine the severity of harm to the population served by using the scale below.

SEVERITY	LIKELIHOOD				
	1 = Very Unlikely	2 = Unlikely	3 - Possible = National trend in healthcare	4 - Likely = Documented Incident has happened	5 - Very Likely = Documented Incident more than one occasion
5--Catastrophic (Unexpected death, catastrophic financial loss)	Medium	Medium	High	High	High
4--Major (Permanent injury, medical treatment required, moderate financial loss)	Medium	Medium	Medium	High	High
3--Moderate (Semi permanent injury, medical treatment required, moderate financial loss)	Low	Medium	Medium	Medium	High
2--Minor (short term injury, first aid treatment required, minor financial loss)	Low	Low	Medium	Medium	Medium
1--Negligible (No injury, no treatment required, no financial loss.)	Low	Low	Low	Medium	Medium

Likelihood of Harm SCORE: _____ ***(A score of 4 or below is minor, 5-7 medium risk and = or > 8 is HIGH RISK)***

Conclusion (Based on arguments in support, not in support and likelihood to harm score):

Actions (if Applicable):

Timeframe for reassessment, if applicable:	**Date:**	
Responsible for follow up, if applicable:	**Person:**	
Route form to the Pt. Safety Officer/Risk Manager	**Date Completed:**	
Completion of Risk Assessment	**Date Completed:**	

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SAFETY MANAGEMENT

SUBJECT: Safety Plan

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 05/96, 06/97, 07/00, 06/08, 03/11, 06/12, 06/15, 12/17

Department Approval:	**~~11/18~~10/21, 03/19**
Environmental Health & Safety Committee Approval:	**~~11/18~~11/21**
Administration Approval:	**~~03/19~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique risks to the patients served, the **workforce (WFM)** ~~employees~~ and medical staff who use and manage it, and to others who enter the environment.

2. The Environment of Care Safety (EC) Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD).

~~1.~~3. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment. An environmental safety program based on applicable laws, regulations, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD. The specific risks of each environment are identified by conducting and maintaining a proactive risk assessment.

4. The Management Plan for Environmental Safety describes the risk, safety, and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, **WFM**~~staff~~, and other individuals, coming to the organization's facilities.

~~2.~~5. -The management plan and the environmental **safety**~~management~~ program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

6. The program is applied to the Medical Center and all **afflicated**~~offsite~~ clinics and care sites owned and operated by TCHD.

7. The Management Plan for Environmental Safety and associated policies extend~~s~~ to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD.

~~3.~~8. The plan also affects all **WFM,**~~staff~~, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. The identification of specific risks faced by patients and **WFM**~~employees~~, and others is essential for designing safe work areas and work practices.
2. The identified risks and proven risk management practices are used to design procedures and controls to reduce the threats of adverse outcomes. In addition, the identified risks and the procedures and controls are used to educate **WFMs**~~staff~~ to effectively use work environments and safe work practices to minimize the potential for adverse impact on **WFMs,**~~them,~~ patients, and other individuals coming into the environment.
3. Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and

regular environmental rounds are essential management tools for improving the safety of the environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase **WFM**staff knowledge.

C. **OBJECTIVES**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, staff activities, and the care and work environment for patients and **WFMs**~~employees~~ to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.
2. Perform additional risk assessments when changes involving these issues occur.
3. Analyze accidents, incidents, and occurrences to identify root cause elements of those incidents.
4. Make changes in the procedures and controls to address identified root causes of incidents.
5. Conduct ~~environmental (~~EOC~~)~~ rounds in all areas of the hospital and affiliated medical practices. Staff making rounds evaluate~~s~~ the physical environment, equipment, and work practices. Rounds are conducted in all support areas at least annually and all patient care areas at least semi-annually.
6. Present quarterly reports of E**O**C management activities to the ~~e~~**E**nvironmental Health & Safety Committee. The reports from each E**O**C area manager will identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified E**O**C issues. The Safety Officer**/designee** coordinates the documentation and presentation of this information.
7. Assure that all departments have current organization-wide and department specific procedures and controls designed to manage identified risks.
8. Review the risks and related procedures and controls at least once every three years to assure that the E**O**C programs are current.
9. Assign qualified individuals to manage the E**O**C programs and to respond to immediate threats to life and health.
10. Perform an annual evaluation of the management plan and the scope, objectives performance and effectiveness of the **Ee**nvironmental **S**~~s~~afety **P**~~p~~rogram.
11. Design and present environmental safety education and training to all new and current **WFMs**~~employees~~, volunteers, members of the medical staff and others as appropriate.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. **Hospital leaders from the following departments** ~~The Manager of Safety (Safety Officer)~~**security,** ~~, Manager of~~ Risk Management, ~~/Q~~**Q**uality Improvement, ~~Manager of~~ Regulatory Compliance, ~~and~~ Infection **Prevention** ~~Control~~, ~~and the Director of~~ **Facilities.** Engineering **andd Environmental Services will** work as the Environmental Safety Leadership Team (ESLT) to develop the environmental safety program.
2. **The ESLT will:**
   - **a.** ~~They~~ collaborate with leaders throughout the organization to conduct appropriate risk assessments, develop risk related procedures and controls, develop staff education and training materials, and manage day-to-day activities of the environmental safety program.
   - ~~1.~~**b.** ~~They also c~~ollaborate with the Patient Safety Committee to integrate environment of care safety concerns into the Patient Safety program.
   - ~~2.~~**c.** ~~The Environmental Safety Leadership Team~~ coordinate~~s~~ the development of reports to the Environmental Health and Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other environmental safety issues.
3. The Environmental Health and Safety Committee
   - **a.** monitors and evaluates the processes used to manage the environment of care. Members of the Environmental Health and Safety Committee are appointed by the Committee Chair.
   - **b.** The E**HSC**~~nvironmental Health and Safety Committee~~ meets a minimum of four (4)

times per year. During each meeting one or more EC performance management and improvement reports is presented. In addition, reports of the findings of environmental rounds, incident analysis, regulatory changes and other issues are presented as appropriate.

c. The Committee:

i. **A**~~a~~cts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes related to changes in regulations.

ii. **Assigns individuals or groups responsibilities for developing solutions to identified**

~~3.~~ **Assigns individuals or groups responsibilities for developing solutions to identified issues.**

~~4. The Committee assigns individuals or groups responsibility for developing solutions to identified issues. Finally, the Committee maintains a tracking log to assure identified issues are acted on and that analysis of activities after implementation of changes demonstrates that the changes are effective.~~

d. Membership of the Committee includes representation from:

i. ~~-~~Nursing Administration,
ii. Facilities Management,
iii. Risk Management,
iv. Quality Improvement,
v. Human Resources,
vi. Senior Administration,
vii. ~~-~~Bio-Medical Services,
viii. Education,
ix. Medical Staff, Physician representation,
x. Infection **Prevention**~~Control~~
~~5.~~**xi.** ~~and o~~**O**thers as deemed appropriate.

~~6.~~**e.** The Board of Directors of TCHD receives regular reports of the activities of the **E**~~e~~nvironmental **S**~~s~~afety **P**~~p~~rogram from the Environmental Health and Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer**/designee**. The Board collaborates with the Chief Executive Officer (CEO) and other senior leadership to assure budget and staffing resources are available to support the environmental safety program.

~~7.~~**f.** The CEO or designee of TCHD receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT and other appropriate staff to address environmental safety issues and concerns.

~~8.~~**4.** The Emergency Management Program contains provisions for management staff on duty to take immediate, appropriate action in the event of a situation that poses an immediate threat to life, health, or property.

~~9.~~**5.** The Human Resources Department with the assistance from the Education Department and other leadership staff are responsible for the development and presentation of appropriate materials for orienting new staff members to the organization, the department to which they are assigned, and task specific safety and infection control procedures. The orientation and ongoing education and training emphasize patient safety.

~~10.~~**6.** Department leaders are responsible for assuring that all staff actively participates in the environmental safety program by observing established procedures and conducting work related activities in a manner consistent with their training. Department leaders also participate in the reporting and investigation of incidents occurring in their departments and in the monitoring, evaluation, and improvement of the effectiveness of the environmental safety program in their areas of responsibility.

~~11.~~**7.** Individual staff members are responsible for being familiar with the risks inherent in their work and present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job related procedures and controls required to

minimize the potential **for**~~of~~ adverse outcomes of care and workplace accidents.

E. **ELEMENTS OF THE ENVIRONMENTAL SAFETY MANAGEMENT PROGRAM:**

1. Appointment of Environmental Safety Leadership ~~(EC.01.01.01 EP1)~~
   a. The CEO **or designee** appoints a team of qualified individuals to assume responsibility for the development, implementation and monitoring of the environmental safety management program. The ~~E~~ESL~~T~~ includes the Safety Officer**/ or designeel**, Manager of Risk~~, Management~~/Quality Improvement **leader,**~~,~~ Manager of Regulatory Compliance and Infection **Prevention**~~Control~~, and the Director of Engineering.
   b. The ESL~~T~~ coordinates the development and implementation of the environmental safety program and assures it is integrated with the patient safety, infection control, risk management, and other programs as appropriate.
   c. The ESL~~T~~ maintains a current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment of TCHD.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified ~~(EC.01.01.01 EP2)~~
   a. The Emergency Management **P**~~p~~rogram includes specific response plans for TCHD that address implementation of an appropriate intervention whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the Hospital Incident Command System (HICS) all hazards response protocol. An appropriate event incident commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Plan. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, staff, physicians, or visitors or the threat of major damage to buildings or property. The objective of the plan is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
   c. The CEO has appointed the Safety Officer**/hospital appointed personnel**, the Nursing Administrative Supervisor on duty, and the **a**~~A~~dministrator on **c**~~C~~all to exercise this responsibility. These individuals are to assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.
3. Environmental Safety Management Plan ~~(EC.01.01.01 EP3)~~
   a. The Environmental Safety Management Program is described in this management plan. The Environmental Safety Management Plan describes the procedures and controls in place to minimize the potential adverse impact of the environment on patients, staff, and other people coming to the facilities of TCHD. The Environmental Safety Management Program is described in this management plan.
4. The hospital identifies safety risks associated with the environment of care ~~(EC.01.02.01 EP1)~~
   a. The ESL~~T~~ of TCHD performs proactive risk assessments to identify risks that create the potential for personal injury of **WFMs**~~staff or others~~ or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting staff, patients, and others. The risk assessments use information from sources such as ~~environmental "~~EOC~~"~~ rounds, the results of root cause analysis (RCA), incident reports, and external reports such as The Joint Commission Sentinel Event Alerts, C**alifornia Department of Health (C**DPH) All Facilities Letters (AFLs), **California Occupational Safety and Health Administration**Cal/OSHA standards, and F**ood and Drug Administration (F**DA) product recall notices.
   b. The ESL~~T~~ coordinates the risk assessment process with the Director of Engineering, department Directors and others as appropriate.
5. The hospital takes action to minimize or eliminate identified safety risks in the physical

environment ~~(EC.02.01.01 EP3)~~

a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of environmental safety in a planned and systematic manner.

6. Development and Management of Policies and Procedures ~~(LD.04.01.07 EP1 & EP2)~~

a. The Safety Officer **or designee** follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks~~. The Safety Officer assists department leaders with the development of department or job specific environmental safety procedures and controls.~~

b. The organization-wide policies and procedures and controls are available to all departments and services on the organizational intranet. Departmental procedures and controls are maintained by department directors. The department directors are accountable for ensuring that all staff are familiar with organizational, departmental, and appropriate job related procedures and controls. Department directors are also accountable for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each staff member is accountable for implementing the policies, procedures and controls related to **their**~~her/his~~ work processes.

c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years.

d. The Safety Officer assists with the reviews of policies and procedures with department heads and other appropriate staff.

7. The hospital maintains all grounds and equipment ~~(EC.02.01.01 EP5)~~

a. The Director of Engineering (Facilities Management) is responsible for**:**

i. ~~managing~~**Managing** the appearance and safety of the hospital grounds

ii. ~~. In addition, the Director of Engineering is responsible for~~ **A**assuring ~~that the~~ equipment used to maintain the **campus**~~grounds~~ is in proper operating condition

~~a.~~**iii.** ~~and that g~~**G**rounds staff **are**~~is~~ trained to operate and maintain the equipment~~.~~

~~b.~~**iv.** ~~The Director of Engineering (Facilities Management) is responsible for~~ **S**scheduling the work required to maintain the appearance and safety of hospital grounds. ~~The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action.~~

8. Engineering and facilities staff and Security Officers/designee will make regular rounds of the grounds to identify unsafe conditions.

9. The Security Manager and Engineering staff reports all deficiencies to the Director of Engineering (Facilities Management) for appropriate action

~~8.~~**10.** The hospital responds to product notices and recalls ~~(EC.02.01.01 EP11)~~

a. The **Risk** Manager ~~of Safety~~ and the Director of Materials Management coordinate a product safety recall system~~. TCHD utilizes the NRAC E-Class system~~ that is designed to quickly assess safety recall notices; ~~to~~ respond to **recalls** ~~those~~ that affect TCHD,~~;~~ and to **ensure**~~assure~~ all active safety recalls are completed in a timely manner.

b. A quarterly report of safety recall notices that required action to eliminate defective equipment or supplies from TCHD is presented to the Environmental Health & Safety Committee~~. by the Manager of Safety.~~

~~9.~~**11.** The hospital prohibits smoking ~~(EC.02.01.03 EP1 & EP2~~)

a. TCHD has developed a Smoke Free Environment policy. The policy prohibits smoking of any kind (i.e.,~~:~~ cigarettes, cigars, pipe, chewing tobacco, e-cigarettes and vapor producing devices) in any hospital building or **campus**~~grounds~~ by all **WFM**,~~, including~~

~~staff,~~ visitors and patients.

b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement product resources to assist **the WFMs**~~staff~~ and patients with smoking cessation as desired. Staff may purchase tobacco replacement products via Employee Health at a discounted cost.

~~10.~~**12.** The hospital takes action to maintain compliance with its smoking policy ~~(EC.02.01.03 EP6)~~

a. The procedures for managing the use of smoking materials are followed and enforced by all leadership and staff.

~~11.~~**13.** The hospital monitors conditions in the environment ~~(EC.04.01.01 EP1 - EP11)~~

a. The Manager of Risk Management coordinates the design and implementation of the incident reporting and analysis process. The ~~Manager of Safety (~~Safety Officer~~)~~/ **designee** works with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

b. Incident reports are completed **per hospital policy** ~~by a staff member or witness to whom~~ **for incidents reported by patients or visitors.** ~~a patient or visitor incident is reported. The completed reports are forwarded to Risk Management~~. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

c. ~~In addition, t~~**T**~~he Manager of~~ Risk Management ~~and~~ the Safety Officer **or designee** collaborate to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee and the Patient Safety Committee, as appropriate. The Safety Officer **or designee** provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

d. The Safety Officer **or designee** coordinates the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of TCHD.

e. The Environmental Health and Safety Committee and the Patient Safety Committee are responsible for identifying opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

f. The Chairperson of the Environmental Health & Safety Committee prepares quarterly reports to the leadership of TCHD. The quarterly reports summarize key issues reported to the EHSC and PSC ~~committees~~ with their recommendations. ~~The q~~**Q**uarterly report**s are** ~~is also~~ used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to ~~assure Hospital~~ **hospital** leaders ~~that management responsibilities have been carried out.~~ Annual reports are provided to the Board of Directors related to EC, or more often if warranted.

~~12.~~**14.** Environmental tours are conducted annually in patient care areas ~~(EC.04.01.01 EP12)~~

a. ~~Environmental "~~EOC~~"~~ rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each patient care area is scheduled for an environmental tour every twelve months. The Safety Officer **or designee** with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).

b. **EOC** ~~Additional environmental "EOC"~~ tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.

c. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.

~~13.~~**15.** Environmental tours are conducted annually in non-patient care areas ~~(EC.04.01.01 EP13)~~

a. ~~Environmental "~~EOC ~~"~~rounds at TCHD are conducted throughout the year on a schedule prepared by the ESLT. Each non-patient care area is scheduled for an environmental tour annually. The Safety Officer **or designee** with the ESLT coordinates correction of identified deficiencies with the appropriate department director(s).

b. **EOC**~~Additional environmental "EOC"~~ tours are performed when construction or other activities create unusual risks that may require design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.

~~14.~~**16.** The hospital uses its tours to identify deficiencies, hazards, and unsafe practices ~~(EC.04.01.01 EP14)~~

a. The ESLT manages a process of **EOC** ~~environmental "EOC"~~ rounds designed to evaluate staff knowledge and skills, observe current environmental and patient safety practices, and to evaluate environmental conditions. Findings of the environmental rounds are used as a resource for improving environmental and patient safety procedures and controls, updating orientation education and education programs, and improving staff performance.

b. The ESLT analyzes the results of the environmental tours to determine if deficiencies are corrected in a timely manner and to determine if there are patterns or trends that require action to improve practices or environmental conditions.

~~15.~~**17.** ~~Every twelve months t~~**T**he hospital evaluates each environment of care management plan **annually**~~including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. (EC.04.01.01 EP15)~~ **using multiple sources such as analysis of environmental rounds, incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes from appropriate committees.**

~~a. The Manager of Safety (Safety Officer) coordinates the annual evaluation of the management plans associated with the Environment of Care functions.~~

a. ~~The annual evaluation examines t~~**T**he management plans **are reviewed:**

i. to determine if the **plans**~~y~~ accurately represent the management of environmental and patient safety risks.

ii. **to** ~~The review also~~ evaluat**ees the**~~es~~ **the** operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources. The ~~sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of Safety Committee meetings, and analytical summaries of other activities.~~

~~b. The findings of the annual review are presented to the Environmental Health and Safety Committee by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.~~

b. Findings of the annual review are presented to the EHSC. Each report presents a balanced summary of an Environment of Care program for the preceding fiscal year. Each report includes an action plan to address identified weaknesses.

c. ~~In addition, the annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any d~~**D**eficiencies identified on an annual basis will be immediately addressed by a plan for improvement.

d. Effective development and implementation of the plans for improvement will be monitored by the Safety Officer**/designee**.

e. The results of the annual evaluation are presented to the E**HSC**~~nvironmental Health and Safety Committee.~~**for review and if required recommendations.** ~~The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.~~

f. The annual evaluation is distributed to the CEO, Board of Directors, organizational leaders, the P**SC**~~atient Safety Committee, the~~ Quality Assurance Performance Improvement Committee and others as appropriate. The manager of each Environment of Care program is responsible for implementing the recommendations in the report as part of the performance improvement process.

~~16.~~**18.** Analysis and actions regarding identified environmental issues ~~(EC.04.01.03 EP1 – EP3)~~

a. The E**HSC**~~nvironmental Health and Safety Committee~~ receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement.

b. Each time a need for improvement is identified the **EHSC**~~Committee~~ summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the quality improvement program, and the patient safety program.

~~17.~~**19.** Improving the Environment ~~(EC.04.01.05 EP1 – EP 3)~~

a. When the leadership of the hospital, regulatory compliance, quality improvement, or patient safety concurs with the E**HSC**~~nvironmental Health and Safety Committee~~ recommendations for improvements to the environment of care management programs, a team of appropriate staff is appointed to manage the improvement project. The E**HSC**~~nvironmental Health and Safety Committee~~ works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.

b. The E**HSC**~~nvironmental Health and Safety Committee also~~ establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, performance improvement, and patient safety leadership.

~~18.~~**20.** Orientation and Ongoing Education and Training ~~(LD.03.01.01 EP6 & EP8; HR.01.04.01 EP1 & EC.03.01.01 EP1 – EP3)~~

a. Orientation and training addressing the environment of care is provided to each employee, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.

b. ~~In addition, a~~**A**nnual EOC training is provided and documented via NetLearning.

c. The Human Resources **(HR)** Department with participation from the Education Department coordinates the general New Employee Orientation **per HR policies.** ~~(NEO) program. New staff members are required to attend the NEO program within 30 days of their date of employment. The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.~~

d. ~~New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.~~

~~e. The Safety Officer collaborates with the EC managers, department leaders, the Manager of Risk Management/Quality, Manager of Regulatory Compliance and Infection Control, the Patient Safety Officer and others as appropriate to develop content materials for general and job related orientation and continuing education programs. The Safety Officer gathers data during environmental rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how job related physical risks are to be managed or eliminated as part of daily work. In addition, the Safety Officer evaluates the degree to which staff and~~

~~licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.~~

~~f. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating environment of care risks is reported to the Environmental Health and Safety Committee. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.~~

F. **GOALS/OBJECTIVES ~~FOR FY19~~2021-2022:**

1. Complete ~~S~~**s**afety risk assessments for all departments, services throughout **TCHD**~~the medical center and off-site locations~~.
2. **Redesign the EOC touring process and scheduling.**
~~2.~~**3.** Continue to provide education to staff in identifying and reporting Work Place Violence.

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

1. Administrative Policy: Smoke Free Environment ~~#205~~
~~1.~~**2.**

H. **REFERENCE(S):**

1. The Joint Commission (TJC). 2021. The Joint Commission E-Edition: Emergency Manangement Chapter.
2. The Joint Commission (TJC). 2021. The Joint Commission E-Edition: Environment of Care Chapter.

~~1. The Joint Commission/NFPA Life Safety Book for Health Care Organizations (2013)~~
~~2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342~~

Tri-City Medical Center
Oceanside, California

Environment of Care
Safety Management

DELETE - combine with Environment of Care Policy: Risk Assessment 1040

SUBJECT: Safety Walk-Through Program **POLICY NUMBER: 1041**

ISSUE DATE: 11/87
REVISION DATE(S): 7/96, 4/97, 7/00, 6/11, 05/15

Department Approval Date(s):	~~04/15~~09/21
Environmental Health and Safety Committee Approval Dates(s):	~~04/15~~11/21
Administration Approval:	11/21
Professional Affairs Committee Approval Date(s):	~~05/15~~ n/a
Board of Directors Approval Date(s):	05/15

~~A. **POLICY**~~

~~1. The Safety Officer will ensure that the ongoing hospital-wide program to collect and evaluate the information regarding hazards and safety practices covers each hospital building's department or service, interior or exterior~~

~~B. **GUIDELINES**~~

~~1. The Environmental Health and Safety Committee (EHSC) members/or designee will survey clinical patient care areas bi-annually (at least twice per calendar year), and non-clinical care areas annually (at least once per calendar year),~~

~~2. As necessary, results of inspections will be forwarded to the (EHSC) for discussion and action plans as needed.~~

~~a. Inspection reports submitted to the EHSC will contain a summary report of the findings from Environment of Care (EOC) rounding Walk-through Inspection Sheet. Problems identified during the walk-through will be reported through the TAMIS System or direct e-mails to the appropriate department leader (Engineering, Environmental Services (EVS, or Biomedical) if repairs are needed.~~

~~b. Issues that cannot be resolved at the time of inspection, or through a Work Order, will be communicated to the Department Director via the EHSC.~~

~~c. EOC rounding questionnaires will be entered into the Verge data system and forwarded to the EHSC for review. The results of the Verge data will be reported to the EHSC for trending and identification of the department specific educational needs.~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SECURITY MANAGEMENT

SUBJECT: **Security Management Plan**

ISSUE DATE: **01/97**
REVISION DATE~~(S)~~: **01/99, 07/00, 04/03, 12/05, 12/11, 06/15, 12/17, 03/19**

Department Approval:	**~~11/18~~10/21**
Environmental Health & Safety Committee Approval:	**~~11/18~~11/21**
Administration Approval:	**~~03/19~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. **EXECUTIVE SUMMARY:**

1. Each environment of care poses unique security risks to the patients served, the **workforce** ~~employees~~ and medical staff who use and manage it, and to others who enter the environment.

~~1.~~**2.** ~~-~~The **S**~~s~~ecurity **M**~~m~~anagement **P**~~p~~rogram is designed to identify and manage the security risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD)~~. The specific risks of each environment are identified~~ by conducting and maintaining a proactive risk assessment. **The** ~~A~~ security management program **manages identified risks using** ~~based on~~ applicable laws, regulations, and accreditation standards~~. is designed to manage the specific risks identified.~~

~~2.~~**3.** The Management Plan for a Secure Environment describes the security risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the security of patients, **workforce**~~staff~~, and other individuals, coming to the organization's facilities. The management plan and the Security Management Program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.

4. The scope of the program is applied to the ~~m~~**M**edical ~~c~~**C**enter and **affiliated clinics** ~~all offsite care centers~~ owned and operated by TCHD.

5. The Security Management Plan and associated policies extend to ~~all~~ inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD.

~~3.~~**6.** The plan also affects all **workforce**~~employees~~, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Security is a system made up of human assets and technology.

~~1.~~ **Timely identification of changes in the types of TCHD security threats facing are performed through initial and ongoing assessments.**

2. Visible and clandestine components of the system are used to reduce the potential for criminal activity, the threat of workplace violence, and to increase feelings of security among patients, **the workforce** ~~staff~~, and **visitors.**~~others coming to TCHD.~~

~~3. Initial and ongoing assessment of security threats is essential for timely identification of changes in the types of security threats facing TCHD.~~

~~4.~~**3.** Collection and analysis of information about adverse security events provides information to help predict and prevent personal violence, crime, and other incidents.

~~5.~~**4.** **Workforce** ~~Staff~~**members** awareness of security is an essential part of an effective program.

TCHD orients and trains all staff to basic components of the security program, including workplace violence prevention and active threat, along with techniques for managing security risks related to work areas or daily activities.

C. **OBJECTIVES:**

1. Perform an initial proactive risk assessment of the buildings, grounds, equipment, **workforce members'** ~~staff~~ activities, and the care and work environment for patients and **workforce**~~employees~~ to evaluate the potential adverse impact on all persons coming to the facilities of TCHD.
2. Perform additional risk assessments when changes in the campus design or patterns of security events indicate a change in the security threat level.
3. Analyze security incidents and occurrences to identify root cause elements.
4. Conduct ongoing random security patrols **(rounds)** in all areas of the medical center, affiliated business offices and outpatient facilities **to** ~~. Staff making rounds~~ evaluate~~s~~ the physical environment, equipment, and work practices.
   ~~4.~~**a.** Rounds are conducted in all support areas and all patient care areas at least once per day.
5. Present reports of Environment of Care management activities to the Environmental Health and Safety Committee quarterly. The reports identify key issues of performance and regulatory compliance, present recommendations for improvement, and provide information about ongoing activities to resolve previously identified security issues. The ~~Manager of~~ Security **Leadership** coordinates the documentation and presentation of this information.
6. Assure that departments have current organization-wide and as needed department specific procedures and controls designed to manage identified security risks.
7. Review the risks and related procedures and controls at least once every three years to assure that the security program is current.
8. Assign qualified individuals to manage the program and to respond to immediate security threats.
9. Perform an annual evaluation of the management plan ~~and of the scope, objectives performance and effectiveness of the security program~~.
10. **Ensures** ~~Design and present~~ security education and training **is provided** ~~-~~to ~~all~~ new and current **workforce members**~~employees~~, volunteers, ~~members of the~~ medical staff, contract staff and others as appropriate.
11. Provide timely response to emergencies and requests for assistance.
12. Communicate with law enforcement and other civil authorities as needed.
13. Manage access to the grounds, buildings, and sensitive areas of TCHD.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Board of Directors of TCHD receives regular reports of the activities of the Security program from the Environmental Health and Safety Committee. The Board reviews the reports and, as appropriate, communicates concerns about identified issues back to the Safety Officer.
2. The Board collaborates with the Chief Executive Officer (CEO) and other senior leaders to **ensure**~~assure~~ budget and staffing resources are available to support the Security Program.
3. The CEO or designee of TCHD receives regular reports of the activities of the Security program. The CEO or designee collaborates with the ~~Manager of~~ Security **Leader** and other appropriate **workforce members** ~~staff~~ to address security issues and concerns.
4. ~~The Manager of~~ Security **Leadership** works under the general direction of the CEO or designee. The Manager of Security is responsible for managing the Security Program. The ~~Manager of Security reports~~**Security reports** program findings to the Environmental Health and Safety Committee. The reports summarize organizational experience, performance management and improvement activities, and other security issues.
5. Department **L**~~l~~eaders are responsible for orienting new **workforce members according to TCHD, Human Resource and unit/department policies and procedures** ~~staff members to~~

~~the department and to job and task specific security procedures. The orientation and ongoing education and training emphasize patient safety~~

~~5.~~**6.** ~~.~~Department **Leaders**~~heads~~ are ~~also~~ responsible for participating in the reporting and investigation of incidents occurring in their departments.

~~6.~~**7.** ~~Individual staff members are responsible for learning and following job and task specific procedures for secure operations~~.

E. **ELEMENTS OF THE SECURITY PLAN:**

1. Appointment of Security Leadership ~~(SEC.EC.01.01.01 EP1)~~
   a. **A**~~The CEO of TCHD appoints the~~ Safety Officer **or Security Leader is appointed to** ~~, and selects a qualified individual capable of~~ overse**e**~~e~~ing the development, implementation and monitoring of the security program. The Safety Officer/**Security Leader**'s **responsibilities are** ~~job is~~ defined by ~~a~~ job description. The **competency of the Safety Officer/Security Leader competency is** ~~CEO or a designee~~ evaluate**d**~~s the competence of the Safety Officer~~ annually **by the CEO or designee.**~~.~~
   b. The ~~Manager of~~ Security **Leader:**
      ~~b.~~**i.** **C**~~c~~oordinates the development and implementation of the security program and assures it is integrated with the patient safety, information management, and other programs as appropriate~~. The Manager of Security's job is defined by a job description. The CEO or a designee evaluates the competence of the Manager of Security annually.~~
      ii. ~~The Manager of Security~~ **M**~~m~~aintains a current knowledge of laws, regulations, and standards of security
      ~~c.~~**iii.** ~~. The Manager of Security also c~~**C**ontinually assesses the need to make changes to procedures, controls, training, and other activities to assure that the security management program reflects the current risks present in the environment of TCHD.
2. Designation of Persons to Intervene When Immediate Threats to Life, Health, or Property are identified ~~(EC.01.01.01 EP2)~~
   a. The Emergency Management **P**~~p~~rogram includes specific response plans for TCHD t**o implement as** ~~hat address implementation of an~~ appropriate ~~intervention~~ whenever conditions pose an immediate threat to life or health, or threaten damage to equipment or buildings. The response plans follow the ~~HICS~~ (Hospital Incident Command System **(HICS**) all hazards response protocol. An appropriate Incident Commander is appointed at the time any emergency response is implemented.
   b. The Immediate Threat Procedure is included in the Emergency Operations Procedure manual. The procedure lists the communications and specific actions to be initiated when situations posing an immediate threat to patients, **workforce**~~staff~~, physicians, or visitors or the threat of major damage to buildings or property.
      ~~b.~~**i.** The objective of the procedure is to identify and respond to high risk situations before significant injuries, death or loss of property occurs.
      ~~c.~~**ii.** The CEO has appointed the Safety **Leader,**~~Officer,~~ the Nursing Administrative Supervisor on duty, and the Administrator on Call to exercise ~~this responsibility.~~**to** ~~These individuals are to~~ assume the role of incident command and to coordinate the mobilization of resources required to take appropriate action to quickly minimize the effects of such situations.
3. Management Plan for a Secure Environment ~~(SEC.EC.01.01.01 EP4)~~
   a. The Security Management Program is described in this management plan. The security management plan describes the policies, procedures and controls in place to minimize the potential that any patients, ~~staff~~**workforce members**, and other people coming to the facilities of TCHD experience an adverse security event.
4. Proactive Risk Assessment ~~(SEC. EC.02.01.01 EP1)~~
   a. The ~~Manager of~~ Security **Leader** ~~of TCHD~~ coordinates proactive risk assessments to

identify risks that create the potential for personal injury of staff or others or adverse outcomes of patient care. The purpose of the risk assessments is to gather information that can be used to develop procedures and controls to minimize the potential of adverse events affecting **workforce members**~~staff~~, patients, and others.

b. The ~~Manager of~~ Security **Leader** works with department directors, managers, the Patient Safety Officer, Risk Manage~~rment~~ and others as appropriate.

c. The Security Department **is**~~will be~~ responsible for enacting proactive security measures as follows:

i. Scheduling patrolling of the Medical Center and parking lots to help prevent work place violence/**in**~~ac~~cidents.

ii. Locking/unlocking of exterior doors, departments, and associated rooms; **and** on-going inspections of all sensitive areas throughout the Medical Center.

iii. Ensuring ~~that~~ all **workforce members**~~employees~~ and physicians properly display their photographic identification badges at all times.

iv. Submitting reports to the Director of Engineering **or designee** pertaining to security and safety violations, including but not limited to: defective lighting, damaged equipment, unsafe situations or conditions that may present a danger to others.

v. Maintaining unrestricted locations for the timely loading and unloading of persons seeking medical treatment in the Emergency Department **(ED)** and Women's Center.

~~v.~~**vi.** Security will also ensure a location for long-term vehicle parking.

~~vi.~~**vii.** Monitoring the Security Department **Closed Circuit Television** (CCTV)~~.~~

~~vii.~~**viii.** Providing campus escort services 24 hours per day as needed for employees and visitors.

5. The hospital takes action to minimize or eliminate identified security risks in the physical environment ~~(EC.02.01.01 EP3)~~

a. The results of the risk assessment process are used to create new or revise existing procedures and controls. They are also used to guide the modification of the environment or the procurement of equipment that can eliminate or significantly reduce identified risks. The procedures, controls, environmental design changes, and equipment are designed to effectively manage the level of security in a planned and systematic manner.

b. In response to ~~the 2016~~ Cal/OSHA, Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations, TCHD has created new environmental risk assessment tools and general employee education programs.

c. TCHD has ~~elected to~~ implement**ed** the Non-Violent Crisis Intervention Program (NVCI) for the mandated training of **workforce members**~~staff~~ working in high-risk areas ~~in~~**per** ~~compliance with~~ the California Health and Safety Code Section 1247.7 and 1257.8. The~~is~~ training includes**, but is not limited to the following**:

i. General safety measures.
ii. Personal safety measures.
iii. The assault cycle.
iv. Aggression and violence predicting factors.
v. Characteristics of aggressive and violent patients and victims.
vi. Verbal and physical maneuvers to diffuse and avoid violent behavior.
vii. Strategies to avoid physical harm.
viii. Restraining techniques.
ix. Resources available to employees coping with violence (stress debriefing, employee assistance programs, etc.).

d. ~~-~~The NVCI program will be offered to ~~ancillary~~**ancillary** staff routinely assigned to the Emergency Department. Ancillary department managers will be responsible for determining staff appropriate for this training.

6. Development and Management of Policies and Procedures ~~(LD.04.01.07 EP1 and EP2)~~
   a. The ~~manager of~~ Security **Leader** follows the administrative policy for the development of organization-wide and department specific policies, procedures, and controls designed to eliminate or minimize the identified risks. ~~The manager of~~ Security assists department leaders with the development of department or job specific environmental safety procedures and controls.
   b. The organization-wide policies, procedures and controls are available to all departments and services on the organizational intranet. Departmental policies, procedures and controls are maintained by department directors **who**~~. The directors~~ are responsible for ensuring ~~that~~ **their workforce are**~~all staff is~~ familiar with organizational, departmental, and appropriate job related policies, **and** procedures~~. and controls~~. Department directors are also responsible for monitoring appropriate implementation of the policies, procedures and controls in their area(s) of responsibility. Each **workforce** ~~staff~~ member is responsible for implementing the policies, procedures and controls related to her/his work processes.
   c. The policies, procedures and controls are reviewed when significant changes in services occur, when new technology or space is acquired, and at least every three years. The ~~manager of~~ Security **Leader** coordinates the reviews of procedures with department leaders and other appropriate **workforce members.**~~staff.~~
7. Identification of Patients, Staff, and Others Entering the Facility ~~(SEC.EC.02.01.01 EP7)~~
   a. The identification **(ID)** of **workforce members are**~~staff is~~ an interdisciplinary function. Several Directors share responsibility for designing identification systems and establishing procedures and controls to maintain the effectiveness of the systems.
   b. The current systems in place ~~at TCHD~~ include photographic ID badges for all **workforce**~~staff~~, volunteers, students, contracted staff and members of the medical staff;~~,~~ password systems to limit access to authorized users of information system applications, physical security systems to limit access to departments and areas of the hospital, and distinctive clothing/badges to facilitate rapid visual recognition of critical groups of **the workforce**~~staff~~.
   c. The **ID**~~identification~~ of patients is also an interdisciplinary function. The current system includes personal identification of patients in medical records and by use of various arm band systems.
   d. The identification of others entering TCHD is managed by the Security and Materials Management Departments. The ~~manager of~~ Security **Leader** in collaboration with the CEO or designee and other appropriate **workforce members**~~staff~~ provides a secure environment that requires identification of all contractors/vendors and the badging of visitors to the various areas of the facility. The Director of Materials Management manages the procedures for identification of vendors. The ~~manager of~~ Security **Leader** takes appropriate action to remove unauthorized persons form areas and to prevent unwanted individuals from gaining access to TCHD.
8. Identification and Management of Security Sensitive Areas ~~(SEC.EC.02.01.01 EP8)~~
   a. The following areas have been designated as sensitive areas:
      i. Emergency Department~~.~~
      ii. Maternal Child Health~~.~~
      iii. Neonatal Intensive Care Unit~~.~~
      iv. Pharmacy Department~~t~~.
      v. Human Resources Department~~.~~
      vi. Adult Critical Care Unit~~.~~
      vii. Information Technology~~.~~
      viii. Administration~~.~~
      ix. ~~3rd Floor Center Tower~~ Progressive Care Unit~~.~~
      x. Medical Records Office and Storage areas~~.~~
      xi. Nuclear Medicine Hot Lab~~.~~

b. **Workforce members** ~~Staff~~ in each sensitive area participates in training addressing the unique risks of the area and the procedures and controls in place to manage them. Key personnel and security staff receive specialized training related to processes in high risk security areas.

c. The Security Plan has a program for the inspection, preventative maintenance and testing of the following security equipment:

i. Emergency Department:
1) Electronic access control.
2) Panic buttons.
3) Closed Circuit Television (CCTV) cameras.
4) Security Officer Station – Posted 24 hours per day.

ii. Women and Newborn Services Units:
1) Electronic access control.
2) Access Control System CCTV.
3) Department policy in place for identifying visitors.
4) Department procedure for uniquely identifying mother-infants.
5) Teaching program to educate parents or guardians to explain the security processes.
6) Unique identification for staff members.
7) Unique **v**~~V~~isitor ~~B~~**b**adge identification for visitors.

iii. Neonatal Intensive Care Unit:
1) Electronic access control.
2) Panic buttons.
3) The Maternal Child Health units are protected with both active video surveillance systems on entrances and exits of the units. ~~Additionally, t~~**T**he unit has electronic access control systems for entrances and exits that alarm if unauthorized entry or exit occurs.

iv. Pharmacy Department:
1) Electronic access control~~.~~
2) Infrared Security System~~.~~
3) Panic buttons~~.~~

v. Business Office:
1) Electronic access control~~.~~
2) Panic buttons~~.~~
3) Local area surveillance system~~.~~

vi. Human Resources department:
1) Panic buttons~~.~~
2) Access Control System CCTV~~.~~

vii. Adult Critical Care Unit:
1) Electronic access control~~.~~

viii. Case Management:
1) Panic buttons~~.~~

9. Management of Security Incidents Including an Infant or Pediatric Abduction ~~(SEC.EC.02.01.01 EP9)~~

a. The ~~Manager of~~ Security **Leader** has developed procedures for rapid response to breaches of security. ~~The o~~**O**n-duty Security Officers and local police have the manpower and technological resources to respond to a wide variety of incidents. The ~~manager of~~ Security **Leader** or a designee is responsible for assessing breaches of security and determining what resources are required to respond effectively.

b. The ~~Manager of~~ Security **Leader**, Safety **Leader**~~Officer~~ and ~~the~~ Director of Women's and Children's Services are responsible for the design and management of systems to reduce the threat of abduction of infants or children and to respond to any threats of or actual abductions.

c. A Code Adam is announced over the paging system, as well as selected radios when a potential or actual abduction has occurred.
   i. All available **workforce**~~staff~~ respond~~s~~ per the Patient Care Services Code Adam.
   ii. The Code Adam plan is tested at least annually and the responses are documented, evaluated, critiqued and as appropriate corrective activity, additional training, or program improvements are made.

d. The ~~Manager of~~ Security **Leader** and ~~the~~ Director of Women and Newborn Services are required to conduct at least one abduction drill annually.

~~d.~~**i.** ~~In addition, a~~**A**ctivations of the abduction alert system and all attempted or actual abductions of infants or children are treated as security incidents and reported and analyzed appropriately.

10. The hospital monitors conditions in the environment ~~(EC.04.01.01 EP1 – EP11)~~

a. ~~The Director of~~ Risk Management coordinates the design and implementation of the incident reporting and analysis process.

~~a.~~**b.** The ~~manager of~~ Security **Leaders** works with ~~the Director of~~ Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, staff member incidents, and property damage related to environmental conditions.

~~b.~~**c.** Incident reports are completed by the staff member or witness to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

~~c.~~**d.** ~~In addition, the Director of~~ Risk Management and ~~the manager of~~ **the** Security **Leader** collaborate to conduct an aggregate analysis of incident reports generated to determine if there are patterns of deficiencies in the environment or **workforce members** ~~staff~~ behaviors that require action. The findings of such analysis are reported to the Environmental Health and Safety Committee **(EHSC)** and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Committee Chairpersons provide summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

~~d.~~**e.** The ~~Manager of~~ Security **Leader** works with the **EHSC** ~~Environmental Health and Safety Committee~~ to collect information about security deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, support services, and a representative from each of the six environments of care functions use the information to analyze safety and environmental issues and to develop recommendations for addressing them.

~~e.~~**f.** The **EHSC** ~~Environmental Health and Safety Committee~~ and the Patient Safety Committee are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the Environment of Care Management Programs.

~~f.~~**g.** The Safety **Leader**~~Officer~~ and the Patient Safety Committee prepare a quarterly report to the leadership of TCHD. The quarterly report summarizes key issues reported to the Committees and the recommendations of them. The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to **ensure**~~assure~~ leaders of management responsibilities have been carried out.

11. **Annually**~~Every twelve months th~~**th**e hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan. ~~(EC.04.01.01 EP15)~~

a. The Safety **Leader**~~Officer~~ coordinates the annual evaluation of the management plans associated with each of the Environment of Care functions.

b. The annual evaluation examines the management plans to determine if they accurately

represent the management of environmental and patient safety risks. The review also evaluates the operational results of each E**nvironment of** C**are (EC)** program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources.

i. The sources include aggregate analysis of environmental rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers,~~ and~~ consultants, minutes **from** ~~of~~ **appropriate committees**~~Safety Committee meetings~~, and analytical summaries of other activities.

ii. The findings of the annual review are presented to the E**HSC**~~nvironmental Health and Safety Committee~~ by the end of the first quarter of the fiscal year.

iii. Each report presents a balanced summary of the E**HSC**~~nvironment of Care~~ program for the preceding fiscal year.

~~c.~~**iv.** Each report includes an action plan to address identified **risk**~~weaknesses~~s.

c. ~~In addition, t~~**T**he annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review.

d. **Identified risk or** ~~Any~~ deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety **Leader**~~Officer~~.

e. The results of the annual evaluation are presented to the E**HSC**~~nvironmental Health and Safety Committee~~. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes. The annual evaluation is distributed to the C**EO**~~hief Executive Officer~~, the Board of Directors, organizational leaders, the Patient Safety Committee, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues ~~(EC.04.01.03 EP1 – EP3)~~
    a. The E**HSC**~~nvironmental Health and Safety Committee~~ receives reports of activities related to the environmental "EOC Rounding" program at least quarterly.
    b. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified; the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital and the Patient Safety Committee as indicated.
13. Improving the Environment ~~(EC.04.01.05 EP1 – EP3)~~
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with the E**HSC**~~nvironmental Health and Safety Committee~~ recommendations for improvements to the environment of care management programs, a team of appropriate **workforce**~~staff~~ is appointed to manage the improvement project. The E**HSC**~~nvironmental Health and Safety Committee~~ works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The E**HSC**~~nvironmental Health and Safety Committee will also~~ establish**s** a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital, quality improvement, and patient safety leadership.
14. Orientation and Ongoing Education and Training ~~(LD.03.01.01 EP6 and EP8; HR.01.04.01 EP1 and EC.03.01.01 EP1 – EP3)~~
    a. Orientation and training addressing the environment of care and workplace safety is provided to each **workforce membe**~~employee~~, contract staff and volunteer. All Licensed Independent Practitioners (LIP) receive orientation to the Environment of Care and workplace safety in accordance with the Medical Staff policies and bylaws.
    b. ~~In addition, a~~**A**nnual E**OC**~~nvironment of Care~~ and workplace safety training is provided and documented via NetLearning.

~~c.~~ The Human Resources Department with assistance from the Education Department coordinates the general New Employee Orientation (NEO) program **per HR and the Education Department policies and procedures** ~~. New employees are required to attend the general NEO orientation program within 30 days of their date of employment. The Human Resources Department and the Education Department maintains attendance records for each new staff member completing the general orientation program.~~

~~d.~~**c.** ~~New staff members are also required to participate in orientation to the department where they are assigned to work. The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures and controls in place to minimize or eliminate them during routine daily operations.~~

~~e.~~**d.** The Safety **Leader**~~Officer~~ collaborates with the E**OC**~~nvironment of Care~~ leaders, the manager of Quality Improvement, Infection Control, Patient Safety Officer and others as appropriate to develop content materials for general and ~~job related~~**job-related** orientation and continuing education programs. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed as part of the annual review of each E**OC**~~nvironment of Care~~ program and revised as necessary.

~~f.~~**e.** The Safety **Leader**~~Officer~~ gathers data during environment of care rounds and other activities to determine the degree to which staff and licensed independent practitioners are able to describe or demonstrate how ~~job related~~**job-related** physical risks are to be managed or eliminated as part of daily work. The environment of care rounds **(tours)** ~~evaluate~~**evaluates** the degree to which **workforce members**~~staff~~ and licensed independent practitioners understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.

~~g.~~**f.** Information about **the workforce**~~staff~~ and **LIPs**~~licensed independent practitioner~~ knowledge and technical skills related to managing or eliminating environment of care risks is reported to the E**HSC**~~nvironmental Health and Safety Committee~~. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

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

1. Patient Care Services: Code Adam Policy

G. **REFERENCE(S):**

1. The Joint Commission Environmental of Care Standards
2. Cal/OSHA Workplace Violence Prevention in Healthcare, Title 8, Chapter 4, § 3342 regulations

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
SAFETY MANAGEMENT

SUBJECT: Visitor Safety **POLICY NUMBER: 1023**

ISSUE DATE: 11/87
REVISION DATE~~(S)~~: 1/97, 7/00, 05/15

Department Approval ~~Date(s)~~:	**~~04/15~~10/21**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~04/15~~11/21**
Administration Approval:	**11/21**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **POLICY**

1. Tri-City Healthcare District **(TCHD)** ~~r~~recognizes its responsibility **for protecting the safety of** ~~to~~ visitors, vendors and contractors who are on **the internal and external** ~~its~~ premises to protect their health and well-being
   ~~1. Internal safety: while the visitor is within the confines of the building.~~
   ~~2. External safety: while the visitor is anywhere on hospital grounds including the parking lot.~~
2. **Visitors with bare feet are not permitted in the internal premises.**
~~2.~~**3.** The hospital is a non-smoking campus, including all electronic and vapor style devices.

B. **DEFINITIONS**

1. **Internal safety – while the visitor is within the confines of the building**
2. **External safety – while the visitor is anywhere the hospital main campus including the parking lot**

~~B. GUIDELINESPROCEDURE~~

~~1. Any hospital visitor who has an accident on the premises is entitled to immediate first-aid and whatever is necessary to preserve life.~~
~~If the injured visitor requires hospitalization, he will be assigned to an attending staff physician~~**d**

C. **GUIDELINES**

1. **TCH visitor who has an incident on the premises is entitled to immediate first-aid and the necessary medical assessment and treatment.**
2. **If the injured visitor requires hospitalization, an attending staff physician will be assigned**
3. **If an injuried visitor desires hospitalization elsewhere, arrangements will be made for transfer to their requesting facility, based on TCHD policies for transferring patients**
4. **Visitors incidents occurring at affiliated sites call 911 to facilitate management of injury and transport for emergency evaluation.**

D. **REPORTING**

1. **The report of injury (RL Solutions reporting system) is to be completed by the department director or designee in whose area the incident occurred.**
2. **The director or designee will notify Security as soon as possible to complete the incident report investigation.**
3. **All records of the visitor incident will be reviewed by the Risk Manager.**

~~2.~~**4.** ~~.~~ If the visitor desires hospitalization elsewhere, arrangements will be made for transfer

~~1. The report of injury) (RL Solutions incident report) is to be completed by the Department Director (or designee) in whose area the accident occurred. Security should be notified as~~

~~soon as possible so that a security incident report investigation can be completed. All records of visitor accidents will be reviewed by Risk Management Department.~~

~~3. Visitors with bare feet are not permitted in the Hospital.~~

5. The hospital is a non-smoking campus, including all electronic and vapor style devices.

~~4. **If a visitor safety incident occurs off of TCMC's main premises, then refer to that off-site's policies and procedures for follow-up.**~~

~~C.~~E. RELATED DOCUMENTS:

1. Administrative Policy Incident Report – RL Solutions
2. Administrative Policy Smoke Free Environment 205

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**03/02**	**SUBJECT:**	**Infection Prevention Risk Assessment ~~and Surveillance Plan~~**
REVISION DATE(S):	**07/13, 08/14, 05/16, 03/17, 02/18 03/19, 02/20**		

Infection Control Department Approval:	**~~03/20~~06/21**
Infection Control Committee Approval:	**~~03/20~~07/21**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~10/21**
Administration Approval:	**~~05/20~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE ~~OF RISK ASSESSMENT~~:**

1. **Tri-City Medical Center conducts an annual Infection Prevention (IP) risk assessment to identify the associated risks for the transmission and acquisition of infectious agents throughout the hospital. It pertains to patients, licensed independent practitioners, staff, volunteers, students, visitors and family. The Risk Assessment is based on the geographic location of the hospital, the program/services provided, and the characteristics of the patient population served, community needs, and the results of analysis of the hospital's infection prevention data from CY 2020. The Risk Assessment is formally reviewed at least annually and periodically reassessed whenever significant changes occur in any of these factors.** ~~Sound epidemiological principles must be considered in the formation of the surveillance program designed to provide maximum information and identify opportunities to reduce disease. Measures directed toward cost-effective care must include best practice and technology to prevent infection. The economic impact of an efficient and flexible infection control plan is especially relevant in times of changing reimbursement and payment patterns. Tri-City Healthcare District's (TCHD) plan outlines how this may be accomplished within the confines of resources, external regulatory guidelines, and medical staff requirements.~~

~~B. TABLE OF CONTENTSPURPOSE OF SURVEILLANCE:~~

~~IP Program Management and Resources~~
~~Geographic Review~~
~~Demographic Review~~
~~Community Outbreaks~~
~~Location of All Services Within Acute Care Setting~~
~~Patient Population Served and Clinical Focus~~
~~Employee Health Review~~
~~Review and Evaluation of FY2020 Hospital Surveillance~~
~~Risk Analysis for CY 2021 – Prioritized Risks Identified~~

~~1. Goals, Objectives and Strategies to Manage Risks~~ ~~The foundation of and most important purpose of this program is to decrease the risk of infectious complications for all patients, healthcare workers, visitors and staff. Ongoing epidemiological information assists with identifying at risk populations and opportunities to interrupt, prevent or reduce the occurrence of healthcare-associated infections. Surveillance will be compared to nationally recognized benchmarks such as the National Healthcare Safety Network (NHSN) rates whenever possible.~~

~~C.~~**B. ~~RESPONSIBILITY~~INFECTION PREVENTION PROGRAM MANAGEMENT AND RESOURCES:**

1. **The hospital identifies the individual(s) with clinical authority over the IP program. The Medical Director of the IP program has the clinical authority over the IP program. The Medical Director serves as the Infectious Disease Specialist and chair of the Infection Prevention Committee.**
2. **The hospital assigns responsibility for the daily management of IP activities to the Infection Preventionist. The Infection Preventionist is the individual with the clinical and administrative authority over the implementation of the daily management of the IP program. The Infection Preventionist reviews program issues with the Medical Director of the IP Program. The current FTEs assigned to the IP program is 1.6. Additional hours have been approved for the Medical Director to provide dedicated services to the IP program.**
3. **The Infection Preventionist has administrative duties that include the following:**
   a. **Developing polices governing control of infections and communicable diseases.**
   b. **Implementing policies governing control of infections and communicable diseases.**
   ~~1.~~**c. Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases.** ~~Successful creation of an organization-wide infection control program requires collaboration with all relevant components/functions. Individuals within the hospital who have the power to implement plans and make decisions related to prevention and control of risks related to infections are included in the design and coordination of processes. In consultation with the Medical Staff, Directors, Medical Director of Infection Control, Environmental Health and Safety Committee, Safety Officer and the Infection Control Committee, the Infection Preventionist (IP) shall identify and have oversight to ensure all hospital practices are performed in a manner which prevents cross contamination. The infection control risk assessment and surveillance plan will implement a systematic process for monitoring and evaluating the quality and effectiveness of the infection control program. Significant deviations are discussed in Infection Control Committee, Quality Improvement Medical Staff Committees as needed, Environmental Health and Safety Committee, Safety Committee and QAPI Committee for further action and follow up.~~

~~2. Infection Prevention and Control Services is staffed with an Infection Preventionist~~ **~~and an Infection Control RN~~**~~. There are computer resources with Internet connection, Microsoft Office software, NHSN National internet based database, a real-time electronic data mining surveillance tool and access to the hospital's electronic medical records (Cerner and Affinity). Telephone with voice mail, and fax access is provided. The office is located within the Surgical Scheduling office.~~

~~3. Infection Control Services works in conjunction with~~ **~~staff and leaders within all departments of the facility~~**~~others, as a consultant and resource for best practices. We support system changes and an interdisciplinary focus to improving care. We believe that all our employees, medical staff, and volunteers play an important role in preventing and controlling infections. Ultimately, the leadership team within the district is responsible for adopting and ensuring compliance with appropriate policies and practices.~~

~~D.~~**C. ~~LINKS WITH INTERNAL SOURCES~~GEOGRAPHIC REVIEW:**

1. The geographic location of TCMC is in a suburban area, adjacent to multiple outpatient/office facilities, freeways, and shopping centers in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is currently home to 3.1 million residents, as of July 1, 2019. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).

~~2.~~

~~E.~~**D. DEMOGRAPHIC REVIEW**

1. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so. As of 2019, the largest San Diego County racial/ethnic groups are White (45.6%) followed by Hispanics (33.7%) & Asian (11.6%). Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment. Approximately, 38.8% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population.

~~2.~~

~~F.~~E. LOCATION OF ALL SERVICES WITHIN ACUTE CARE SETTING

~~G.~~1.

Lower Level				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
	Assembly Rooms			
	Cafeteria			
	Employee Health			
	Medical Records			
	Pharmacy			
	Sterile Processing			
	Quality/Risk/Infection Prevention			
Level 1				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
North Wing	Acute Rehab	X		
South Tower	ICU	X		
Pavilion	Cardiology Services		X	X
1st floor	Emergency		X	
1st floor	Laboratory			X
1st floor	Pulmonary Rehab		X	X
1st floor	Radiology	X	X	X
~~**Level 2**~~				
~~**Location**~~	~~**Departments**~~	~~**Inpt/OBV**~~	~~**OutPt**~~	~~**Ambulatory**~~
Level 2				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
North Wing	Labor and Delivery	X		
Center Tower	Mother Baby/Post Partum	X		
South Tower (~~12~~E/~~21~~W)	Patient Rooms	X		
Pavilion (2P)	Patient Rooms	X		
Level 3				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
Center Tower	PCU (Forensics)	X		
Pavilion **(3P)**	Patient Rooms	X		

South Tower **(3E/3W)**	Patient Rooms	X		
South Tower	NICU	**X**		
Level 4				
Location	**Departments**	**Inpt/OBV**	**OutPt**	**Ambulatory**
Pavilion (4P)	**Patient Rooms**	**X**		
South Tower (4E/4W)	**Patient Rooms**	**X**		

1. ~~On at least an annual basis, the **Infection Prevention and Control (IPC)**IP department will meet with the affected departments (i.e. Medical Staff and Employee Health) to assess whether the goals and priorities have been achieved and what steps are required to implement any indicated changes. The goals are shared with and reviewed by the Infection Control Committee. Education on infection control goals and priorities will be included with quarterly reports and during individual meetings with the hospital leadership. The IP**C** staff reports to Infection Control Committee **monthly**quarterly and attends other medical staff and hospital committees as requested, regulatory requirements and department specific Quality Reports are reviewed.~~

~~H. LINKS WITH EXTERNAL SOURCES:~~

1. ~~The San Diego County Public Health Department, state health authorities, the Division of Occupational Safety and Health, and other recognized infection control specialists, for example, the Centers for Disease Control and Prevention (CDC), Association for Professionals in Infection Control and Epidemiology (APIC), Society for Healthcare Epidemiology of America (SHEA), and the California Healthcare Association (CHA) are important links between the district and outside resources. Infection Control department subscribes to automatic notifications available via email from the CDC, San Diego County Public Health (CAHAN) and California Department of Health and Human Services. Infection surveillance covers a broad range of processes and activities with potential for intervention and these organizations assist with the where, when, and how of targeting.~~
2. ~~Healthcare associated infections (HAI) are reported by the IP**C** staff to the external healthcare organizations when the infection was not known at the time of transfer. TCHD receives reports from outside organizations when a patient develops an infection that might meet criteria for a healthcare associated infection. Home Health/Hospice quality review staff report directly to Infection Control Committee.~~
3. ~~The following conditions will be reported to external healthcare organizations with the intent to satisfy The Joint Commission IC 02.01.01(and recorded in the patient's electronic medical record (EHR). The Infection Surveillance Report will document notification to the referring healthcare organization within 7 days of discovery by the TCHD Infection Prevention and Control Staff:~~
   a. ~~Positive culture from a surgical site and surgery performed at another facility.~~
   b. ~~Influenza rapid test is positive and patient was discharged to another healthcare facility prior to results being known.~~
   c. ~~Positive C difficile toxin test known after the patient was discharged to another healthcare facility.~~
   d. ~~Positive MDRO culture known after the patient was discharged to another healthcare facility and the patient had no history of the same MDRO.~~
   e. ~~Unusual occurrences based on the opinion of the Infection Prevention staff in consultation with the Infection Control Medical Director and Director of Regulatory Compliance.~~

~~I. PERTINENT RISK FACTORS:~~

1. ~~Each facility is unique and we considered the following factors in our planning.~~

~~a. National and international published scientific studies, community standard of care, professional recommendations and regulatory requirements.~~
~~b. A review of hospital specific surveillance data from years past.~~
~~c. Medically fragile and at-risk populations such as newborns and those with invasive devices.~~
~~d. The increasing antibiotic resistance in our facility and across the United States and the nation (as reported by the CDC in NHSN).~~
~~e. The vaccination/immunity rates of the community and employees.~~

~~J. **EPIDEMIOLOGICAL FACTORS: INTERNAL AND EXTERNAL:**~~

~~1. TCHD is impacted by factors such as location, population served, community health, financial status, population age, clinical focus, and healthcare worker demographics and these were included in our planning.~~
~~2. The hospital's geographic location is in northern San Diego County. San Diego County is the second most populous of California's 58 counties, and the fifth largest county in the United States. San Diego is home to 3.34 million residents, as of July 1, 2018.~~
~~3. Located within the North County geographic region are 3 college campuses along with a Marine Corp Base (Camp Pendleton).~~
~~4. San Diego County is becoming increasingly bicultural due to its close proximity to Mexico. In addition, the county is already ethnically diverse, and will be increasingly so.~~ **~~As of 2019, t~~**~~The largest San Diego County racial/ethnic groups are White (~~**~~45.6~~**~~64.7%) followed by Hispanics (~~**~~33.7~~**~~33.5%) & Asian (~~**~~11.6~~**~~16.79%). Approximately 21.5% of the county's populations are immigrants, including refugees, who come from other countries, speak many different languages, and have a variety of needs as they assimilate into their new environment.~~ **~~Approximately,~~** ~~38.8% of people in San Diego County speak a non-English language. The senior and disabled populations are growing disproportionately compared to the rest of the population.~~ **~~San Diego's homeless population is one of the largest in California. As of 2017, increasing trends seen in the homeless population are serious mental illness and substance/alcohol abuse.~~** ~~Since 2015, San Diego County has become the 4th largest population of homeless individuals in the US.~~

~~5.~~**2. According to the US Census Bureau 2019 QuickFacts, the ~~D~~d**emographic information ~~(as of 2017)~~ on the three cities most often served by TCHD is listed below.

City	Median income	Total # residents	White	Hispanic	Asian ~~& Pacific Islander~~	African American
Oceanside	$ 72~~4~~,69~~7~~~~09~~	17**5,742**~~6,193~~	46.**8**~~9~~ %	36.2%	7.**8**~~4~~%	4.**9**~~5~~%
Vista	$ ~~68,130~~**72,125**	101,**638**~~568~~	**39.6**~~40~~ %	**50.9**~~52.4~~ %	**4.2**~~3.4~~%	**3.1**~~2.7~~%
Carlsbad	$ 1**10,478**~~01, 6461~~	115,3**82**~~30~~	7~~3~~**2.3**~~2~~ %	1**34.9**~~3~~%	**8.0**~~7.8~~%	0.9%

~~a. http://www.city-data.com/city/Oceanside-California.html~~
~~b. http://www.city-data.com/city/Vista-California.html~~
~~c. http://www.city-data.com/city/Carlsbad-California.html~~

~~6. Enteric illness represents a significant burden of disease in the US and because of this the San Diego County Health and Human Services Agency conducts outbreak investigation and education to reduce the medical and cost-related impact of these diseases in the community. Food borne illnesses largely result from the ingestion of food or water contaminated by fecal matter or ingestion of infected animal products. Hospitals play an important role in early intervention by the identification and reporting of significant bacteria. The most common~~

~~mandated reported enteric illnesses in SD County are Campylobacter, Hepatitis A, Salmonella and Shigella.~~

~~7.~~ **~~From 2018 to 2019 reported cases and rates of chlamydia, gonorrhea and early syphilis increased in San Diego County. Cases of early syphilis increased by 56.4% from 55 cases to 86 cases in 2019. Congenital syphilis rates have steadily increased from 2015 through 2019. Expanded syphilis screening recommendations for pregnant women were implemented in early 2021 by CDPH. While the number of newly diagnosed cases of HIV has steadily decreased in San Diego County over the years, the number living with HIV continues to increase.~~** ~~In San Diego, overall rates for Chlamydia and Gonorrhea have increased since 2018, while cases of early Syphilis have decreased slightly. National trends were reflective at the local level, including high rates of STD's among young women and MSM (men who have sex with men). San Diego County has the third largest number of HIV & AIDS cases in California.~~

8. ~~In 2019~~**8**, San Diego County reported **265**~~226~~ new active TB (tuberculosis) cases, compared with **226**~~237~~ in 201**8**~~7~~. In 201**9**~~8~~, San Diego County's annual TB incidence was **7.9**~~6.8~~ cases per 100,000 persons, which is higher than the California state rate of 5.3, and more than twice the national rate of 2.**7**~~8~~.

~~In 2020, San Diego County reported 192 new active TB (tuberculosis) cases, compared to 265 in 2019. In 2020, San Diego County's annual TB incidence was 5.7 cases per 1000,000 persons. This rate has fluctuated over the past decade remaining less than 9 per 100, 000. The substantial decrease in 2020 may be due to impact of the pandemic, and examination of the decrease is underway.~~

~~An estimated 80% of active TB cases are due to the progression of LTBI (latent tuberculosis infection) to active TB.~~ **~~About 175,000 San Diegans have LTBI, which can progress to active TB without treatment.~~**

~~9. TB drug susceptibility information was available for 197 cases (99%) of 198 culture proven cases for 2018 in San Diego. Resistance to at least one of the 4 major first line drugs was found among 41 (21%) of these specimens. A multidrug-resistant (MDR TB) strain was found in 3 (1.5%) of the cases. Vigilance in diagnosing MDR TB and close monitoring of treatment is of extreme importance because of the complexity of treating such patients and the risk of spread within the community.~~

~~10. At TCHD, most AFB positive smears and cultures grow organisms that are not communicable person to person. In 2018, there were 3 patients with pulmonary TB and 1 with extrapulmonary TB. An additional 14 cases were reported as rule out TB in 2018. In 2019, 12 patients were confirmed with TB, 2 of those cases were MDR TB. An additional 20 cases were reported as rule out TB.~~ **~~In 2020, 3 patients were confirmed with pulmonary TB. None were MDR TB. In addition we reported 1 with extra pulmonary TB. 24 additional cases were reported as rule out TB.~~**~~The number of active TB patients seen annually at TCHD varies from 5 –12.~~

~~11.~~**3.** Tri City Medical Center Financial Characteristics for Fiscal Year 20**20**~~19~~

a. The top six insurance coverage are as follows:

MEDICARE	2**4.8%**~~5%~~
MEDI-CAL HMO	**16.9%**~~21%~~
Medicare SR HMO~~MEDI-CAL~~	**15.1%**~~21%~~
MEDI-CAL~~Medicare SR HMO~~	**12.8%**~~11%~~
Other Governmental	**12.8%**~~6%~~
HMO	4.**4**%

b. Patient Census:

	Average. Daily Census	Average. Length of Stay*	Total Pt. Days
Acute Care (excludes all below)	**112.4**~~117.5~~	4.6~~02~~	**41,012**~~42,894~~
ICU*	**14.9**~~15.6~~	**3.4**~~2.76~~	**5,449**~~5,691~~
~~BHU~~	~~2.7~~	~~8.51~~	~~979~~
NICU	**9.4**~~10.2~~	8.8~~92~~	**3,439**~~3.736~~
Rehab Serv.	**7.1**~~6.5~~	14.2~~63~~	**2,589**~~2,356~~

i. *ICU ALOS includes discharges, transfers out, and expirations. All other areas are based only on discharges.

c. In acute care FY **2020**~~19~~, the three largest age groups are **60-69**~~66-75~~ year olds (**18.67**~~16~~%), **70-79**~~26-35~~ year olds (**17.7**~~15.4~~%), and **80-89**~~56-65~~ year olds (**13.8**~~15.3~~%).

d. **16.6**~~Twelve~~ percent (**8684**~~6,849~~/**52,277**~~56,437~~) of Emergency Department patients are admitted to the hospital.

~~12. The total number of employees working at TCHD FY 20**20**19 is approximately 2,**524**701 with about 1,**572**729 (6**2**4%) staff providing direct patient care. This number includes **511**482 employees which were terminated at some point during FY20**20**18.~~

~~13.~~**4.** TCHD's primary focus is on basic community services. The top ten major diagnostic categories (DRGs) are the following:

a. Obstetrics
b. **Newborns & Neonates**~~Musculoskeletal & Connective Tissue~~
c. Infectious & Parasitic Diseases
d. Circulatory System
e. **Musculoskeletal & Connective Tissue**~~Newborns & Neonates~~
f. Nervous System
g. Respiratory
h. Digestive System
i. Kidney & Urinary Tract
j. Hepatobiliary System & Pancreas

~~14.~~**5.** Top five Inpatient Surgical Procedures (Fiscal Year 20**20**~~19~~): Cesarean section (CSEC), spinal fusion (FUSN), hip prosthesis (HPRO), ~~cholecystectomy (CHOL), and~~ knee prosthesis (KPRO) **and cholecystectomy (CHOL).**

~~15.~~**6.** Home Care Services provides skilled, intermittent care to individuals in a home setting. The restorative, rehabilitative services are provided by Registered Nurses, Licensed Vocational Nurses, Masters of Social Work, Licensed Clinical Social Workers, Certified Home Health Aides, Physical Therapists, Occupational Therapists, Speech Therapists and/or Dietitians. For FY ~~2019~~ 2020 in Home Care:

Average LOS	Top Payers	Top Primary DX Categories
~~3 days~~ 36.8 days	Medicare-~~54.65%~~ 52.44% HMO/PPO ~~27.36%~~ 42.08%	-Factors influencing Status/Sup Class -Injury/Poisoning -Circulatory (not HTN, HF or CVD) -Respiratory (COPD) -Musculoskeletal/Connective Tissue -Respiratory (not COPD) Circulatory-CVD Genitourinary 1. Other health services for specific procedures and after care 2. All Other injuries excluding fractures 3. Diseases of Cardiovascular System 4. Diseases of Respiratory System excluding complications of care 5. Complications of surgical and medical care

~~16. General Process~~

~~K.~~F. EMPLOYEE HEALTH

1. The Employee Health department at TCMC works collaboratively with the Infection Prevention Department to minimize the spread of infectious disease to and from employees.
   a. The total number of employees working at TCHD FY 2020 is approximately 2,524 with about 1,572 (62%) staff providing direct patient care. This number includes 511 employees which were terminated at some point during FY2020.

2. The Employee Health department contributes to the prevention and control of communicable diseases by established policies and procedures listed in TCMC policies. Together with Infection Prevention they work collaboratively in:
   a. Investigating and monitoring exposures to communicable disease and illness.
   b. Establishing pro-active policies and procedures for management of employee infection risks related to disasters, bioterrorism, and emerging pathogens.
   ~~3.~~**c.** Establishing guidelines for work restrictions due to communicable disease.

~~L.~~

~~M.~~G. REVIEW AND EVALUATION OF FY2020 HOSPITAL SURVEILLANCE

See related document: Infection Control Annual **Program** Evaluation

~~N.~~

~~O.~~H. RISK ANALYSIS FOR FY2021

Risk Issue / Incident	Has incident occurred in previous 12 months (Yes / No)	Prevention or Control Strategy In place (Yes / No)	Event likely to occur in next 12 mos. 1=low 2 = med 3 =high	Potential Impact on Patients or Facility 0=none 1=low 2=med 3=high	Risk Score =Event likely times Potential Impact	Priority Rank H,M, L
Device or Procedure related Risks						
Central line BSI	Yes	Yes	3	3	6	H
Ventilator Associated Pneumonia	No	Yes	1	2	2	L
Catheter related UTI	Yes	Yes	3	3	9	H
Surgical Site Infections	Yes	Yes	3	3	9	H
Equipment Related Risks						
Disinfection/Sterilization of medical devices-(failure)	Yes	Yes	2	3	6	M
Cleaning of common equipment—wet contact time (failure)	Yes	Yes	3	2	6	M
Pathogen Exposure Risks for Patients and Staff						
MDROs (multi drug resistant organisms)	Yes	Yes	3	3	9	H
C. difficile	Yes	Yes	3	3	9	H
Influenza –Seasonal	Yes	Yes	2	3	6	M
Infestations (Scabies, Lice, bed bugs)	Yes	Yes	3	3	9	H
Tuberculosis	No	Yes	2	3	6	M
Communicable Diseases(COVID-19)	Yes	Yes	3	3	9	H
Internal Environmental Risks						
Construction or Renovation Projects	Yes	Yes	3	2	6	M
Repairs/Maintenance that affect patient care areas	Yes	Yes	3	2	6	M
Laundry and linen problems	No	Yes	2	2	4	M
Medical Waste mishandling	No	Yes	1	1	1	L
Mold	No	Yes	1	2	2	L
Water Intrusion/ Disruption	Yes	Yes	3	2	6	M
Environmental cleanliness-terminal cleaning failure	Yes	Yes	3	3	9	H

Risk Issue / Incident	Has incident occurred in previous 12 months (Yes / No)	Prevention or Control Strategy In place (Yes / No)	Event likely to occur in next 12 mos. 1=low 2 = med 3 =high	Potential Impact on Patients or Facility 0=none 1=low 2=med 3=high	Risk Score =Event likely times Potential Impact	Priorit Rank H,M,
Device or Procedure related Risks						
Central line BSI	Yes	Yes	3	3	6	H
Ventilator Associated Pneumonia	No	Yes	1	2	2	L
Catheter related UTI	No	Yes	3	3	9	H
Surgical Site Infections	Yes	Yes	3	3	9	H
Equipment Related Risks						
Disinfection/Sterilization of medical devices-(failure)	Yes	Yes	2	3	6	M
Cleaning of common equipment—wet contact time (failure)	Yes	Yes	3	2	6	M
Pathogen Exposure Risks for Employees and Visitors						
MDROs (multi drug resistant organisms)	Yes	Yes	3	3	9	H
C. difficile	Yes	Yes	3	3	9	H
Influenza –Seasonal	Yes	Yes	2	3	6	M
Pertussis	No	Yes	1	3	3	M
Tuberculosis	Yes	Yes	3	3	9	H
Communicable Diseases(COVID-19)	Yes	Yes	3	3	9	H
Internal Environmental Risks						
Construction or Renovation Projects	Yes	Yes	3	2	6	M
Repairs/Maintenance that affect patient care areas	Yes	Yes	3	2	6	M
Laundry and linen problems	No	Yes	2	2	4	M
Medical Waste mishandling	No	Yes	1	1	1	L

Safe Food Handling: cool down logs, labeling	No	Yes	1	2	2	L
Ice Machines – schedule for cleaning Ice containers	No	Yes	1	2	2	L
Employee Related Risks						
Hand Hygiene (non-compliance)	Yes	Yes	2	2	4	M
PPE (non-compliance)	Yes	Yes	3	3	9	H
Needlestick: Bloodborne pathogen exposure	Yes	Yes	2	3	4	M
PAPRs (non-compliance,)	No	Yes	2	3	6	M
Unidentified TB patients in Emergency department & direct admit	No	Yes	1	3	4	M
External Environment Risks						
Community outbreaks of communicable diseases with influx of infectious patients	Yes	Yes	3	3	9	H
New Emerging/Re-emerging Pathogens (e.g., pandemic flu, Avian flu, SARS-COV, etc.)	Yes	Yes	3	3	9	H
Compliance with NPSG, JC, CDPH	Yes	Yes	3	3	9	H
Mandatory Reporting and use of NHSN	Yes	Yes	3	3	9	H

Low (L) = < 3

Medium (M) = 3—6

High (H)= > 6

~~Q.~~

Mold	No	Yes	1	2	2	L
Water Intrusion/ Disruption	Yes	Yes	3	2	6	M
Environmental cleanliness-terminal cleaning failure	Yes	Yes	3	3	9	H
Safe Food Handling: cool down logs, labeling	No	Yes	1	2	2	L
Ice Machines – schedule for cleaning Ice containers	No	Yes	1	2	2	L
Employee Related Risks						
Hand Hygiene (non-compliance)	Yes	Yes	2	2	4	M
PPE (non-compliance)	Yes	Yes	3	3	9	H
Needlestick: Bloodborne pathogen exposure	Yes	Yes	2	3	4	M
PAPRs (non-compliance,)	No	Yes	2	3	6	M
Unidentified TB patients in Emergency department & direct admit	No	Yes	1	3	4	M
External Environment Risks						
Community outbreaks of communicable diseases with influx of infectious patients	Yes	Yes	3	3	9	H
New Emerging/Re-emerging Pathogens (e.g., pandemic flu, Avian flu, SARS-COV, etc.)	Yes	Yes	3	3	9	H
Compliance with NPSG, JC, CDPH	Yes	Yes	3	3	9	H
Mandatory Reporting and use of NHSN	Yes	Yes	3	3	9	H

Low (L) = < 3

Medium (M) = 3—6

High (H)= > 6

~~R.~~

~~a. Infection Prevention staff will regularly review, information from internal sources (case manager, RLs) or external sources (other IC practitioners, home health/hospice, or nursing homes) and the positive microbiology reports (furnished by the clinical laboratory). The following are some of the patterns or issues that are evaluated:~~

~~i. Clusters of infections by the same organism, in the same ward or service or infections after undergoing the same procedure.~~

~~ii. Infections due to unusual or highly resistant/significant organisms such as MRSA, VRE, ESBL, CRE, and/or C.difficile Infection.~~

~~iii. All cases of reportable communicable diseases as mandated by Title 17. These shall be reported in accordance with the ordinances of the County of San Diego Department of Health.~~

~~b. Unusual or problem situations shall be brought to the Infection Control Committee for review and discussion. See Epidemiologic Investigation of a Suspected Outbreak policy.~~

~~c. In the absence of the Infection Prevention staff, hospital staff can direct questions to Employee Health Services or the Medical Director of Infection Control and/or Chair of the Infection Control Committee.~~

~~S. TARGETED AND FOCUSED SURVEILLANCE FOR FY 202019:~~

~~1. Infection control surveillance activities are systematic, active, concurrent, and require ongoing observation while meeting mandated reporting requirements. Our efforts are directed towards high risk, high volume and device/procedure associated infections. (such as urinary tract infections, selected surgical site infections, ventilator-associated events , and central line bacteremia) Goals will include **mitigating and** limiting unprotected exposure to pathogens throughout the organization, **e**Enhancing hand hygiene and **minimizing**limiting the risk of transmission of infections associated with procedures, medical equipment and supplies and medical devices.~~

~~2. Surgical Site Infections:~~

~~a. Due to ever-decreasing lengths of stay, the majority of postoperative infections are not seen while the patient is in the hospital. Further, the increasing trend toward more outpatient surgery and shorter postoperative hospital stays limits the ability of infection control practitioners to detect infections.~~

~~b. Surgical Site Infections that occur within 30 to 90 days (based upon the individual NHSN definitions). Surgical patients are risk stratified using the methods described in the CDC's NHSN surgical site component.~~

~~c. Case finding methods include a review of all microbiology cultures, and ICD coding for post-operative infection. Potential cases have a chart review performed by Infection Prevention staff using the most recent NHSN definitions (Centers for Disease Control and Prevention).~~

~~d. Infection rates are identified using the NHSN definitions and are reported to the California Department of Public Health through NHSN. In accordance with California senate bill requirements: facilities are required to report surgical site infections on 29 surgical procedures. Tri City Medical Center performs and reports on 25 of the procedures, they are listed below:~~

~~AAA~~	~~Abdominal aortic aneurysm repair~~	~~Resection of abdominal aorta with anastomosis or replacement~~
~~APPY~~	~~Appendix surgery~~	~~Operation of appendix (not incidental to another procedure)~~
~~BILI~~	~~Bile duct, liver or pancreatic surgery~~	~~Excision of bile ducts or operative procedures on the biliary tract, liver or pancreas (does not include operations only on gallbladder)~~
~~CARD~~	~~Cardiac surgery~~	~~Open chest procedures on the valves or septum of heart; does not include coronary artery bypass graft, surgery on vessels, heart transplantation, or pacemaker implantation~~
~~CBGB~~	~~Coronary artery bypass graft with both chest and~~	~~Chest procedure to perform direct revascularization of the heart; includes~~

	donor site incisions	obtaining suitable vein from donor site for grafting.
CBGC	Coronary artery bypass graft with chest incision only	Chest procedure to perform direct vascularization of the heart using, for example, the internal mammary (thoracic) artery
CHOL	Gallbladder surgery	Cholecystectomy and cholecystectomy
COLO	Colon surgery	Incision, resection, or anastomosis of the large intestine; includes large-to-small and small-to-large bowel anastomosis; does not include rectal operations
CSEC	Cesarean section	Obstetrical delivery by Cesarean section
FUSN	Spinal fusion	Immobilization of spinal column
FX	Open reduction of fracture	Open reduction of fracture or dislocation of long bones that requires internal or external fixation; does not include placement of joint prosthesis
GAST	Gastric surgery	Incision or excision of stomach; includes subtotal or total gastrectomy; does not include vagotomy and fundoplication
HPRO	Hip prosthesis	Arthroplasty of hip
HYST	Abdominal hysterectomy	Removal of uterus through an abdominal incision
KPRO	Knee prosthesis	Arthroplasty of knee
LAM	Laminectomy	Exploration or decompression of spinal cord through excision or incision into vertebral structures
NEPH	Kidney surgery	Resection or manipulation of the kidney with or without removal of related structures
OVRY	Ovarian surgery	Operations on ovary and related structures
PACE	Pacemaker surgery	Insertion, manipulation or replacement of pacemaker
REC	Rectal surgery	Operations on rectum
SB	Small bowel surgery	Incision or resection of the small intestine; does not include small-to-large bowel anastomosis
SPLE	Spleen surgery	Resection or manipulation of spleen
THOR	Thoracic surgery	Non cardiac, nonvascular thoracic surgery; includes pneumonectomy and hiatal hernia repair or diaphragmatic hernia repair (except through abdominal approach.)
VHYS	Vaginal hysterectomy	Removal of the uterus through vaginal or perineal incision
XLAP	Abdominal surgery	Abdominal operations not involving the gastrointestinal tract or biliary system. Includes diaphragmatic hernia repair through abdominal approach.

e. GOAL#1: The combined surgical site infection rate will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

f. GOAL#2: Each individual surgical site infection rate (that is able to be calculated) will not be statistically significantly higher than the most recent published NHSN rates, using the standardized infection ratio (SIR).

3. Antibiotic Resistant Bacteria

a. Antibiotic resistance is an ongoing concern. Multiple studies have documented increased costs and mortality due to infections caused by multidrug resistant organisms. Data will

~~be collected using positive cultures on patients with community acquired and hospital acquired methicillin resistant Staphylococcus aureus (MRSA), Vancomycin resistant enterococci (VRE), Extended spectrum-beta-lactamase (ESBL), *and Carbapenem-resistant Enterobacteriaceae (CRE)*. MDRO and C.difficile infection risk assessment is performed annually to determine need for additional interventions, resources, and surveillance. In addition, positive blood cultures with MRSA or VRE and positive C.difficile infections are reported to CDPH through NHSN Multi-Resistant Organism & Clostridium difficile Infection Module (LabID Event Reporting).~~

~~b. GOAL#1: The number of healthcare associated MRSA infections will remain below the Institute for Healthcare Improvement's (IHI) published rate of 3.95 hospital acquired infections per 1000 patient days for the calendar year.~~

~~# Patients with + MRSA and/or VRE cultures~~
~~1000 patient days~~

~~c. GOAL#2: The MRSA and VRE Lab ID events (Blood culture specimen) rate will not be statistically higher than the most recent NHSN published rates (using the SIR).~~

~~4. Clostridium difficile (C. difficile) surveillance is performed utilizing the Multi-Resistant Organism and Clostridium difficile Infection Module (LabID Event Reporting).~~

~~a. All positive C. difficile results are entered into NHSN. Increases in hospital onset (HO) cases will be reviewed and action taken if they are epidemiologically associated.~~

~~b. GOAL #1: The C. difficile hospital onset (HO) rate will not be more than expected based upon NHSN SIR Rates.~~

~~5. Ventilator Associated Event – Adult Critical Care Unit~~

~~a. VAE is conducted on persons in the ICU who had a device to assist or control respiration continuously through a tracheostomy or by endotracheal tube within the 48 hour period before the onset of infection (inclusive of the weaning period). Current CDC/NHSN VAE definitions are followed. The definition has three tiers: ventilator associated condition (VAC), infection related ventilator associated condition (IVAC), and possible ventilator associated pneumonia (PVAP). All PVAP cases will be reviewed & reported to Critical Care Committee and the Infection Control Committee.~~

~~i. GOAL #1: There will be less PVAP cases than the prior year. The number of PVAP cases will trend lower than the prior year.~~

~~ii. GOAL #2: The NHSN standardized utilization ratio (SUR) will be less than 1.0 (PVAP- Tier 3).~~

~~6. Central Line Associated Bloodstream Infection (CLABSI) –~~

~~a. Patients with a central line (defined by NHSN as a vascular access device that terminates at or close to the heart or one of the great vessels) and a primary bloodstream shall be counted. If a bloodstream infection occurs while a central line is in place or if a central line was inserted > than two calendar days before the onset of infection a chart review will be performed. Current CDC/NHSN definitions are used to determine CLABSI events.~~

~~b. GOAL #1: Using NHSN definitions for CLABSI, the CLABSI rate for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).~~

~~c. GOAL #2: Using NHSN definitions for CLABSI, the CLABSI rate for non-ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).~~

~~7. Catheter Associated Urinary Tract Infection (CAUTI)~~

~~a. Symptomatic urinary tract infection – Patients with positive urine cultures and indwelling foley catheters are reviewed. Current CDC/NHSN definitions are used to determine CAUTI events.~~

~~b. GOAL #1: Using NHSN definitions for catheter associated urinary tract infection (CAUTI), the CAUTI SIR for ICU patients will not be statistically higher than the NHSN standardized infection ratio (SIR).~~

~~c. GOAL #2: Using the NHSN definitions for CAUTI, the CAUTI SIR for non ICU patients will not be more than expected based upon the NHSN standardized infection ratio (SIR).~~

~~8. Hand Hygiene~~

~~a. Hand hygiene compliance rates are collected by manual observation performed by unit staff on a monthly basis. The Hand Hygiene compliance rates are reported to the Managers, Directors, Regulatory Compliance Committee, and the Infection Control Committee. Tri City Medical Center follows the World Health Organization's 5 Moments model for hand hygiene.~~

~~b. **GOAL #1: Overall hand hygiene compliance rate will be equal to or greater than at least 950% per quarter.**~~

~~9. Environmental and Patient Care Rounds~~

~~a. Multidisciplinary environment of care **(EOC)** rounds are **will be** performed monthly and overseen by the Safety Officer **or designee. Results of the rounds will be** and reported out to the Environmental Health & **and** Safety (EHSC) Committee and Infection Control Committee **(ICC)**. From these rounds, Infection Control will assess & prioritize potential risks for infection, contamination and exposures to help eliminate and mitigate such risks. These **EOC** rounds will **assist with** identify**ing** risks associated with, but not limited to, medical equipment and supplies. In addition **to EOC rounds, scheduled** tracers are performed monthly on a schedule throughout the patient care areas.~~

~~b. **GOAL #1: Infection Control will be represented 100% of the time during scheduled environmental rounds.**~~

~~c. **GOAL #2 Infection Control will be represented 100% of the time during scheduled tracers.**~~

~~d. GOAL #3: Engineering staff in collaboration with Infection Control will complete an Infection Control Construction Permit 100% of the time for projects that require a Class III or higher containment.~~

~~10. Reportable Diseases~~

~~a. Assisted by the Microbiology Laboratory and Emergency Department, required reporting to Public Health is performed by phone, fax or mail using the California Confidential Morbidity Report or other special form as directed by the County of San Diego Department of Health. Case finding is done through review of microbiology reports and calls from hospital staff (including physicians).~~

~~b. GOAL: Required reportable disease will be sent to the local health department within the required time frame 100% of the time.~~

~~11. Employee Health collects and reports the following:~~

~~a. GOAL#1: There will be 10% less needle stick injuries from the previous calendar year~~

~~i. Number of needle sticks injuries and details of department involved, device, and cause.~~

~~b. GOAL#2: 100% of employees will complete the annual tuberculosis screen~~

~~i. # Staff completing annual TB screening (PPD, blood test or survey)/ # employees in whom compliance is required.~~

~~c. GOAL #3: Greater than 90% of Tri City Medical Center staff (per NHSN definition) will receive influenza vaccine.~~

~~i. # Employees and who received influenza vaccine/# employees who worked at least one day during the flu season.~~

~~d. GOAL #4: Greater than 90% of Tri City Medical Center inpatient Acute Rehab unit staff (per NHSN definition) will receive influenza vaccine.~~

~~12. Home Care, collects and reports the following:~~

~~a. GOAL #1: CAUTI and CLABSI rates will be monitored and reported to the Infection Control Committee quarterly.~~

~~b. GOAL #2: There will be less than two CAUTI infections in the calendar year.~~

~~i. # UTI cases with foley catheter/Total # device days.~~

~~c. GOAL #3: There will be no infections related to central lines in the calendar year.~~

~~i. # BSI cases with Central Line/Total # device days.~~

J. GOALS, OBJECTIVES, STRATEGIES, EVALUATION

1. **Using the risk analysis and the summary of healthcare-associated infection surveillance outcomes, prioritized risks are identified based on their nature, scope, and impact on the care, treatment, and services provided.**

2. **Goals and objectives, with specific strategies are developed and implemented to address the prioritized risks. These strategies may take the form of policy and procedure, surveillance and monitoring activities, education and training programs, environment and engineering controls, or combinations thereof. Strategies may differ in approach, form, scope, application and/or duration depending on the specific risk issue, the care setting(s) and environment.**

~~T.~~K. RELATED DOCUMENT(S):

1. Infection Control Policy: **Infection Prevention Program Plan**~~Philosophy~~
2. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
3. Infection Control **Annual Evaluation**~~Risk Assessment~~ 2021~~0~~

~~U.~~L. REFERENCE(S):

1. County of San Diego Public Health & Human Services Agency, Public Health Services. Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/
2. **APIC Text of Infection Control and Epidemiology, 2021.**
3. **https://www.census.gov/quickfacts/fact/table/missionviejocitycalifornia,orangecountycalifornia/PST045217**
4. **Joint Commission, Hospital Accreditation Standards**
5. **CMS Conditions of Participation: IC**
6. **Title 22, Calif. Code of Regulations**
7. **Health and Safety Code**
8. **CDC Guidelines as listed**
9. **CDPH AFL 09-07**
10. **FDA 21 CFR Part 1271**

~~1.~~

~~2. Centers for Disease Control and Preventions, National Healthcare Safety Network (NHSN) Tracking Infection in Acute Care Hospitals/Facilities. (2017 2021) http://www.cdc.gov/nhsn/acute-care-hospital/index.html~~

~~3.~~**11.** County of San Diego Tuberculosis Control and Refugee Health Program.) TB Statistics-Fact Sheet ~~2016~~2020 (March 12, 2021). Retrieved from http://www.sandiegocounty.gov/hhsa/programs/phs/tuberculosis_control_program/

~~4. Friedman, C. (2014). Infection Prevention and Control Programs in P. Grota (Ed.), APIC Text of Infection Control and Epidemiology (4th ed). Washington DC; 2014~~

~~5. The City of San Diego (2017), Economic development: Population https://www.sandiego.gov/economic-development/sandiego/facts~~

12. **https://datausa.io/profile/geo/san-diego-county-ca/**
13. **https://www.sandiegocounty.gov/hhsa/statistics_demographics.html**
14. **https://www.california-demographics.com/san-diego-county-demographics**

~~6.~~

TCMC 2021 IP Risk Assessment

Risk Issue / Incident	Has incident occurred in previous 12 months (Yes / No)	Prevention or Control Strategy In place (Yes / No)	Event likely to occur in next 12 mos. 1=low 2 = med 3 =high	Potential Impact on Patients or Facility 0=none 1=low 2=med 3=high	Risk Score =Event likely times Potential Impact	Priority Rank H,M, L
Device or Procedure related Risks						
Central line BSI	Yes	Yes	3	3	6	H
Ventilator Associated Pneumonia	No	Yes	1	2	2	L
Catheter related UTI	Yes	Yes	3	3	9	H
Surgical Site Infections	Yes	Yes	3	3	9	H
Equipment Related Risks						
Disinfection/Sterilization of medical devices-(failure)	Yes	Yes	2	3	6	M
Cleaning of common equipment—wet contact time (failure)	Yes	Yes	3	2	6	M
Pathogen Exposure Risks for Patients and Staff						
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C. difficile	Yes	Yes	3	3	9	H
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Mold	No	Yes	1	2	2	L
Water Intrusion/ Disruption	Yes	Yes	3	2	6	M
Environmental cleanliness-terminal cleaning failure	Yes	Yes	3	3	9	H

Safe Food Handling: cool down logs, labeling	No	Yes	1	2	2	L
Ice Machines – schedule for cleaning Ice containers	No	Yes	1	2	2	L
Employee Related Risks						
Hand Hygiene (non-compliance)	Yes	Yes	2	2	4	M
PPE (non-compliance)	Yes	Yes	3	3	9	H
Needlestick: Bloodborne pathogen exposure	Yes	Yes	2	3	4	M
PAPRs (non-compliance,)	No	Yes	2	3	6	M
Unidentified TB patients in Emergency department & direct admit	No	Yes	1	3	4	M
External Environment Risks						
Community outbreaks of communicable diseases with influx of infectious patients	Yes	Yes	3	3	9	H
New Emerging/Re-emerging Pathogens (e.g., pandemic flu, Avian flu, SARS-COV, etc.)	Yes	Yes	3	3	9	H
Compliance with NPSG, JC, CDPH	Yes	Yes	3	3	9	H
Mandatory Reporting and use of NHSN	Yes	Yes	3	3	9	H

Low (L) = < 3

Medium (M) = 3—6

High (H)= > 6

Infection Control Risk Assessment: 2020

*Updated Nov 2020

Potential	Probability					Risk/Impact (Health, Financial, Legal, Regulatory)					Current Systems/Preparedness					Score
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/	Serious Loss (Function	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Multi-Drug Resistant Organisms (MDRO)																
MRSA		X							X					X		7
C Diff			X						X					X		6
CRE				X					X					X		5
VRE				X					X					X		5
ESBL/other Gram Negative bacteria				X					X					X		5
Prevention Activities																
Lack of Hand Hygiene Compliance			X						X					X		6
Lack of Respiratory Hygiene/ Cough Etiquette				X					X					X		5
Lack of Patient Influenza Immunization			X					X							X	6
Lack of LIPs Influenza Immunization			X					X						X		7
Isolation Activities																
Lack of Adherence to Standard Precautions			X						X					X		6
Delayed Identification of ATD: airborne transmissible diseases			X						X					X		6
Policy and Procedure																
Failure to follow established policy or procedure- TB discharge approval				X					X					X		5
Emergency																
Ebola Preparedness				X			X							X		7
Influx of Infectious		X		X			X		X					X		9
Pandemic: COVID-19		X		X			X		X					X		9

Pandemic: Influenza				X					X					X		5
Potential	**Probability**					**Risk/Impact (Health, Financial, Legal, Regulatory)**					**Current Systems/Preparedness**					**Score**
	Expected	Likely	Maybe	Rare	Never	Catastrophic Loss (life/limb/ function/ financial)	Serious Loss (Function / Financial/ Legal)	Prolonged Length of Stay	Moderate Clinical/ Financial	Minimal Clinical/ Financial	None	Poor	Fair	Good	Solid	≥ 10 Hi 7-9 Med ≤ 6 Lo
	4	3	2	1	0	5	4	3	2	1	5	4	3	2	1	
Healthcare Associated Infections (HAI)																
Central Line Associated Blood Stream Infections				X			X							X		7
Catheter Associated Urinary Tract Infections				X					X					X		5
Surgical Site Infections				X			X							X		7
Ventilator Associated Event (PVAP) in ICU				X			X							X		7
Lice and Scabies				X						X					X	3
Norovirus				X					X					X		5
Influenza				X					X					X		5
Bloodborne Pathogens				X					X					X		5
Environment																
Legionella Disease				X			X							X		7
Air Handling				X					X				X			6
Cleaning/ Disinfection			X						X					X		6
Monitoring Negative Air Pressure Rooms				X					X					X		5
Lack of Negative Pressure Rooms				X					X					X		5
Infection Related to Construction/ Renovation				X			X							X		7
Employee Health																
Lack of Staff Influenza Immunization			X						X					X		6
Lack of Staff Immunization, other			X						X					X		6
New hire health screen				X						X					X	3
Exposure to Bloodborne Pathogens			X				X							X		8

Exposure to infectious disease			X						X					X		6
Annual TB screening of staff			X						X						X	5
Pertussis				X					X					X		5
Lack of LIP Screening			X							X				X		5
Staff Exposures to COVID-19			X						X					X		6
Other																
Risk of Community Outbreak		X		X				X	X					X		8

The Infection Control (IC) Risk assessment grid is a visual tool to develop IC program priorities and stratify infection risks based on our geography, location in the community, prevalent infections in the community, our patient population and the review of our previous IC data analysis. The annual IC Plan is developed based on these risks.

The IC Risk assessment is an ongoing, continual process. A more focused review is done on an annual basis after reviewing the quarterly and annual reports with the Infection Control Committee.

Risk Assessment Completed: Nov 2020

ID MD, ICC Chair IP EH Quality RN MD Disaster
Pharmacy EOC OR EVS Facilities/Engineering Lab Administration

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**ABDOMINAL ANGIOGRAM**
~~Purpose:~~	~~To outline the nursing care of the patient~~
~~Supportive Data:~~	~~An Abdominal Angiogram is a diagnostic~~ ~~including renal, mesenteric, hypogastric a~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.~~
~~Equipment:~~	~~Angio Tray with flushes system. Doctor to determine all other equipment.~~

Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

~~A.~~ ~~**INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
~~3. Gloves are worn to protect HCW from blood or body fluids~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B.~~ ~~**PRE-PROCEDURE**~~

~~1. Prepare consent for Abdominal Angiogram, Possible Angioplasty, Possible Thrombolysis, Possible stent Placement with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~2. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~3. Complete Procedural Verification Pre-Phase section~~
~~4. Change patient into gown~~
~~5. Start IV of Normal Saline 0.9%.~~

~~C.~~ ~~**INTRA-PROCEDURE**~~

~~1. Assist the physician as directed.~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D.~~ ~~**POST-PROCEDURE**~~

~~1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**ABSCESS DRAINAGE**
Purpose:	To outline the nursing care of the patient
Supportive Data:	An abscess drainage is a procedure used to diagnose the nature of abnormal fluid collection and /or treat sepsis, or relieve associated pain. Possible done in Cat Scan or Ultrasound per radiologist preference.
Nursing Impactions:	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction, or history related problems.
Equipment:	Angio tray Neff set Assorted size dilators Connection tube and drainage bag MD to determine additional supplies

Delete policy. Use Elsevier Online Skills - Incision and Drainage

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Cat Scan or Ultrasound Guided Abscess Drainage with contrast and sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. Complete Procedural Verification Pre-Phase section
3. View information from nurse pre-call sheet. Complete or obtain any new patient information.
4. Change patient into gown
5. Start IV of Normal Saline 0.9%

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital signs according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, Med Surg, and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**ACUTE STROKE ANGIOGRAM**
~~Purpose:~~	~~To outline the nursing care of the patient~~
~~Supportive Data:~~	~~An Aortagram is a diagnostic test of the a~~ ~~carotid dissection, cerebral aneurysm, AV~~ ~~brain tumor and to evaluate cerebral flow.~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia depending on neurological status. Patients need to be monitored for signs of bleeding, allergic reaction, LOC, neurological changes, fluid overload, and history related problems.~~
~~Equipment:~~	~~Angio Tray with flush system. Doctor to determine all other equipment.~~

Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.~~
~~3. Gloves are worn to protect HCW from blood or body fluids.~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Obtain detailed report from transferring facility or nursing staff.~~
~~2. Patient to be transport to department on cardiac monitor and with a nurse. If unable to transport in timely manner I.R nurse and tech aid to retrieve patient.~~
~~3. Prepare consent for Cerebral/Carotid Angiogram with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~4. View information from nurse pre-call sheet or patient chart. Complete or obtain any new patient information.~~
~~5. Complete Procedural Verification Pre-Phase section.~~
~~6. Change patient into gown (if applicable)~~
~~7. Start IV 18-20 gauge with Normal Saline 0.9%.~~
~~8. Base line Neurological exam or NIH scale to be filled out.~~
~~9. Remove dentures and/or hearing aids.~~
~~10. Position patient in supine position~~
~~11. See Sterile Tray set~~
~~12. Perform Time Out~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Double flush and double aspirate.~~
~~4. Follow instruction as directed by Interventional Radiologist~~
~~5. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D. **POST-PROCEDURE**~~

~~1. Neurological examTransport patient to PACU, ICU, or Telemetry giving detailed patient hand off report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**ANGIOGRAM**
Purpose:	To outline the nursing care of the patient unde
Supportive Data:	An Aortagram is a diagnostic test of the arteria PVD, arterial thrombosis, AAA. Once the diagr possible that an Angioplasty or vascular Stent could be placed. An Angioplasty is a therapeutic procedure used to reduce a blockage(s) in an artery to restore blood flow. A Vascular Stent is a device deployed in an artery, to restor blood blow.
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction, LOC, neurological changes, fluid overload, and history related problems.
Equipment:	Angio Tray with flush system. Doctor to determine all other equipment.

Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Aortagram with Runoff, Possible Angioplasty, Possible Stent placement, Possible Thrombolysis with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV 18 gauge with Normal Saline 0.9%.
6. Base line Neurological exam.
7. Remove dentures and/or hearing aids.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Double flush and double aspirate.
4. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Neurological exam
2. Transport patient to SPRA, PACU, ICU, and Telemetry ivin detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**BIOPSY**
Purpose:	To outline the nursing care of the patient u
Supportive Data:	Procedure in which the radiologist obtains is used to determine if a lesion is benign o diagnose abnormal cells related to infecti
Nursing Implications	Conscious sedation maybe used for analg signs of bleeding, allergic reactions or hist
Equipment:	Biopsy tray, Medium Sheet 1 Box 4 X 4's Biopsy needle per radiologist's preference
Infection Control	1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water. 2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn. 3. Gloves are worn to protect HCW from blood or body fluids. 4. Wear clean gloves it touching mucus membranes or non-intact skin. Once gloves touch any surface (i.e., patient, IV pole, countertop, doorknob or phone) they are no longer 'clean'. 5. Change gloves when moving from one body site to another, for example, moving from oral to foley care. 6. Perform hand hygiene each time gloves are removed or changed. 7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes (for example, when discontinuing blood or body fluid filled tubes or irrigation wounds). Add a gown to protect your clothes.

Delete and utilize PCS Procedure: Specimen Handling for Surgical/Procedural Areas in conjunction with Elsevier Online Skills - Specimen Collection (Perioperative)

A. **PRE-PROCEDURE**
1. Prepare consent for CT or Sonographic guided liver, pancreas, lung or kidney biopsy with sedation. Patient will need to sign after informed consent by the radiologist.
2. View information on Nurse's Notes from the pre-call. Complete any missing information.
3. Change patient into a gown.
4. Prep site per radiologist. Start an IV of D5W 1/2 NS unless the patient is diabetic. If diabetic start an IV with NS.

B. **INTRA-PROCEDURE**
1. Assist the physician as directed.
2. Monitor vital signs Q 5 to 15 as per level of sedation

C. **POST-PROCEDRE**
1. Transport patient to SPRA, PACU or the unit and transfer care via report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Distribution: INTERVENTIONAL RADIOLOGY

PROCEDURE: BLOOD PATCH

Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

Purpose:	To outline the nursing care of the patie
Supportive Data:	A small amount of spinal fluid leaked ir ts like a band-aid and seals the leak.
Nursing Implications:	Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Epidural tray set-up. Isovue 200 or 300 (MD to determine additional supplies) K-50 Doctor to determine all other equipment.

INFECTION CONTROL

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

PRE-PROCEDURE

1. Prepare consent for Fluoroscopy Guided Epidural Blood Patch. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start **STERILE** IV Hep-lock in sterile environment.

INTRA-PROCEDURE

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section

POST-PROCEDURE

1. Transport patient to SPRA, PACU, ICU, Med Surg, and Telemetry giving detailed patient report.

ISSUED:	REVIEWED:	REVISED:	APPROVED:
6/08	6/10,6/11		6/08

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/20	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**CAROTID/CEREBRAL ANGIOGRAM**
Purpose:	~~To outline the nursing care of the patient~~
Supportive Data:	~~An Aortagram is a diagnostic test of the a~~ ~~carotid dissection, cerebral aneurysm, AVM brain tumor and to evaluate cerebral flow.~~
Nursing Implications	~~Minimal sedation is used for analgesia depending on neurological status. Patients need to be monitored for signs of bleeding, allergic reaction, LOC, neurological changes, fluid overload, and history related problems.~~
Equipment:	~~Angio Tray with flush system. Doctor to determine all other equipment.~~

Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

A. ~~**INFECTION CONTROL**~~

1. ~~Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
2. ~~Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.~~
3. ~~Gloves are worn to protect HCW from blood or body fluids.~~
4. ~~Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
5. ~~Change gloves when moving from one body site to another.~~
6. ~~Perform hand hygiene each time gloves are removed or changed.~~
7. ~~Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

B. ~~**PRE-PROCEDURE**~~

1. ~~Prepare consent for Cerebral/Carotid Angiogram with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
2. ~~View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
3. ~~Complete Procedural Verification Pre-Phase section~~
4. ~~Change patient into gown~~
5. ~~Start IV 18-20 gauge with Normal Saline 0.9%.~~
6. ~~Base line Neurological exam.~~
7. ~~Remove dentures and/or hearing aids.~~

C. ~~**INTRA-PROCEDURE**~~

1. ~~Assist the physician as directed~~
2. ~~Complete Procedural Verification Intra-Procedure section~~
3. ~~Double flush and double aspirate.~~
4. ~~Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

D. ~~**POST-PROCEDURE**~~

1. ~~Neurological exam~~
2. ~~Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report~~.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interven
PROCEDURE:	**CAT SCAN GUIDED BIOPSIES**
~~Purpose:~~	~~To outline the nursing care of the patien~~
~~Supportive Data:~~	~~Procedure in which a sample of tissue is~~ ~~to determine is a lesion is benign or mal~~ ~~abnormal cells related to infection.~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia.~~ ~~bleeding, allergic reaction or history related problems.~~
~~Equipment:~~	~~Biopsy Tray. Doctor to determine all other equipment.~~

DELETE - PCS Procedure: Specimen Handling For Surgical/Procedural Areas; Elsevier Online Skills - Specimen Collection (Perioperative) ; Elsevier Online Skills - Sterile Field: Setup (Perioperative)

~~A.~~ ~~**INFECTION CONTROL**~~

1. ~~Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
2. ~~Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
3. ~~Gloves are worn to protect HCW from blood or body fluids~~
4. ~~Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
5. ~~Change gloves when moving from one body site to another.~~
6. ~~Perform hand hygiene each time gloves are removed or changed.~~
7. ~~Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B.~~ ~~**PRE-PROCEDURE**~~

1. ~~Prepare consent for Cat Scan/Ultrasound guided (liver, pancreas, lung, thyroid, and kidney) biopsy with Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
2. ~~View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
3. ~~Complete Procedural Verification Pre-Phase section~~
4. ~~Change patient into gown~~
5. ~~Start IV of Normal Saline 0.9%.~~

~~C.~~ ~~**INTRA-PROCEDURE**~~

1. ~~Assist the physician as directed~~
2. ~~Complete Procedural Verification Intra-Procedure section~~
3. ~~Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D.~~ ~~**POST-PROCEDURE**~~

1. ~~Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interv
PROCEDURE:	CAT SCAN GUIDED BONE MARROV
~~Purpose:~~	~~To outline the nursing care of the patie~~
~~Supportive Data:~~	~~Procedure in which a sample of bone~~ ~~used to determine abnormal lab value~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia~~ ~~bleeding, allergic reaction or history re~~
~~Equipment:~~	~~Bone Marrow Tray. Doctor to determine all other equipment.~~

DELETE - PCS Procedure: Specimen Handling For Surgical/Procedural Areas; Elsevier Online Skills - Specimen Collection (Perioperative) ; Elsevier Online Skills - Sterile Field: Setup (Perioperative); Elsevier Online Skills - Bone Marrow Biopsy and Aspiration

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
~~3. Gloves are worn to protect HCW from blood or body fluids~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Prepare consent for Cat Scan guided Bone Marrow biopsy with sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~2. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~3. Complete Procedural Verification Pre-Phase section~~
~~4. Change patient into gown~~
~~5. Start IV of Normal Saline 0.9%.~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D. **POST-PROCEDURE**~~

~~1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventiona
PROCEDURE:	**CENTRAL VENOUS LINE INSERTION**
Purpose:	To outline the nursing care of the patient unde
Supportive Data:	A Central Venous Line involves placement of located vein using vascular interventional tech
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Minor PICC Tray. Doctor or Physician Assistant to determine all other equipment.

DELETE - follow PCS Procedure: Central Venous Access Devices, Adults; Elsevier Online Skills - Central Venous Catheter Insertion

A. **INFECTION CONTROL**

1. Hand hygiene is performed prior to and immediately after touching a patient and after removing or changing gloves. Change gloves when moving from one body site to another.
2. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
3. Gloves are worn to protect HCW from blood or body fluids. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch a surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
4. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Placement of CENTRAL VENOUS LINE INSERTION. Patient will need to sign after informed consent by the Interventional Radiologist or Physician Assistant.
2. View information from nurse pre-call sheet or chart. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown

C. **INTRA-PROCEDURE**

1. Complete Procedural Verification Intra-Procedure section
2. Assist the physician as directed
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Discharge or return to room.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**DIALYSIS GRAFT/FISTULA ANGIOGRAM, PL**
~~Purpose:~~	~~To outline the nursing care of the patient underg~~
~~Supportive Data:~~	~~An Aortagram is a diagnostic test of the arterial graft/fistula and dilate stenotic areas that may b increase venous pressures on dialysis. If clotte PTD or TPA pulse spray.~~
~~Nursing Implications~~	~~Patients need to be monitored for signs of bleed problems.~~
~~Equipment:~~	~~Angio Tray with flush system. Doctor to determine all other equipment.~~

DELETE - Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.~~
~~3. Gloves are worn to protect HCW from blood or body fluids.~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Prepare consent for Dialysis Graft/ Fistulagram Angiogram, Possible Angioplasty, Possible Thrombolysis, and Possible Stent with contrast. Patient will need to sign after informed consent by the interventional radiologist.~~
~~2. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~3. Complete Procedural Verification Pre-Phase section~~
~~4. Assess Graft/Fistula for blood flow~~
~~5. Change patient into gown~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Monitor vital signs through procedure.~~

~~D. **POST-PROCEDURE**~~

~~1. Discharge with instructions.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventio

DELETE - utilize Elsevier Online Skills - Gowning and Gloving Team Members

PROCEDURE:	**GOWNING AND GLOVING**
Purpose:	Nursing responsibilites in gowing and glovi ng closed/open, changing a contaminated gown before
Supportive Data:	N/A
Equipment:	N/A

A. **STERILE GOWN:**
1. Scrub person:
   a. Open sterile gown and gloves on a surface near but not on the back table using principles of sterile technique.
   b. Following surgical scrub, the scrub nurse grasps inner neckline of gown and allows the gown to unfold completely.
   c. Insert both arms into gown leaving hands inside gown, above cuffs.
2. Circulating Nurse:
   a. Pulls gown over shoulders of scrub person touching only on inside of gown. Secure at the neckline and waist.

B. **GLOVING CLOSED:**
1. Scrub Person:
   a. Hands inside of cuff, grasp the folded cuff of the glove
   b. Place the glove upside down on enclosed hand with fingers pointed toward the body and thumb to thumb.
   c. Grasp the inferior glove cuff with the enclosed thumb.
   d. With Opposing enclosed hand, stretch the glove up and over the stockinette cuff.
   e. Advance the hand through the cuff of the sleeve, keeping the stockinet cuff completely covered by the glove.
   f. Repeat for other hand.
   g. Remove glove power by washing hands w/ sterile water.
2. Circulating Nurse:
   a. Hold tab attached to sterile tie while scrub persons pivots.
   b. Hold tab securely while scrub person pulls tie away.
   c. Scrub person secures this at waist.

C. **GLOVING OPEN:**
1. Steps
   a. Extend hands through cuff of the sterile gown
   b. Grasp the inner side of the cuff with the opposite hand. Do not touch the outside of the glove.
   c. Insert hand and pull glove up over the entire cuff of the gown
   d. Place gloved hand under the cuff of the opposite glove, lift and insert ungloved hand into glove, pull the glove over the hand completely covering the gown glove
   e. Remove glove power using sterile water.
2. Scrub Person:
   a. Completes gowning and gloving. Do not touch bare arms.
3. Circulating Person:
   a. Repeat entire gowning and closed gloving procedure.
   b. Hold tab attached to sterile tie while scrub person pivots
   c. Hold tab securely while scrub person pulls tie away.
   d. Scrub person secures this at waist.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11	n/a	n/a	n/a	11/21	n/a	06/08

D. **GOWNING AND GLOVING TEAM MEMBERS:**

1. Scrub person:
   a. Pass towel to newly scrubbed team member. Do not contaminate self by touching bare hands or any of scrubbed team members.
   b. Open gown, allow unfolding and placing over stretched arms of team member
   c. Release gown allowing circulating person to pull gown over shoulders of team member and secure at neckline and waist.
   d. Grasp sterile glove, palm facing ungloved team member, thumb to thumb.
   e. Stretch cuff open and grasp firmly while team member advances hand into glove.
   f. Repeat with other glove, then turn gown of team member, if a wraparound gown.
   g. Remove glove power with sterile water

E. **CHANGING A CONTAMINATED GOWN (and Before Donning Sterile Gloves):**

1. Scrub Person:
   a. Completes gowning and gloving. Do not bare arms.
2. Circulating Nurse:
   a. Unties scrub nurse gown and removes. Do not touch bare arms
   b. Repeat entire gowning and closed gloving procedure. Do not touch bare arms.

Tri-City Medical Center	Interventional Radiology

DELETE - utilize PCS Procedure: Central Venous Access Devices, Adults

PROCEDURE:	**IMPLANTABLE POWER PORT ACCES**
Purpose:	To permit repeated access for short or le d products, nutritional and other fluids, suc as bolus injections, and venous blood sampling.
Supportive Data:	See Infection Control Manual Bloodborne Pathogen Exposure Control Plan.
Equipment:	1. Non-sterile gloves 2. Mask and goggles or full face shield 3. Alcohol wipes 4. Sterile drape 5. Sterile gloves 6. Use only safety, non-coring needles to access implanted port, 7. Extension tubing per patient needs for length and gauge. 8. Anti-reflux valve attached to extension tubing 9. 10mL syringe filled with sterile normal saline a. Chloraprep or Betadine if patient is allergic to Chloraprep or alcohol. 10. Transparent dressing or 2x2 split sterile gauze and 4x4 or 2x2 sterile gauze. 11. Steri-strips (optional) 12. Tape 13.1. Flush solution

A. **ACCESSING PROCEDURE:**

1. The physician or RN with power port competency must be present for the power injection into the port. If identification of the port is in question, the radiologist or radiologic technician will verify the port as a power injectable port by the scout scan or CXR. The maximum flow rate allowed is 5 ml/sec and the pressure is not to exceed 300 psi.
   a. Obtain physician's order to use implanted device.
   b. Assemble supplies and use power rated safety needles.
   c. Explain procedure to patient.
   d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.
   e. Use Standard Precaution while accessing implanted venous ports (Refer to Infection
   f. Control Policy IC.5 Standard and Transmission Based Precautions)
   g. Avoid talking over site and have the patient turn away from the site to prevent contamination.
   h. Assemble equipment on sterile field.
   i. Perform hand hygiene and don sterile gloves and using aseptic technique
   j. Prime the non-coring power rated needle and extension tubing (with anti-reflux valve attached) with a 10 mL normal saline pre-filled syringe. Leave the syringe attached.
   k. Using Chloraprep, cleanse area over implanted port thoroughly with a gentle back-and forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
      i. Locate port septum by palpation and triangulate port between the thumb and first two fingers of non-dominant hand.
      ii. Aim for the center of the port and insert the needle, perpendicular to port septum.
      iii. Advance needle through skin and septum until it reaches the bottom of the reservoir.
   l. Do not begin injection until proper needle placement has been confirmed by blood aspiration.
   m. Secure needle to chest with adhesive dressing.
      i. Withdraw 5 mL from accessed implanted port and discard (removes heparin)

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ii. Flush port with 10 mL of normal saline after heparin has been removed
iii. Administer contrast via port by power injector.

B. **DE-ACCESSING PROCEDURE:**

1. Check for blood return prior to flushing port with a 10 mL pre-filled normal saline syringe.
2. Flush port with 10 mL normal saline
3. ALWAYS flush port with specific flush prior to de-accessing heparinize port 500 units Heparin in pre-filled syringe (100units/m1)
4. Perform hand hygiene and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable.
5. Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage.
6. Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol.
7. To remove the safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased.
8. Discard needle in a sharps container.
9. Apply small band-aid.

Tri-City Medical Center	Interventic

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	INFERIOR VENACAVAGRAM
Purpose:	To outline the nursing care of the patient undergoing an Angiogram/Filter placement.
Supportive Data:	Inferior Vena Cava filter Placement to prevent migration of emboli in patients with known Deep Vein Thrombosis at risk pulmonary emboli. Also used for patients with known pulmonary emboli with contraindications for anticoagulation.
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Angio Tray with flushes system. Doctor to determine all other equipment.

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Inferior Venacavagram with Contrast and Sedation, Possible placement of Vena Cava Filter. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV of Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

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Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**MESENTERIC AORTAGRAM (EMBOLI**
Purpose:	To outline the nursing care of the patient
Supportive Data:	An Aortagram is a diagnostic test of the a... GI bleeding, tumor and related blood flow issues.
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Angio Tray with flushes system. Doctor to determine all other equipment.

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Mesenteric Angiogram, Possible Embolization with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV of Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

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Tri-City Medical Center	Interventi

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	MESENTERIC AORTAGRAM
Purpose:	To outline the nursing care of the patient u
Supportive Data:	An Aortagram is a diagnostic test of the arterial system. Implications include bowel, GI bleeding, tumor and related blood flow issues.
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Angio Tray with flushes system. Doctor to determine all other equipment.

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Mesenteric Angiogram, Possible Stent placement, Possible Thrombolysis with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV of Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

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Tri-City Medical Center	Intervent	Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**MYELOGRAM**	
Purpose:	To outline the nursing care of the patient undergoing a myelogram.	
Supportive Data:	A myelogram is a diagnostic exam used to diagnostic abnormalities of the spinal cord. A cat scan of the spine is usually obtained post procedure.	
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction, or history related problems.	
Equipment:	Myelogram tray (main radiology to set up tray) Isovue 200 for lumbar myelogram Isovue 300 for cervical myelogram, obese, multilevel, or hardware in spine Radiologist may determine additional supplies	

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Cervical/Lumbar Myelogram with Contrast and Sedation. Patient will need to sign after informed consent by the radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV of Normal Saline 0.9%.
6. Shave and /or prep site

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

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Tri-City Medical Center	Intervent	DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**PERCUTANEOUS NEPHROSTOMY, ST**	
Purpose:	To outline the nursing care of the patient undergoing a stone removal.	
Supportive Data:	To place a device to allow external drainage from kidney due to ureteral obstruction, need to divert urine to allow tear or fistula to heal, or decompression of hydronephrosis. Stone removal: To relieve ureteral obstruction caused by calculi lodged in renal pelvis or ureter. Ureteral Stent: Bypass obstruction in ureter caused by calculi, stricture, tumor, or edema and allow urine to floe to bladder	
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.	
Equipment:	Angio Tray with flushes system. Neff set Needle Guide w/ large ultrasound Antibiotic therapy Renal dilators Doctor to determine all other equipment.	Hockey stick Glide wire Wittich basket Bruhanna Basket with sheath 24 FR Malecot Nephrostomy

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Percutaneous Nephrostomy, Possible Removal of Calculi, Possible Ureteral Stent placement with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV of Normal Saline 0.9%.
6. Prep site per radiologist after ultrasound exam.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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Tri-City Medical Center	Interventi	DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**PERCUTANEOUS NEPHROSTOMY**	
~~Purpose:~~	~~To outline the nursing care of the patient undergoing an Percutaneous Nephrostomy~~	
~~Supportive Data:~~	~~To place a device to allow external drainage from kidney due to ureteral obstruction, need to divert urine to allow tear or fistula to heal, or decompression of hydronephrosis.~~ ~~Ureteral Stent: Bypass obstruction in ureter caused by calculi, stricture, tumor, or edema and allow urine to floe to bladder~~	
~~Nursing Implications~~	~~Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.~~	
~~Equipment:~~	~~Angio Tray with flushes system.~~ ~~Neff set~~ ~~Needle Guide w/ large ultrasound~~ ~~Doctor to determine all other equipment.~~	~~Hockey stick~~ ~~Glide wire~~

~~A.~~ ~~**INFECTION CONTROL**~~

1. ~~Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
2. ~~Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
3. ~~Gloves are worn to protect HCW from blood or body fluids~~
4. ~~Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
5. ~~Change gloves when moving from one body site to another.~~
6. ~~Perform hand hygiene each time gloves are removed or changed.~~
7. ~~Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B.~~ ~~**PRE-PROCEDURE**~~

1. ~~Prepare consent for Percutaneous Nephrostomy, Possible Ureteral Stent placement with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
2. ~~View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
3. ~~Complete Procedural Verification Pre-Phase section~~
4. ~~Change patient into gown~~
5. ~~Start IV of Normal Saline 0.9%.~~
6. ~~Prep site per radiologist after ultrasound exam.~~

~~C.~~ ~~**INTRA-PROCEDURE**~~

1. ~~Assist the physician as directed~~
2. ~~Complete Procedural Verification Intra-Procedure section~~
3. ~~Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D.~~ ~~**POST-PROCEDURE**~~

1. ~~Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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Tri-City Medical Center	Interven	**PCS Procedure: Skin Preparation, Surgical/Procedural; Elsevier Online Skills - Skin Preparation Agent: Skin and Tissue Injury Prevention (Perioperative)**	
PROCEDURE:	**PRE-OPERATION SKIN PREPARATIO**		**ON**
~~Purpose:~~	~~To outline responsibilities for RN, RT, an preparation to Include: Shaving the patie~~		
~~Supportive Data:~~	~~Pre-operation skin preparation is done to the surgical wound by: 1) removing hair, Reducing resident microbial count to leas growth of microbes.~~		~~ring kin. 2) und~~
~~Equipment:~~	~~Medi-Flex ChloraPrep surgical solution (10.5m1 or 25 ml), Disposable/electric razor, Non-sterile gloves~~		

~~A.~~ ~~**SHAVING THE PATIENT:**~~

1. ~~Obtain shaving supplies, battery operated surgical clipper with cutting head attached.~~
2. ~~Explain procedure to patient.~~
3. ~~Don non-sterile gloves.~~
4. ~~Expose area to be shaved.~~
5. ~~Femoral approach requires preparation of both groins. Be careful to maintain patient privacy by using a surgical towel.~~
6. ~~Prep on area 2-3 inches above inguinal crease, 2-3 inches to the right and left of femoral artery pulse and down to 2 inches above the knee.~~
7. ~~Subclavian approach requires preparation of chest wall from mid-neck down to nipple line and from left axillary border to right axillary border.~~
8. ~~Drape the perimeter of Subclavian area with sterile surgical towels~~
9. ~~Internal jugular vein requires preparation of area from ears to clavicle and mid-neck along jaw line to area 2 inches posterior of carotid artery~~
10. ~~Brachial approach requires preparation of area 4-5 inches above and below antecubital fossa.~~
11. ~~Shave operative site with electric razor. Traction promotes complete removal of hair and prevents possible nicks in skin folds. Avoid cutting warts, moles or other skin protrusions.~~
12. ~~Remove loose hair from operative area by using damp towel or 3 inch tape like material.~~
13. ~~Return electric razor to charger box after cleaning it.~~
14. ~~Discard disposable razor in sharps container~~
15. ~~Return electric razor to charger box after cleaning.~~

~~B.~~ ~~**PREPPING THE PATIENT:**~~

1. ~~Exposing area to be prepped according to description of area (s) outlined above.~~
2. ~~Prepare kit using sterile technique. Note patient allergies. Chloraprep solution should be applied to clean, dry, residue free skin.~~
3. ~~Don sterile gloves. Maintain sterility prep throughout procedure.~~
4. ~~Place sterile drape towels along sides of patients to prevent pooling of solution under patient.~~
5. ~~For 25 ml applicator. Allow the solution to flow into sponge.~~
6. ~~For 10 ml applicator hold sponge in a downward position and press down on the lever until it snaps. Allow solution to flow into sponge.~~

~~C.~~ ~~**PAINTING:**~~

1. ~~Beginning at the puncture/incision. Paint a single uniform coat of solution on the skin. Use only light pressure. If pooling occurs, immediately blot with the sponge applicator. Prep using a back and forth or up and down motion over site for 2 minutes.~~

~~D.~~ ~~**DRYING:**~~

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1. Allow solution to dry thoroughly on skin for 3 minutes. As it dries, color changes to tinted teal color, atthis point it is no longer flammable. Do not use a towel to blot dry. Once dry, proceed with draping as outlined in policy "Patient Draping".

E. **REMOVAL OF PREP SOLUTION:**

1. Alcohol based solution continues to kill bacteria for up to 48 hours and is designed to be left on the skin post operatively. When removal is desired When removal is desired, apply sterile normal saline 0.9% and wipe away with sterile gauze

Tri-City Medical Center	Interventi	DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**PULMONARY ANGIOGRAM**	
Purpose:	To outline the nursing care of the patient undergoing a Pulmonary Angiogram.	
Supportive Data:	An Aortagram is a diagnostic test of the arterial system. Diagnosis of Pulmonary embolism, evaluate chronic thormboebolic disease, congenital abnormalities, arteriovenous fistulas and hemoptysis.	
Nursing Implications	Minimal sedation is used for analgesia Patients need to be monitored for signs of bleeding, allergic reaction or history related problems	
Equipment:	Angio Tray with flush system. Doctor to determine all other equipment.	

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Pulmonary Angiogram, Possible Thrombolysis with contrast sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV with Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, ER and Telemetry giving a detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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Tri-City Medical Center	Interv

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	RENAL ANGIOGRAM (EMBOLIZATI
Purpose:	To outline the nursing care of the patie... Embolization
Supportive Data:	An Aortagram is a diagnostic test of the arterial system. Diagnosis of renal artery stenosis, intra-renal hemorrhage, tumor and/or related flow. Angioplasty/Stent is therapeutic to dilate a renal artery stenosis and improve renal blood flow.
Nursing Implications	Minimal sedation is used for analgesia Patients need to be monitored for signs of bleeding, allergic reaction or history related problems Angioplasty/Stent: Patient may be require for hospitalization Ace inhibitors and Angiotension II receptors need to be held for 48 hours prior to procedure.
Equipment:	Angio Tray with flush system. Doctor to determine all other equipment.

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Renal Angiogram, Possible Embolization with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV with Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, ER and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
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Tri-City Medical Center	Interv	DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**RENAL ANGIOGRAM**	
Purpose:	To outline the nursing care of the patient undergoing a renal angiogram.	
Supportive Data:	An Aortagram is a diagnostic test of the arterial system. Diagnosis of renal artery stenosis, intra-renal hemorrhage, tumor and/or related flow. Angioplasty/Stent is therapeutic to dilate a renal artery stenosis and improve renal blood flow.	
Nursing Implications	Minimal sedation is used for analgesia Patients need to be monitored for signs of bleeding, allergic reaction or history related problems Angioplasty/Stent: Patient may be require for hospitalization Ace inhibitors and Angiotension II receptors need to be held for 48 hours prior to procedure.	
Equipment:	Angio Tray with flush system. Doctor to determine all other equipment.	

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Renal Angiogram, Possible Angioplasty, Possible Stent Placement, Possible Thrombolysis with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV with Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, ER and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Inter
PROCEDURE:	**SCRUB PERSON SET UP**
Purpose:	~~To establish set guidelines for total responsibilites of scrub person.~~
Supportive Data:	~~Skill Level RN, Scrub Technician, and Interventional Technician.~~

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

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

1. ~~Perform surgical hand scrub according to department policy.~~
2. ~~Dry with sterile towel.~~
3. ~~Put on sterile gown and don sterile gloves. Circulator will tie the back. (See policy "Gowning and Gloving")~~
4. ~~Drape x-ray handle and image intensifier with sterile bag.~~
5. ~~Drape control panel making sure procedure site is correct.~~
6. ~~Connect and flush all tubing to transducer contrast and flush solution.~~
7. ~~Check for correct supplies on table.~~
8. ~~Hand physician sterile towel to dry hands~~
9. ~~Hand physician sterile wet towel to wash power off gloves~~
10. ~~Follow physician instructions. Scrub tech is responsible for flushing all sheaths, catheters, and needles during procedure and wiping all wires. Scrub tech is responsible for assisting physician with wire catheter insertions and removal.~~
11. ~~State total amount of contrast administrated to monitor person.~~
12. ~~Once case has started, scrub tech will not break scrub.~~
13. ~~Discard used supplies in appropriate containers.~~
14. ~~Collect reusable equipment, rinse in basin, drain, wrap in towel and place in plastic container for decontamination.~~

B. ~~**PRECAUTIONS:**~~

1. ~~Sterility is of vital importance. Personal protective equipment is mandatory and will be worn (glasses, lead, and glove.) Radiation protection equipment is available and used during all procedures.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Interventio	**DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)**
PROCEDURE:	**STERILE TRAY SETUP**	
~~Purpose:~~	~~Provide a standard set up procedure~~	
~~Supportive Data:~~	~~Skill Level: RN, IR Tech, and IR Scrub Tech~~	
~~Equipment:~~	~~Sani-cloth~~ ~~2 pair surgical gloves~~ ~~1 Custom angiograms pack with contrast syringes~~ ~~2 bags Heparin 1000 units in 500m1 of Normal Saline~~ ~~Sheath and catheter to be determined by doctor~~ ~~1 vial Sodium Bicarbonate 4.2%~~ ~~Contrast to be determined by doctor~~	~~Sterile disposable Angiopack~~ ~~1 pack sterile towels,~~ ~~1 25ML ChloraPrep Applicator~~ ~~1 medium sheet~~ ~~1 Angiogram cart~~ ~~1 vial Lidocaine 1%~~

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

1. ~~Tray is disinfected with Sani-cloth and wiped dry.~~
2. ~~IR Angiopack is opened in normal sterile fashion and draped over angiogram cart~~
3. ~~Surgeon gloves, sterile towels, angiogram pack/flush, 25m1 ChloraPrep applicator and labeling system added in sterile fashion.~~
4. ~~Circulator will:~~
   a. ~~Add 1 bag of Heparin 1000 units in 500 ml of Normal Saline to large basin.~~
5. ~~Connect 1 bag Heparin 1000 units in 500m1 Normal Saline to flush system and hang.~~
6. ~~Connect contrast determined by doctor to flush system and hang.~~
7. ~~Label all bowls and syringes with labeling system.~~
8. ~~Sheaths, catheters, arterial needles, and wires will be wiped down and flushed with heparin solution.~~
9. ~~9 ml of Lidocaine 1% with 1 ml of Sodium Bicarbonate is drawn up in 10 ml syringe.~~
10. ~~Verify all connections on the Angiopack are tight.~~
11. ~~Cover tray with sterile medium drape~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, **02/20**	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**SURGICAL HAND SCRUB**

DELETE – follow Patient Care Services Procedure: Surgical Hand Antisepsis

Purpose:	~~Prevent infection, remove dirt, oil, and mic~~ ~~extremities. Leave an antimicrobial residue on the skin to prevent growth of mircooranisgms.~~	
Supportive Data:	~~AORN Standards~~	
Nursing Implications		
Equipment:	~~Antimicrobial soap~~ ~~Scrub brush~~ ~~Sterile gown~~ ~~Triseptin~~	~~Plastic nail cleaner~~ ~~Sterile towels~~ ~~Avagard cleansing solution~~ ~~Antimicrobial soap~~

A. ~~**TRISEPTIN ANTIMICROBIAL SOAP:**~~

1. ~~Use antimicobial soap (Triseptin) to wash hands and arms 11/2 minutes to remove gross contamination from the skin.~~
2. ~~Clean nails and subungual area with a disposable plastic nail cleaner.~~
3. ~~Rinse hands and arms thoroughly.~~
4. ~~Using Triseptin, scrub the hands and arms 2 inches above the elbow for 1% minutes.~~
5. ~~Rinse hands and arms thoroughly. Hold hands upright so water runs down arms.~~
6. ~~Hold hands and arms up and out from scrub cloths. Using a towel, dry from hand to elbow.~~

B. ~~**AVAGARD /PARACHLORAMETAXYLENOL CLEANSING SOLUTION**~~

1. ~~Use Avagard cleansing solution to wash hands and arms for 1% minutes to remove gross contamination from skin.~~
2. ~~Sterile scrub brush is open and placed in accessible area.~~
3. ~~Wet hand and arms to 2 inches above elbow~~
4. ~~Apply anti-microbial soap, lather, wash hands and arms thoroughly, then rinse. Remove surface dirt, oil, and microbes.~~
5. ~~Take sterile scrub brush in one hand, using the other to clean underneath nails with the nail cleaner. Repeat for the other hand.~~
6. ~~Moisten the scrub brush and apply anti-microbial soap, scrub along nails of each hand, holding the hands above the elbows throughout the procedure.~~
7. ~~Begin with the thumb, scrub all four surfaces, moving on to each finger in like manner including web spaces. All surfaces must be clean to provide maximum effect of scrubbing.~~
8. ~~Scrub the back of the hand, the palm.~~
9. ~~Move to the other hand following the same procedure in 7 and 8. Apply more anti-microbial soap as needed.~~
10. ~~Scrub lower half of each forearm using a circular pattern, moving from one arm to the other. Moving sequentially up both arms prevents return microbes from periphery to cleanest area.~~
11. ~~Scrub upper half of each forearm using a circular pattern, moving from one arm to the other. Moving sequentially up both arms prevents return microbes from periphery to cleanest area.~~
12. ~~Scrub ante-cubital space and elbow to 2 inches above elbow using a circular pattern moving from one arm to the other.~~
13. ~~Rinse hands and arms keeping hands higher than elbows. Allow water to drop off at elbows. Prevent contamination of first scrubbed cleanest areas.~~
14. ~~Holding hands up and elbows away from body, enter assigned room bending slightly at the waist.~~

C. ~~**DRYING THE CLEANSED AREA**~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

1. Grasp sterile towel near corner, lift up and away from sterile area. Prevent contamination of sterile field.
2. Step back from sterile field, bend slightly at the wrist, allow to unfold to its full length and width. Prevent contamination of sterile field and towel from brushing against unsterile scrub suit.
3. Holding the top half, dry the opposite hand, moving up the arm using a rotating motion without returning to a previous dried area.
4. The towel is reversed and the opposite hand is dried in a similar manner.
5. The towel is discarded without manipulation.

D. **PRECAUTIONS:**

1. Inspect hands to assure that nails are free of polish and trimmed short, cuticles are in good condition, and no cuts or skin problems exist. Nails should be no longer than the end of the fingertips. No rings allowed.
2. Adjust operating room cap to ensure complete hair coverage, place clean mast over nose and mouth and then tie securely to prevent venting at the sides.
3. Ascertain that scrub shirt fitted, ties or ticked in the trousers to avoid contamination of scrubbed hands and arms by brushing against

Tri-City Medical Center	Interventional Radiology

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	TRANS-JUGULAR INTRA-HEPATIC P(PS)
Purpose:	To outline the nursing care of the patient
Supportive Data:	A TIPPS is a therapeutic procedure to control acute bleeding from esophageal/gastric varices due to portal hypertension; and/or control of intractable ascites.
Nursing Implications	These patients are usually critically ill and may require blood transfusion, FFP or platelet administration during procedure. Close monitoring of vital signs and coagulation factors is necessary. Patient may require embolization of persistent varices. Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.
Equipment:	Angio Tray with flushes system. Micro-punture kit Amplatz extra stiff wire x 180cm Namic pressure transducer Ring Tran jugular Hepatic Access Set or Rosch Liver access kit 5 FR C-2 Cobra catheter K50 CO2 set up Doctor to determine all other equipment

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Tran jugular Intra-hepatic Portal Caval Shunt with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Shave and/or prep area
6. Start IV of Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, **02/20**	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Inter	DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)
PROCEDURE:	**TUNNELED DIALYSIS CATHETER**	
~~Purpose:~~	~~To outline the nursing care of the pati ement.~~	
~~Supportive Data:~~	~~A vascular access device (VAD) is inserted to provide long-term intravenous (IV) therapy for administration of medications, fluids, nutrition, blood products, and repeat access or to provide dialysis.~~	
~~Nursing Implications~~	~~Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.~~	
~~Equipment:~~	~~Angio Tray without flushes system and large bowl. Doctor to determine all other equipment.~~	

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
~~3. Gloves are worn to protect HCW from blood or body fluids~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Prepare consent for Tunneled Dialysis Catheter Placement with Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~2. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~3. Complete Procedural Verification Pre-Phase section~~
~~4. Change patient into gown.~~
~~5. Pre-Operation skin preparation procedure.~~
~~6. Radiologist to check chest area with ultrasound.~~
~~7. Surgical scrub techniques for Scrub tech or RN.~~
~~8. Start IV of Normal Saline 0.9%.~~
~~9. Possible Antibiotic therapy~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~
~~4. Port flushed w/ Heparin 1000 units/ml (amount to be determined)~~

~~D. **POST-PROCEDURE**~~

~~1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, **02/20**	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventi	**DELETE - utilize PCS PROCEDURE: Specimen Handling for Surgical/Procedural Areas; Elsevier Online Skills - Specimen Collection (Perioperative)**
PROCEDURE:	**ULTRASOUND GUIDED BIOPSIES**	
~~Purpose:~~	~~To outline the nursing care of the patient u~~	
~~Supportive Data:~~	~~Procedure in which a sample of tissue is te to determine is a lesion is benign or malign abnormal cells related to infection.~~	~~ed se~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia. Pa bleeding, allergic reaction or history related problems.~~	~~f~~
~~Equipment:~~	~~Biopsy Tray. Doctor to determine all other equipment.~~	

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
~~3. Gloves are worn to protect HCW from blood or body fluids~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Prepare consent for Cat Scan/Ultrasound guided (liver, pancreas, lung, thyroid, and kidney) biopsy~~
~~2. with Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~3. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~4. Complete Procedural Verification Pre-Phase section~~
~~5. Change patient into gown~~
~~6. Start IV of Normal Saline 0.9%.~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~D. **POST-PROCEDURE**~~

~~1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center	Distribution: INTERVENTIONAL RADIOLOGY Delete and utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	UPPER/LOWER EXTERMITY AORTAGRAM
~~Purpose:~~	~~To outline the nursing care of the patient undergoing an Angiogram~~
~~Supportive Data:~~	~~An Aortagram is a diagnostic test of the arterial system. Implications include, PVD, arterial thrombosis, AAA. Once the diagnostic process has been completed it is possible that an Angioplasty or Vascular Stent could be placed. An Angioplasty is a therapeutic procedure used to reduce a blockage(s) in an artery to restore blood flow. A Vascular Stent is a device deployed in an artery, to restore blood flow.~~
~~Nursing Implications:~~	~~Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems.~~

~~INFECTION CONTROL~~

1. ~~Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
2. ~~Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
3. ~~Gloves are worn to protect HCW from blood or body fluids~~
4. ~~Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
5. ~~Change gloves when moving from one body site to another.~~
6. ~~Perform hand hygiene each time gloves are removed or changed.~~
7. ~~Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~PRE-PROCEDURE~~

1. ~~Prepare consent for Upper/Lower Extremity Angiogram, Possible Angioplasty, Possible Stent placement, Possible Thrombolysis with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
2. ~~View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
3. ~~Complete Procedural Verification Pre-Phase section~~
4. ~~Change patient into gown~~
5. ~~Start IV of Normal Saline 0.9%.~~

~~INTRA-PROCEDURE~~

1. ~~Assist the physician as directed~~
2. ~~Complete Procedural Verification Intra-Procedure section~~
3. ~~Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~

~~POST-PROCEDURE~~

1. ~~Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

ISSUED:	REVIEED:	REVISED:	APPROVED:
6/08	6/10.6/11		6/08

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
02/20	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**UTERINE ARTERY ANGIOGRAM (EMBOLI**
Purpose:	To outline the nursing care of the patient und with Embolization
Supportive Data:	An Angiogram is a diagnostic test of the arterial system. Diagnosis of Uterine artery stenosis, intra-renal hemorrhage, tumor and/or related flow. Angioplasty/Stent is therapeutic to dilate a renal artery stenosis and improve renal blood flow.
Nursing Implications	Minimal sedation is used for analgesia Patients need to be monitored for signs of bleeding, allergic reaction or history related problems Patient may be require for hospitalization
Equipment:	Angio Tray with flush system. Doctor to determine all other equipment.

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn.
3. Gloves are worn to protect HCW from blood or body fluids.
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for Uterine Artery Angiogram, Possible Embolization with Contrast and Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown
5. Start IV with Normal Saline 0.9%.

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, ER and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, **02/20**	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology
PROCEDURE:	**VASCULAR CATHETER PLACEMENT**
~~Purpose:~~	~~To outline the nursing care of the patient un~~ ~~at.~~
~~Supportive Data:~~	~~A vascular access device (VAD) is inserted~~ ~~therapy for administration of medications, flu~~ ~~at access or to provide dialysis.~~
~~Nursing Implications~~	~~Minimal sedation is used for analgesia. Pati~~ ~~bleeding, allergic reaction or history related~~
~~Equipment:~~	~~Minor PICC Tray. Doctor to determine all other equipment.~~

DELETE - utilize PCS Procedure: Central Venous Access Devices, Adults; Elsevier Online Skills - Central Venous Catheter Insertion

~~A. **INFECTION CONTROL**~~

~~1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.~~
~~2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn~~
~~3. Gloves are worn to protect HCW from blood or body fluids~~
~~4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.~~
~~5. Change gloves when moving from one body site to another.~~
~~6. Perform hand hygiene each time gloves are removed or changed.~~
~~7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.~~

~~B. **PRE-PROCEDURE**~~

~~1. Prepare consent for Temporary Vascular Catheter Placement with Possible Sedation. Patient will need to sign after informed consent by the interventional radiologist.~~
~~2. View information from nurse pre-call sheet. Complete or obtain any new patient information.~~
~~3. Complete Procedural Verification Pre-Phase section~~
~~4. Change patient into gown.~~
~~5. Pre-Operation skin preparation procedure.~~
~~6. Radiologist to check chest area with ultrasound.~~
~~7. Surgical scrub techniques for Scrub tech or RN.~~
~~8. Start IV of Normal Saline 0.9%.~~
~~9. Possible Antibiotic therapy~~

~~C. **INTRA-PROCEDURE**~~

~~1. Assist the physician as directed~~
~~2. Complete Procedural Verification Intra-Procedure section~~
~~3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.~~
~~4. Port flushed w/ Heparin 1000 units/ml (amount to be determined)~~

~~D. **POST-PROCEDURE**~~

~~1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.~~

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, **02/20**	**10/21**	**n/a**	**n/a**	11/21	n/a	06/08

Tri-City Medical Center	Interventional Radiology

DELETE - utilize Elsevier Online Skills - Sterile Field: Setup (Perioperative)

PROCEDURE:	VERTEBROPLASTY
Purpose:	To outline the nursing care of the patient [illegible]
Supportive Data:	A therapeutic study to provide pain relief [illegible] osteoporatic vertebral collapse or compression fracture.
Nursing Implications	Minimal sedation is used for analgesia. Patients need to be monitored for signs of bleeding, allergic reaction or history related problems. Patient prone for procedure.
Equipment:	Angio tray without flushes. Doctor to determine all other equipment.

A. **INFECTION CONTROL**

1. Unless hands are soiled use a waterless hand hygiene product. If hands are soiled, wash with soap and water.
2. Hand hygiene is performed prior to and immediately after touching a patient, whether or not gloves are worn
3. Gloves are worn to protect HCW from blood or body fluids
4. Wear clean gloves if touching mucus membranes or non-intact skin. Once gloves touch and surface (i.e., patient, equipment, countertops) they are no longer 'clean'.
5. Change gloves when moving from one body site to another.
6. Perform hand hygiene each time gloves are removed or changed.
7. Wear personal protective equipment to protect your eyes, nose and mouth from spray or splashes. A gown is worn to protect cloth.

B. **PRE-PROCEDURE**

1. Prepare consent for (Location) Vertebroplasty with Sedation. Patient will need to sign after informed consent by the interventional radiologist.
2. View information from nurse pre-call sheet. Complete or obtain any new patient information.
3. Complete Procedural Verification Pre-Phase section
4. Change patient into gown.
5. Pre-Operation skin preparation with betadine.
6. Surgical scrub techniques for Scrub tech or RN.
7. Start IV of Normal Saline 0.9%.
8. Possible Antibiotic therapy

C. **INTRA-PROCEDURE**

1. Assist the physician as directed
2. Complete Procedural Verification Intra-Procedure section
3. Monitor vital sign every according to patient sedation level. If patient falls into Ramsey Scale score of 3 and over use Sedation Analgesia IV.H Policy.

D. **POST-PROCEDURE**

1. Transport patient to SPRA, PACU, ICU, and Telemetry giving detailed patient report.

Department Review	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 02/20	10/21	n/a	n/a	11/21	n/a	06/08

Tri-City Medical Center
Oceanside, California

LABORATORY
SAFETY MANUAL/LABORATORY INFECTION PREVENTION AND CONTROL

ISSUE DATE: 01/03 **SUBJECT: Laboratory Infection Prevention and Control**

REVISION DATE(S): 07/03, 07/06, 10/09, 09/12~~, 04/21~~

Department Approval:	**~~04~~10/21**
Laboratory Medical Director Approval:	**10/21**
Medical Executive Committee Approval:	**11/21~~09/12~~**
Administrative Approval:	**11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/12**

A. **DEFINITION(S):**

1. **~~I~~Infection Prevention and Control: The discipline concerned with preventing healthcare-associated infections.**
2. **Personal Protective Equipment: The protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.**
3. **Universal Precautions: The concept of bloodborne disease control requiring all human blood and other potentially infectious materials to be treated as if infectious for HIV, HBV, HCV or other bloodborne pathogens, regardless of the perceived "low risk" status of a patient or patient population.**

~~1.~~**4. Hand Hygiene: the act of cleaning one's hands with soap and water to remove viruses/bacteria/microorganisms, dirt, grease, or other harmful and unwanted substances stuck to the hands.**

B. **POLICY:**

1. Infection Control: The laboratory follows written policies and procedures for infection control that comply with national, federal, state (or provincial), and local guidelines on occupational exposure to bloodborne pathogens and other infectious pathogens, and to the institution's exposure control plan. (GEN.74000).
   a. Refer to Infection Control Policy Manual: Bloodborne Pathogen Exposure Plan.
2. Specimen Handling/Processing: The laboratory safely handles specimens suspected to contain highly infectious pathogens. (GEN.74050).
   a. ~~Standard~~ **Universal** Precautions must be adhered to when obtaining, handling or processing all blood and other potentially infectious materials.
      i. This includes control sera and reagents from biological sources.
      ii. See department specific Blood Borne Pathogen Task Assessments in the Laboratory Safety Manual.
   b. After drawing a blood culture specimen, do not change the needle, and inject the specimen directly into the blood culture bottle.
   c. Needleless systems will be used whenever possible.
   d. Safety needle devices must be used at all times.
   e. All containers of biological samples shall be sealed or covered or kept in sealed containers unless currently being analyzed.
   f. Care should be taken to avoid all spillage and creation of aerosols during transfer steps.
3. Personal Protective Equipment (PPE) Provision and Usage: Appropriate personal protective equipment (gloves, gowns, masks and eye protectors, etc.) is provided and maintained in a sanitary and reliable condition in all work areas whenever blood and other potentially infectious

materials are handled and in circumstances during which exposure is likely to occur. (GEN74100).

a. All Laboratory personnel must wear laboratory issued coats or fluid resistant gowns supplied by Tri-City Medical Center (TCMC) when performing specimen collection including venipuncture, when handling specimens not in a secondary container such as a bag, when performing testing of specimens, and when performing tasks that require its use.
b. Lab coats and gloves may not be worn outside the laboratory and may not be worn in areas within the lab where food and drinks are allowed.
    i. The exception is lab coats may be worn from a work area through a clean area to another work area such as a phlebotomist dispatched to a unit.
c. Laboratory coats or fluid resistant gowns upon which biological material has been spilled are a biohazard and must be expeditiously removed, placed in the dirty linen hamper, or disposed of appropriately. The fluid resistant gown may be placed in the regular trash, if it is disposable.

4. PPE Instruction: Personnel are instructed in the proper use of personal protective clothing/equipment (eg, gloves, gowns, masks, eye protectors, footwear) and records are retained. (GEN.74200).
    a. Training for laboratory staff in proper use of PPE is performed during the initial department competency training and records are kept in their employee file.
    b. See department specific Blood Borne Pathogen Task Assessments for PPE use in specific tasks.
5. Hand Hygiene: All personnel remove gloves and clean hands using an effective antimicrobial method following contact with blood or other potentially infectious materials or after each patient contact. (GEN.74250).
    a. See Infection Control Policy Manual: Hand Hygiene.
6. Manual Manipulation of Needles: There is a written policy that prohibits the recapping, purposeful bending, breaking, removing from disposable syringes, or other manual manipulations of needles. (GEN.74300).
    a. Needles must never be recapped by hand.
    b. Needles must not be not cut or bent**, broken or removed from disposable syringes.**
7. Eating/Mouth Pipetting: There is a written policy that prohibits smoking, vaping, eating, gum chewing, drinking, application of cosmetics and lip balm, manipulation of contact lenses, and mouth pipetting in all technical work areas. (GEN.74400).
    a. Mouth pipetting of any substance is prohibited. Mechanical pipettes or suitable alternative devices are used.
    b. No foods or beverages may be present in any part of the Laboratory where specimen handling and/or testing is performed. This includes front office and phlebotomy areas.
    c. Food and beverages may be consumed in the administrative offices, employee break room, conference room pathology offices and transcription area.
    d. No smoking, vaping, eating, drinking, chewing gum, donning earrings or application of cosmetics are permitted in any Laboratory working area.
    e. Oral and ocular contact with any surface, including hands, capable of harboring and transmitting infectious agents, is prohibited.
8. Specimen Transport Procedures: The laboratory receives, handles, and transports specimens (blood and other potentially infectious materials) in appropriately labeled and well-constructed containers with secure lids to prevent leakage during transport. (GEN.74500).
    a. See Pre-Analytical General Procedure: Specimen Handling, Transportation, Special Collection, Processing, Aliquoting, and Criteria for Rejection.
    b. See Safety Manual Related Document: Laboratory Pneumatic Tube System Spill Clean Up.
9. Spill Handling: The laboratory follows written procedures for handling spills of blood and other potentially infectious materials. (GEN.74600).
    a. See General Safety and Safety Training Manual Procedure: Laboratory Spills.

10. Hepatitis B Vaccinations: Personnel reasonably expected to have direct contact with blood and other potentially infectious materials are identified and offered hepatitis B vaccinations free of charge. Personnel that decline the vaccine sign a declination form. (GEN.74700).
    a. See Employee Health and Wellness Policy Manual: Employee Health – Hepatitis B Vaccination.
11. Viral Exposure: There is a policy for follow-up after possible and known percutaneous, mucous membrane or abraded skin exposure to HIV, HBV or HCV that includes the following elements (GEN.74800):
    a. HIV, HBV and HCV testing of the source patient after consent is obtained.
    b. Appropriate clinical and serologic evaluation of personnel.
    c. Consideration of appropriate prophylaxis for personnel acutely exposed to HIV, HBV or HCV, based upon medical indications, the serologic status and the individual's informed consent.
    d. Reporting of the exposure as required by law.
    e. See Employee Health and Wellness Policy Manual: Occupational Exposure to Blood/Body Fluid Secretions.
    f. Records of occupational exposure and follow up are kept in the Employee Health and Wellness Department.
12. Tuberculosis (TB) Exposure Plan: The laboratory follows a written tuberculosis exposure control plan that includes the following (GEN.74900):
    a. TB exposure screening at defined intervals for all personnel who may have occupational exposure to tuberculosis.
    b. Use of engineering and practice controls for hazardous activities that may potentially aerosolize Mycobacterium tuberculosis.
    c. See Infection Control Policy Manual: Aerosol Transmissible Diseases and Tuberculosis Control Plan.
13. Sterilizing Device Monitoring: All sterilizing devices are monitored periodically with a biologic indicator (or chemical equivalent) for effectiveness of sterility under conditions that simulate actual use. (GEN.75000).
    a. See Sterile Processing Department Procedure: Sterilization Standards Procedure.
14. Cleaning Procedures:
    a. Bench tops are cleaned after use, and at least daily at the end of the shift, with a 1:10 aqueous solution of bleach or hospital-approved disinfectant.
    b. The Environmental Services Department personnel clean floors, hand washing sinks, and furniture.
    c. Department personnel clean refrigerators, machines and computers on a routine basis.

~~C.~~ **PROCEDURE:N/A**
~~1.~~**C.**

~~D.~~ **FORM(S):N/A**
~~1.~~**D.**

E. **RELATED DOCUMENT(S):**
1. Safety Manual Related Document: Laboratory Pneumatic Tube System Spill Clean Up
2. **Laboratory Department specific Blood Borne Pathogen Task Assessments**
3. **Infection Control Policy Manual: Bloodborne Pathogen Exposure Plan**
4. **Infection Control Policy Manual: Hand Hygiene**
5. **Pre-Analytical General Procedure: Specimen Handling, Transportation, Special Collection, Processing, Aliquoting, and Criteria for Rejection**
6. **General Safety and Safety Training Manual Procedure: Laboratory Spills**
7. **Employee Health and Wellness Policy Manual: Employee Health – Hepatitis B Vaccination**
8. **Employee Health and Wellness Policy Manual: Occupational Exposure to Blood/Body Fluid Secretions**

9. Infection Control Policy Manual: Aerosol Transmissible Diseases and Tuberculosis Control Plan

~~1.~~**10. Sterile Processing Department Procedure: Sterilization Standards Procedure**

~~F. EXTERNAL LINK(S):N/A~~

~~1.~~**F.**

G. **REFERENCES:N/A**

~~1. Infection Control Policy Manual: Bloodborne Pathogen Exposure Plan~~
~~2. department specific Blood Borne Pathogen Task Assessments~~
~~3. Infection Control Policy Manual: Hand Hygiene~~
~~4. Pre-Analytical General Procedure: Specimen Handling, Transportation, Special Collection, Processing, Aliquoting, and Criteria for Rejection~~
~~5. General Safety and Safety Training Manual Procedure: Laboratory Spills~~
~~6. Employee Health and Wellness Policy Manual: Employee Health – Hepatitis B Vaccination~~
~~7. Employee Health and Wellness Policy Manual: Occupational Exposure to Blood/Body Fluid Secretions~~
~~8. Infection Control Policy Manual: Aerosol Transmissible Diseases and Tuberculosis Control Plan~~
~~9. Sterile Processing Department Procedure: Sterilization Standards Procedure~~

~~**ISSUE DATE: 1/03 SUBJECT: Department Specific: Clinical Laboratory**~~

~~**REVISION DATE: 7/03; 7/06, 10/09, 9/12 POLICY NUMBER: IC.7.1**~~

~~**Infection Control Committee Approval: 9/12**~~
~~**Medical Executive Committee Approval: 9/12**~~
~~**Board of Directors Approval: 9/12**~~

~~a. **POLICY:**~~

~~1. Microorganisms in the Laboratory can be inhaled, ingested or inoculated through the skin. There is also a danger of exposure to blood and body fluids via needle puncture, leaking syringes or contamination while separating needles from syringes. Other commonly recognized exposure incidents include spills and breakage resulting in sprays (aerosol) of infectious materials, and injuries with broken glass or other sharp instruments. Therefore, all Laboratory personnel are expected to strictly adhere to health and safety practices.~~
~~2. Personal Protective Equipment:~~
~~a. All Laboratory personnel must wear laboratory issued coats or fluid resistant gowns supplied by TCMC when performing specimen collection including venipuncture, when handling specimens not in a secondary container such as a bag, when performing testing of specimens and when performing task that require its use as per the Blood borne Pathogen Exposure Control Plan.~~
~~b. Lab coats and gloves may not be worn outside the laboratory and may not be worn in areas within the lab where food and drinks are allowed. The exception is lab coats may be worn from a work area through a clean area to another work area such as a phlebotomist dispatched to a unit.~~
~~c. Laboratory coats or fluid resistant gowns upon which biological material has been spilled are a biohazard and must be expeditiously removed, placed in the dirty linen hamper, or disposed of appropriately. The fluid resistant gown may be placed in the regular trash, if it is disposable.~~

d. Refer to the Bloodborne Pathogen Exposure Control Plan for complete information.

3. Oral and Body Surfaces:
   a. No smoking, eating, drinking, chewing gum, donning earrings or application of cosmetics are permitted in any Laboratory working area. Smoking is not allowed
   b. Oral and ocular contact with any surface, including hands, capable of harboring and transmitting infectious agents, is prohibited.
4. Food and Beverages
   a. No foods or beverages may be present in any part of the Laboratory where specimen handling and/or testing is performed. This includes front office and phlebotomy areas.
   b. Food and beverages may be consumed in the administrative offices, employee break room, conference room pathology offices and transcription area.
5. Specimen Collection/Handling
   a. STANDARD PRECAUTIONS must be adhered to when obtaining, handling or processing ALL blood/body fluid specimens or potentially infectious materials, see Blood Borne Pathogen Task Assessment in the Laboratory Safety Manual.
   b. After drawing a blood culture specimen, do not change the needle, and inject the specimen directly into the blood culture bottle.
   c. Needleless systems will be used whenever possible.
6. Handling of Sharps
   a. Safety needle devices must be used at all times.
   b. Needles must never be recapped by hand.
   c. Needles must not be not cut or bent.
7. Centrifugation:
   a. Blood bank serological centrifuges are cleaned weekly with approved disinfectant solution. In case of breakage, immediately clean and disinfect the area.
   b. Other centrifuges must be disinfected monthly. In case of breakage, immediately clean and disinfect the area.
   c. All centrifuge surfaces, including carrier cups, must be disinfected.
   d. All samples must be stoppered when centrifuged in order to prevent aerosol formation and spillage.
   e. Centrifuges must always be balanced prior to operation.
   f. Specimens spun in angle head centrifuges must never be filled to the extent that liquid will be in contact with the tube lips.
8. Opening Specimen Containers and Transfer of Specimens:
   a. Do not pop vacuum container stoppers. Popping the stopper generates aerosols, prime sources for bloodborne disease transmission.
   b. Cover stoppers with a bio wipes and twist them off gently allowing the aerosol to be contained in the biowipe.
   c. Any specimen spillage on containers is hazardous. Care should be taken to avoid all spillage and creation of aerosols during transfer steps.
9. Control Sera and Reagents from Biological Sources:
   a. All material prepared from biological sources are biohazardous in that they are high probability agents for transmission of disease.
   b. All such materials must be treated as though they were specimens capable of transmitting infectious disease.
10. Spillage of Biological Samples:
   a. Spills on paper, or on disposable surfaces, any worksheet, request or report upon which a biological sample has been spilled, should be recopied and the contaminated paper discarded as biohazard waste.
   b. Spills on non-disposable surfaces must be cleaned promptly with an aqueous 1:10 dilution of bleach or hospital-approved disinfectant.
11. Pipetting:

a. Mouth pipetting of any substance is prohibited. Mechanical pipettes, rubber bulbs or suitable alternative devices are used.
b. Rubber bulbs and tubing, used for capillary tube pipetting, are disposed of periodically, in the regular trash.
c. Glass Pasteur pipettes are disposed of as sharps waste.

12. Storage of Biological Samples:
    a. All containers of biological samples shall be sealed or covered or kept in sealed containers unless currently being analyzed.
13. Cleaning Procedures:
    a. Bench tops are cleaned after use, and at least daily at the end of the shift, with a 1:10 aqueous solution of bleach or hospital-approved disinfectant.
    b. The Environmental Services Department personnel clean floors, hand washing sinks, and furniture.
    c. Department personnel clean refrigerators, machines and computers on a routine basis.
14. Pathology Medical Waste Disposal:
    a. Sections of specimens (tissues, organs, etc.) are placed in 10% Formalin prior to transporting to the laboratory.
    b. Specimens are disposed of by contracted medical waste service.
15. Microbiology's/Laboratory's Role in the Infection Prevention and Control Program:
    a. Laboratory Services provide a copy of appropriate serology, virology and microbiology reports to the Infection Control Physician to assist in the surveillance program.
    b. The Microbiology Department provides antibiotic profiles and antibiotic sensitivity patterns of the most commonly isolated bacteria. Such information may be useful in determining the etiology of some infections as well as useful tool in identifying trends in the emergence of resistant organisms and changes in the hospital flora, or provides valuable data for antibiotic usage.
16. Reporting Infectious/Communicable Diseases and Conditions:
    a. Contract and on site Laboratory Services are responsible for reporting as required, certain diseases to the local Public Health Office. (See IC.12 Required Reporting)
    b. The Laboratory will also notify the Infection Control Department, Nursing Manager/ Supervisor and Attending Physician of cases of positive acid fast smears or cultures, on inpatients and outpatients.
17. AIDS/HIV Testing and Consent:
    a. Administrative Manual for Consent and Occupational Exposure Policies.
    b. All AIDS/HIV confirmed positive results are reported to Public Health as required by law. (See IC.12 Required Reporting)
    c. All CD4+ T-cell test results are reported to Public Health as required by SB1184.
18. Laboratory Blood Bank:
    a. Objective: to provide guidelines for the safe handling of blood and blood products to lessen the risk of exposure of hospital patients and Laboratory personnel to bloodborne infections.
    b. Staff Responsibilities: Those on duties in or rotate through the blood bank area are responsible for adhering to established Blood Bank policies and procedures and infection control guidelines. (Hospital and Departmental)
    c. Infectious Agent screening: blood products are received from the American Red Cross (ARC) or the San Diego Blood Bank (SDBB) and have been pre- screened for infectious agents according to AABB acceptable standards.
    d. Blood Preservations/Safety Measures:
        i. All whole blood products are kept refrigerated at 1 - 6 C. Refrigerators are equipped with alarms to signal significant deviations from acceptable temperature levels.

ii. Blood is to be administered to the patient within two (2) to three (3) hours and it is to hang no longer than four (4) hours.
iii. The Blood Bank will not accept blood for return, which has been away from the Laboratory Blood Bank for a period longer than 30 minutes. (Also see Blood Bank Quality Control/
iv. The Blood Bank dispenses, by single units. More than one unit per patient at a single time is released only in emergency cases where blood is continuously infused (e.g. traumatic hemorrhaging) or via ice chest to the OR.

e. All personnel must wear personal protective clothing (lab coats) in the Blood Bank area when performing task requiring its use (se Blood Borne Task Assessment for the Transfusion Service.
f. Lab coats and other protective clothing in the Lab area must be removed before going to the cafeteria or leaving the hospital at the end of the shift.
g. Cleaning Procedures:
i. Blood spills should be flooded with Clorox bleach solution (1:10) or hospital-approved disinfectant and allowed to stand for a period of 10 minutes before wiping or mopping up.
ii. All flat surfaces are cleaned with a bleach solution or approved disinfectant as recommended by the general Laboratory Manual at the end of each day or more often as needed during the course of a day.
h. Medical Waste (Infectious Waste):
i. Blood bags are to be handled and disposed of as medical waste by bagging in a labeled red plastic bag and placed in the medical waste container.
ii. Blood bags from the patient care areas of the hospital are to be red bagged and held in the dirty utility area on each nursing floor for disposal.
iii. All blood is considered a possible source of infection and is treated as such by using proper protection (e.g. use gloves for handling specimens).

19. Morgue:
a. Objective: To ensure optimum levels of sanitation and functional safety in the morgue.
b. Supportive data: Occupational transmission of disease associated with autopsy has been documented. Accidents include exposure to aerosol, spill/splatter, and sharps injury and have resulted in blood-borne diseases and tuberculosis. Careful attention to Standard precautions with engineering controls, work safety practices, and personal protective equipment will decrease the occupational risk.
c. General Cleanliness:
i. The pathologist scrubs sinks and Countertops with a hospital approved disinfectant after use.
ii. Environmental Services is notified after each autopsy so the area can be cleaned. Floors and walls (if soiled) are mopped with hospital approved disinfectant. Mop heads, sponges, and other cleaning items are disposed of or sent to the laundry after completing the cleaning.
iii. The body refrigerator and lifters are cleaned by Environmental Services on a regular basis.
iv.
v. Equipment:
1) All cutting board areas are assumed to be contaminated. Cutting board will be cleaned of gross blood and debris by washing with soap and water. Spray with hospital-approved disinfectant and let sit wet for required time period per manufactures instructions (10 minutes is usual).
2) Instruments are washed with soap and water, and sprayed with hospital approved disinfectant per manufactures instructions (10 minutes is usual) before returned to the locked instrument drawer.

3) Sharps are disposed according to hospital policy. Full containers (at the 3/4 full mark) are capped and carried by the pathologist to the lab for disposal.

vi. Attire: Protective covering (gown, booties, apron, goggles and mask or face shield will be worn by all personnel during autopsies.

vii. Specimens and Autopsy Material:

1) Discard extraneous specimens down the morgue garbage disposal
2) Large pathological specimens are placed in red bag waste and disposed of according to hospital's waste management policies

d. Traffic Control: Only authorized personnel are allowed.

b. **REFERENCES:**

1. Philosophy IC.2
2. Standard and Transmission Based Precautions IC.5
3. Participation of Staff in the Infection Control Program IC.7
4. Hand Hygiene IC.8
5. Cleaning and Disinfection IC.9
6. Employee Health Services Policies
7. Administrative Policy #401 Injury Prevention Program
8. Mandatory Reporting of Positive HIV and Vial Hepatitis Results. Reference Laboratory Manual. Rev. 7/5/2012.
9. Laboratory Safety Manual. Rev 9/2011.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 07/11	**SUBJECT:** Credentialing Policy, da Vinci Robotic Surgery
REVISION DATE(S): 07/12, 01/14, 02/19	**POLICY NUMBER:** 8710 – 563

Medical Staff Department Approval:	~~03/17~~08/21
Division of GVS Approval:	~~06/17~~09/21
Credentials Committee Approval:	~~11/17~~11/21
Medical Executive Committee Approval:	~~11/17~~11/21
Administration Approval:	01/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **PURPOSE**

1. To provide criteria for use in credentialing physicians who request privileges in da Vinci robotic surgery. For purposes of this policy, terms da Vinci and robotic are interchangeable.

B. **INITIAL CREDENTIALING FOR MULTIPLE PORT PROCEDURES:**

1. For surgeons with prior da Vinci experience:
   a. Physicians must have privileges to perform the underlying procedure either as an open or laparoscopic procedure.
   b. If residency/fellowship training included robotic surgery training, provide:
      i. letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device; and
      ii. The surgical log of a minimum of ten (10) da Vinci cases;
      iii. Proctoring: A minimum of two (2) cases within a one-hundred-eighty (180) day period must be proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
         1) Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.
   c. For surgeons with prior da Vinci experience at an outside institution, provide:
      i. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
      ii. Proctoring: A minimum of one (1) case must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).
   d. The above-listed proctoring requirements may be waived for any surgeon on the Intuitive Surgical, Inc. List of Approved Proctors. However, privilege-specific proctoring requirements must be followed.
2. For surgeons without prior da Vinci experience:
   a. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
   b. Completion of an Intuitive Training Program or comparable program, which includes didactic and hands-on training including cadaver, animal lab, or simulator (See Phase II-Preparation and System Training of Surgeon Clinical Pathway-Intuitive Surgery).
   c. A minimum of one (1) live case observation.
   d. Proctoring: A minimum of three (3) cases within a one hundred eighty (180) day period must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).

i. Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

3. Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed.
4. For all physicians granted robotic surgery privileges, the first ten (10) cases will be reviewed for evaluation of case selection, OR time, blood loss, conversion to open procedure, complications, length of hospital stay, etc.
5. For privileges to assist in robotic surgery (for MD/DO, PA, RNFA):
   a. Unrestricted surgical assisting privileges
   b. Documented experience in robotic assisting or completion of Intuitive Training Program for assistants (including on-line module and on-site training by Intuitive or a robotics-trained assistant)
   c. Proctoring: A minimum of six (6) cases must be proctored by the primary surgeon. Surgeons granted privileges for both robotic surgery and to assist in robotic surgery may be deemed to have satisfied proctoring requirements as an assistant in robotic surgery once proctoring requirements as the robotic surgeon have been fulfilled.

C. **INITIAL CREDENTIALING FOR SINGLE PORT PROCEDURES:**

1. Unsupervised multiple port robotic surgery privileges;
2. Completion of either:
   a. Single port Intuitive (or comparable) training program OR
   b. Training modules
      i. Proctoring: Two (2) cases with a qualified single port surgeon.

D. **REAPPOINTMENT CRITERIA**

1. A minimum of ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present.
2. If less than ten (10) but greater than or equal to five (5) cases have been performed successfully during the previous 24-month period, the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
3. If fewer than five (5) cases have been performed successfully within the previous 24-month period, additional certified hands-on training must be obtained either by simulator, cadaver or animal lab AND the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
4. For single port procedures, a minimum of two (2) procedures during the previous 24-month period. If fewer than two (2) cases, training modules must be redone or the next one (1) case must be concurrently proctored by a qualified single port surgeon.

E. **ONGOING PROFESSIONAL PRACTICE EVALUATION**

1. Robotic-performed cases may be reviewed on an ongoing basis by the appropriate Division/Department/Committee with the goal of patient safety and successful performance of the procedure(s). This may include OR time, blood loss, conversion to open procedure, complications, length of hospital stay.

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 01/17 **SUBJECT: Consultation To Perinatal Unit**

REVISION DATE(S):

Women and Newborn Services Department NICU Approval:	**~~01/19~~08/21**
Perinatal Collaborative Practice Approval:	**~~01/19~~08/21**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/19~~10/25**
Administration Approval:	**~~04/19~~11/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **DEFINITION(S):**

1. Perinatal Unit: A perinatal unit means a maternity and newborn service of the hospital for the provision of care during pregnancy, labor, delivery, postpartum and neonatal periods with appropriate staff, space, equipment and supplies.

B. **POLICY:**

1. A neonatologist or Allied Health Professional (AHP) shall be available for perinatal unit consults as requested by an OBGYN or Certified Nurse Midwife.

Tri-City Medical Cent
Oceanside, California

DELETE - Incorporated Into Standards of Care Policy

Women and Newborn Services
Neonatal Intensive Care Unit (NICU)

SUBJECT: **FAMILY CENTERED CARE, NICU**

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

Department Approval:	~~02/17~~06/20
Perinatal Collaborative Practice Approval:	~~04/17~~08/21
Division of Neonatology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~05/17~~10/25
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~06/17~~ n/a
Board of Directors Approval:	06/17

~~A. **DEFINITION(S):**~~

~~1. Family centered care: An approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families.~~

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

~~1. Core Concepts of Family-Centered Care:~~

~~a. Dignity and Respect: Health care practitioners listen to and honor family perspectives and choices. Family knowledge and values in addition to cultural beliefs, backgrounds are incorporated into the planning and delivery of patient care.~~

~~b. Information Sharing: Health care practitioners communicate and share complete unbiased information with infants' families in an affirming and useful manner. Infants' families receive timely, complete, and accurate information in order to effectively participate in care and decision-making.~~

~~c. Participation: Patients and families are encouraged and supported in participating in care and decision-making at the level they choose.~~

~~d. Collaboration: Patients, families, health care practitioners, and leaders collaborate in program development, implementation, and evaluation; of healthcare facility design, education, and delivery of care.~~

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

~~1. Physical Accommodations~~

~~a. A private space for families to meet with caregivers for consultation and family discussions will be available.~~

~~b. 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.~~

~~2. Family Resources~~

~~a. Social Work Consultation will be ordered on admission for coordination of family support and resource identification.~~

~~3. Healthcare Personnel Responsibilities:~~

~~a. Inform families of patient's/parent's rights and responsibilities. Parents are to be treated as full members of the health care team.~~

~~b. Provide hospital/unit orientation which should include:~~

i. Orientation to unit environment and practices.
ii. Orientation to NIC-View camera system, Obtain signed consent prior to participation.
iii. Education regarding NICU Visitation Policy.
1) Parents should have access to their infant 24 hours a day, including during procedures, rounds, and nursing change of shift reports. Reference NICU Visitation Policy.
2) Encourage parents to identify family members who may be involved in the infant's care.
3) Encourage Parent phone calls to the unit when they are unable to be at the bedside.

c. Encourage family/caregiver participation and hands-on care as appropriate to the infant's physiologic status and in preparation for discharge. Ensure parents of their role in care while infant is in the NICU.
d. Provide Developmentally Supportive Care to all infants in the NICU and provide education about this mode of care to the family.
e. Foster continual, open, and honest communication about medical, psychosocial and ethical issues relevant to the infant and family.
f. Provide information on what parents can expect during certain procedures and encourage participation when possible.
g. Procedures for documentation and completion of forms should include information about the family's strengths, preferences, concerns, and goals specific to their infant, as well as the developmental strengths and needs of the infant.
h. Provide explanations and access to educational materials to foster informed decisions concerning the child's medical and nursing care.
i. Education provided to Parent/Caregiver(s) should be individualized to family's strengths and competencies.
ii. Provide an opportunity for families to ask questions about their NICU experience and share concerns that may arise.
i. Incorporate roles and activities of participating disciplines and parents/caregiver into the plan of care.
j. There should be a daily contact or attempt with parents to keep parent/caregiver informed of latest care developments.
k. As part of the care improvement process at discharge, parents shall be encouraged and informed of the process to offer feedback through a patient satisfaction survey.

4. 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.
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.

D. **REFERENCE(S):**

1. Gardner,S.L., Voos, K., & Hills, P.. (2016). Families in Crisis: Theoretical and Practical Considerations, In Gardner, S. L., Carter, B. S. et al.(Eds.), Merenstein & Gardner's Handbook of Neonatal Intensive Care (821-864).St. Louis, Missouri: Elsevier.
2. Institute for Family Centered Care. (2003). Collaborating with Patients and Families to Improve Quality and Patient Safety. *Advances in Family Centered Care, 9*(1), 1-3.
3. Lewandowski, L., Tesler, M. D. (2003). Family-Centered Care: Putting it into Action. *The SPN/ANA Guide to Family-Centered Care.*
4. National Association of Nurses, American Nurses Association. (2013). Neonatal Nursing: Scope and Standards of practice (2nd Ed.). Silver Spring, Maryland. American Nurses Association.
5.1. The Advisory Board. (2006).*The Family as Patient Care Partner.*

Tri-City Medical Center	Women and Newborn Services— Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**INTRAFACILITY TRANSPORT OF THE NICU PATIENT**
Purpose:	Establish a standard of care for transporting NICU patients to other departments within Tri-City Medical Center (for Procedural Transports).
Equipment:	Transport isolette Manual resuscitator bag with reservoir Neopuff resuscitator Pulse oximeter Cardiac monitor **(based on patient acuity)** Full oxygen cylinder Gas source in the area to which patient is being transported
Issue Date:	09/07

A. **POLICY:**

1. Prior to transfer, NICU staff member will call the receiving department to ~~i~~ensure department's readiness for patient.
2. NICU patients will be transported in transport isolette with a NICU nurse.
3. NICU nurse will remain with the patient throughout transport.
4. Patients requiring mechanical ventilation will also be accompanied by **a** Respiratory Care Practitioner (RCP).
5. The interdisciplinary team (Physician, ~~Allied Health Professional (AHP),~~ RN, RCP) will determine if the acuity warrants additional personnel.
6. Confirm patient identity per hospital policy.
7. The RN is responsible for:
   a. Obtaining ~~Transport bag from NICU (for procedural transports.)~~**necessary equipment and supplies for transport.**
   b. **Patient monitoring and safety throughout the transport.**~~Overseeing the transport for patient monitoring and safety.~~**.**
   c. ~~Monitoring oxygen flow and oxygen saturation if not accompanied by a RCP.~~
   d. Documentation in the patient's medical record.
8. The RCP is responsible for:
   a. Verification of transport isolette and equipment prior to transport.
   b. Managing oxygen flow and oxygen saturation.
   c. Maintaining airway security and patency.
   d. Monitoring ventilator for correct connections and proper function.
   e. Documentation in patient's medical record.
9. Family centered care: The parents are invited to accompany the patient on transport. If they are unable to attend, the Physician~~/AHP~~ and NICU RN will update the parents about the patient's clinical status.

B. **DOCUMENTATION:**

1. The transport will be documented in the patient's medical record: including time of departure and arrival back on unit.
2. The RCP will document the ventilator check for intubated patients.

C. **REFERENCE(S):**

1. American Academy of Pediatrics (AAP) and American College of OB and GYN (ACOG). (2017). Guidelines for perinatal care (8th ed.).

Women and Newborn Services NICU	~~Department of OB/GYN~~	~~Division of Neonatology/~~ Perinatal Collaborative Practice	Division of Neonatology/ ~~Department of Pediatrics~~	Pharmacy &Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/15, 05/19	~~n/a~~	01/15, 06/19, **08/21**	n/a	n/a	03/15, 07/19, **10/21**	08/19, **11/21**	4/15, n/a	06/09, 06/11, 08/12, 04/15, 08/19

2. Beauman, S. & Bowles, S. (Eds.) (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th edition). National Association of Neonatal Nurses.

~~1. Kilpatrick, S. J., & Papile, L. (Eds.). (2017). *Guidelines for Perinatal Care 8th Edition*. American Academy of Pediatrics and The American College of Obstetricians and Gynecology.~~

~~Ikuta, Linda M., and Sandra S. Beauman, eds. (2011). Policies, Procedures, and Competencies for Neonatal Nursing Care. Glenview, IL: National Association of Neonatal Nursing Care~~

Tri-City Medical Center
Oceanside, California

WOMEN'S AND& NEWBORNCHILDREN'S SERVICES MANUAL
—NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 07/07 **SUBJECT:** Visitation Guidelines in the NICU

REVISION DATE(S): 01/09, 04/09, 06/11, 08/12, 11/16, 10/13, 06/17

Department Approval:	01/1712/20
Perinatal Collaborative Practice Approval:	04/1708/21
Division of Neonatology Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	05/1710/25
Administration Approval:	
Professional Affairs Committee Approval:	06/17 n/a
Board of Directors Approval:	06/17

A. **PURPOSE:**

1. These guidelines are flexible and intended to support family centered care and the diverse needs of our families in the NICU while maintaining a safe, quiet, and healing environment.

B. **POLICY:**

~~The following guidelines are intended to support family visiting in the neonatal intensive care unit (NICU) embracing the Family Centered Care concept while maintaining a safe, quiet environment.~~
~~"Family" is defined as any person(s) who play a significant role in an individual's life inclusive of person(s) not legally related to the individual.~~
~~Members of family include spouses, domestic partners, step-parents, both different-sex and same-sex significant others, and any other persons operating in a caretaker role.~~
~~Only those visitors, including siblings, that are appropriate to visit in the NICU as defined in this policy, will be admitted past the first set of doors and be allowed to sit in the unit lounge~~

1. Parents are essential partners with the healthcare team in caregiving and decision making for their infant. They are welcome to be with their infant 24 hours a day.
2. To be culturally sensitive and supportive, we acknowledge that parents decide who their support system is while their infant is in the NICU.
3. Family and friends are welcomed when accompanied by a parent. They are encouraged to visit during hospital visiting hours and will need to leave the bedside during change of shift.
4. Parents and their guests will complete a daily health screening prior to entering the NICU.
5. All guests, other than siblings, should be at least 18 years of age, unless the parent defines them as a support person.
6. One or two support persons may be designated by the parent to be at the bedside when the parent is not available,
7. Siblings of the infant, including a previously discharged sibling, are welcome in the NICU.
8. NICU staff reserves the right to limit the number of guests at the bedside in the best interest of infants, families, and staff.
   a. The parent and nurse will discuss the number of people welcomed at the bedside. This number will vary based on infant, family, and NICU needs.
   b. The nurse may limit family at the bedside to "one or two at a time" if it is necessary to provide safe care (nurse needs readily available access to patient and equipment) or if there is increased activity on unit (special procedures, high census, privacy of other infants/parents).

~~a.~~**c. Parents should never be expected to leave the infant's bedside so that others may be present.**

~~These guidelines are flexible to support the diverse needs of our families.~~

C. **PROCEDURE:**

1. **Upon entering the NICU, parents will be identified by infant ID band number or photo ID.**
   a. **If parent is known to NICU staff member, ID does not need to be verified.**
2. **NICU staff will educate parents and guests on how they can protect their infant from infection; including health screening, handwashing, and hand gel use.**
   a. **Parents and guests will wash hands when entering or re-entering the NICU.**
   b. **Parents and guests will wash or gel hands before and after touching infant.**
   c. **Parents and guests will wash or gel hands anytime they touch their personal property.**

~~1.~~3. **Health Screening will be completed by parents, family and friends once a day.**

~~2.~~4. **NICU staff will educate parents and guests on patient privacy.**

~~Staff shall greet family and visitors in the NICU entryway to identify who they are and whom they are visiting. Parents ID bands must be checked upon entrance. Take this opportunity to instruct families/visitors about the NICU visitation guidelines.~~

~~Parents/banded individuals have 24-hour access to the NICU, inclusive of change of shift.~~

~~Visitors may visit with a parent/banded individual at any time except during change of shift (0645 to 0745 and 1845 to 1945).~~

~~Banded individuals who are in the unit at the beginning of change of shift may remain. Banded individuals requesting entrance into the unit during change of shift will be asked to wait in the waiting room until the conclusion of change of shift unless they have been requested to enter by the nurse for feeding purposes.~~

~~Visitors who are not parents or siblings may not visit unless they are 18 years or older.~~

~~Visitors are limited to two (2) visitors per patient at the bedside at any one time.~~

~~One of the bedside visitors must be a banded parent/individual. (Please note this will include employees.)~~

~~Foster parents as designated by Department of Health Services and with valid identification.~~

~~Each multiple may have up to two visitors; only one banded individual is required per family.~~

~~Siblings must be 12 years and older to visit unless they are the previously discharged sibling of a multiple. They are encouraged to visit with the following conditions:~~

~~An adult must supervise siblings at all times. Nurses are not to provide care to siblings.~~

~~The discharged sibling of a multiple will be allowed to the bedside on following conditions:~~

~~Passes NICU health screening prior to admission to the unit.~~

~~All siblings 12 years and older must show proof of up-to-date immunizations before entering the NICU.~~

~~All siblings will be health screened each time they enter.~~

~~All siblings under the age of 18 will be prohibited during RSV/Flu season, inclusive of the previously discharged sibling of a multiple.~~

~~All Visitors will be interviewed, including but not limited to, the following for admittance to the NICU:~~

~~Exposures: visitors who have had exposure to chickenpox, measles, tuberculosis will not allowed to visit.~~

~~Fever: No admittance will be granted to the NICU if the visitor presents with a temperature greater that 100.4 degrees Fahrenheit. Re-admittance to the NICU will be allowed when the visitor is afebrile for 24-hours.~~

~~Exception: Mothers that are febrile as a result of infections of non-transmissible concern may visit if:~~

~~The mother is afebrile times one.~~

~~Fever is cleared by OB as being of a non-transmissible origin.~~

~~Signs of infection: visitors with signs of infection, including but not limited to, nausea, vomiting, cough, sneezing, sore throat, conjunctivitis, and draining wounds (does not include scrapes or~~

~~small cuts that are scabbed over), will not be allowed to visit for the duration of the illness, e.g., the signs and symptoms are resolved.~~
~~Skin Lesions/Herpes Simplex (Oral Herpes Lesion)~~
~~Parents who present with skin lesions, including open abscesses and oral herpes lesions (cold sore) that are open or draining are to wear a surgical mask and gloves until crusted over.~~
~~When the herpes lesion is completely crusted over, the visitor will be instructed to wear a mask and not to allow the sore to touch the infant.~~
~~Shingles~~
~~No admittance will be granted to the NICU of the visitor presents with shingles that are blistered or weeping.~~
~~Re-admittance to the NICU can occur when the shingles are dry and crusted. Visitor is instructed to not touch the affected area and not allow the lesion to touch the infant.~~
~~Rashes~~
~~No admittance will be granted to the NICU if the visitor presents with an undiagnosed rash.~~
~~Visitors with undiagnosed rash will be instructed to see their personal physician for diagnosis of origin. No admittance will be allowed until confirmation of origin is obtained and a non-contagious diagnosis is made.~~
~~No admittance will be granted to the NICU for visitors who have not had chicken pox or been vaccinated and have been exposed to anyone with chicken pox in the past three weeks. No admittance will be allowed from day 8 to day 21 after exposure.~~
~~Visitors who are diagnosed with measles or rubella will not be allowed to visit until 7 days after the onset of rash.~~
~~Instruct all family members/visitors to follow the hand washing procedure prior to handling the baby.~~
~~Encourage patient/family confidentiality.~~
~~The RN staff reserves the right to monitor and/or restrict visitation based upon unit activity and critical status of any infant.~~

5. **Assignment of designated support persons**
   - a. **Parent will complete "Designation of Support Person" form (limited to two persons).**
   - b. **The designated support person(s) will remain the same throughout the infant's hospitalization.**
   - c. **The parent will determine the amount of information that may be given to the designated support person.**
   - d. **The designated support person may not receive updates over the phone.**
   - e. **The designated support person may not bring other family or friends to be with the infant.**
6. **Sibling visitation will be arranged with the bedside nurse prior to arrival.**
   - a. **Sibling visits are between 0900-1100, 1500-1700 and 2000-2200.**
   - b. **Sibling visitation time will be limited to a time period that is developmentally appropriate for the sibling. Maximum time at bedside will not exceed 30 minutes.**
   - c. **Parent will pre-arrange sibling visit with nursing staff.**
   - d. **Parent will provide a copy of immunization records for each brother and/or sister who will be visiting.**
   - e. **Siblings should be prepared for the hospital environment and the infant's illness as appropriate.**
   - f. **Siblings are to be under family supervision at all times.**
   - g. **Sibling behavior is monitored by the parents and staff to ensure a safe and restful environment for the infant.**

~~3.~~**7.** At any time, the unit may close for **infection control or other** medical ~~purposes~~**reasons**.
   - a. During seasons where there are more colds and flu, ~~the visiting~~**these guidelines** ~~policy~~ may ~~be restricted further.~~**change.**
   - ~~a.~~**b. During medical emergencies or procedures, entry to the NICU may be restricted.**

D. **REFERENCES:**

1. **Beauman, S.S. & Bowles, S. (2019). Policies, procedures, and competencies for neonatal nursing care, 6th edition. Chicago, IL: National Association of Neonatal Nurses.**
2. **Griffin, T., 2013. A Family-Centered "Visitation" Policy in the Neonatal Intensive Care Unit That Welcomes Parents as Partners. *The Journal of Perinatal & Neonatal Nursing*, 27(2), pp.166-167.**
3. **Horikoshi, Y., Okazaki, K., Miyokawa, S., Kinoshita, K., Higuchi, H., Suwa, J., Aizawa, Y. and Fukuoka, K., 2018. Sibling visits and viral infection in the neonatal intensive care unit. *Pediatrics International*, 60(2), pp.153-156.**
4. **Phillips, H. and Sumpter, D., 2018. A Systematic Review of Young Sibling Visitation Policies in the NICU. *Journal of Nursing & Healthcare*, 3(4).**

~~Changes will be posted outside the NICU.~~

Tri-City Medical Center
Oceanside, California

Outpatient Behavioral Health Services

SUBJECT: Exchange and Replacement of Medication

ISSUE DATE: 08/96
REVISION DATE: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/17

Department Approval:	~~08/20~~11/21
Division of Psychiatry Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/21~~11/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

A. **PURPOSE:**

1. To provide an effective method for the exchange and replacement of expired or dispensed medications.

B. **POLICY:**

1. The Pharmacist and Registered Nurse (RN) are responsible for inspecting the medication storage cabinet monthly to determine completeness of stock and expired medications.

C. **PROCEDURE:**

1. Who may perform/responsible: Pharmacist and RN.
2. The pharmacist and RN inspects the contents of the medication storage cabinet monthly, for completeness of stock and expired medications.
3. The Pharmacist is responsible for returning expired medications to the pharmacy for proper disposal. The medication is then replaced and locked in the medication storage cabinet.
4. The results of the pharmacist inspection are documented by hospital Pharmacist.
5. There's a psychiatric emergency box that contains medications, for emergencies only. This box is stored in the nurses' office with two secure locks. Any medications given by the RN from the emergency box must be done with a physician's order.
6. ~~When an emergency stock medication is used, the RN enters into the Stock Medication Log, the name of the patient taking the medication, the date of administration and the dosage. Nursing will document effectiveness in a nursing note in the medical record. When the medication is depleted or out of date it is replaced by the hospital pharmacy.~~

~~D. **FORM(S):**~~

~~1. Stock Medication Log~~

Tri-City Medical Center	Distribution: Women & Newborn Services
PROCEDURE:	**DINOPROSTONE (CERVIDIL)**
Purpose:	To outline the nursing management of a patient receiving Dinoprostone (Cervidil) placement for labor induction. Dinoprostone (Cervidil) may be used for ripening of the cervix and induction of labor. Cervical Ripening may be required when induction of labor is indicated and the cervix is unfavorable
Supportive Data:	Dinoprostone (Cervidil) is indicated for ripening an unfavorable cervix in pregnant women at or near term with a medical or obstetrical indication for induction of labor. Cervical ripening refers to the softening and effacement (thinning) of the cervix, and is thought to represent the maturation of the reproduction system in terms of labor induction readiness. Procedure may be done by either a provider or a Registered Nurse (RN).
Equipment:	1. Dinoprostone (Cervidil) 10mg vaginal suppository with an intact retrieval tape 2. Single sterile exam glove 3. Sterile, water soluble lubricant

A. **POSSIBLE INDICATIONS FOR USE:**

1. Post Term Gestation
2. Intrauterine Growth Restriction (IUGR)
3. Oligohydramnios
4. Gestational Hypertension/ Pre-Eclampsia
5. Obstetrical or medical indication for induction of labor (Diabetes, Hypertension)
6. Premature Rupture of Membranes (PROM)
   - ~~6.~~**a. Caution should be exercised in the administration of Cervidil in patients with ruptured membranes.**
7. Fetal Demise

B. **CONTRAINDICATIONS:**

1. Abnormal Fetal Lie
2. Patients with known hypersensitivity to prostaglandins~~/Asthma~~
3. Existing tachysystole or uterine hypertonus
4. Clinical suspicion or evidence of Category III tracing
5. Abnormal presentation
6. Non-cephalic presentations (breech)
7. Placenta previa, vasa previa/abruption
8. Prior uterine scar (previous cesarean section or uterine surgery)
9. Unexplained heavy vaginal bleeding in third trimester
   - ~~10. Contracted pelvis~~
- ~~11.~~**10.** Active herpes

C. **USE CAUTION WHEN ADMINISTERING TO WOMEN WITH:**

1. History of:
   a. Asthma
   b. Glaucoma
   c. Hepatic Disease
   d. Pulmonary Disease
   e. Renal Disease
   f. Cardiac Disease
   g. Multiparous with > 6 pregnancies.
   h. Polyhydramnios

Department Review	Department of OB/GYN	Division of Neonatology	Department of Pediatrics	Pharmacy & Therapeutics	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
1/95;2/97;3/03;5/09;12/12;1/16; **02/20**	01/13, 02/16, **06/21**	**n/a**	**n/a**	6/16, **07/21**	**5/13, 08/16, 11/21**	**11/21**	6/13, 09/16, **n/a**	6/13, 09/16

D. **PROCEDURE/PREPARATION:**

1. The RN shall verify provider's order and ensure informed consent was obtained and signed by the patient.
2. The RN shall verify prenatal record is available for review.
3. Maternal-Fetal assessment
   a. Maternal Assessment:
      i. Assess baseline maternal temperature, pulse, respirations, and blood pressure.
      ii. In the absence of ruptured membranes assess cervical dilatation, effacement, station, consistency and position of cervix prior to insertion of Dinoprostone (Cervidil).
      iii. Assess uterine activity, including palpation of contraction(s).
   b. Fetal Assessment:
      i. Obtain a 20-30-minute fetal heart rate tracing.
      ii. Confirm fetal lie and vertex presentation for viable fetus.
      iii. Notify the provider of a Category II or III fetal heart rate tracing BEFORE placing Dinoprostone (Cervidil).
4. Start a large bore peripheral intravenous (IV) line 18 G or larger.
5. Obtain lab work as ordered by provider.
6. Dietary restrictions limited to sips of clear liquids and/or ice chips per provider order

E. **INSERTION:**

1. Have the patient empty her bladder
2. Obtain Dinoprostone (Cervidil) suppository.
   a. Never use Dinoprostone (Cervidil) vaginal suppository without its retrieval system.
3. Don sterile examination glove and apply a minimal amount of lubricant.
   a. Excessive amounts of lubricant can prevent optimal release of the Dinoprostone (Cervidil) from the vaginal suppository.
4. Insert Dinoprostone (Cervidil) vaginal suppository immediately after removing it from its packaging:
   a. Place Dinoprostone (Cervidil) vaginal suppository between index and middle finger of sterile gloved hand and insert into vagina.
   b. Advance suppository to the posterior fornix and place suppository transversely.
   c. Ensure that retrieval system (length of attached tape) is accessible.
5. Maintain patient in a lateral recumbent position with a left or right tilt, for at least two hours, or as ordered by provider. **After the initial 2 hours patient may ambulate per provider order.**

F. **MONITORING:**

1. Assess fetal heart rate and uterine activity every 30-minute X 4, then at hourly intervals during the latent phase of labor (cervical dilatation less than or equal to 4 cm).
   a. The need for continuous verses intermittent monitoring is based on fetal well-being and is at the discretion of the provider.
2. Vital signs (VS) (pulse, respirations, and blood pressure): monitor VS every 30 minutes x 2 after each dose, then every 4 hours if stable and patient is not in active labor. When patient is in active labor, monitor VS (pulse, respirations, and blood pressure) hourly. If patient has an epidural, refer to VS protocol per procedure.

G. **REMOVAL OF THE DINOPROSTONE (CERVIDIL) INSERT:**

1. Upon the onset of active labor
~~2. With **after** Spontaneous rupture of membranes.~~
~~3.~~**2.** Prior to amniotomy.
~~4.~~**3.** Within 12 hours of insertion.
~~5.~~**4.** At least 30 minutes prior to the initiation of oxytocin augmentation.

~~6.~~**5.** Removal should be considered if tachysystole occurs.
   a. If fetal heart rate tracing is a Category II progressing to a Category III appropriate intrauterine resuscitation measures should be implemented, such as position change, administer oxygen via non-rebreather mask, and IV fluids.
      i. If no immediate improvement is observed, notify provider
      ii. Remove Dinoprostone (Cervidil)
      iii. Anticipate provider order for tocolytics such as terbutaline

H. **DOCUMENTATION:**
1. Document fetal heart rate status, uterine activity, and cervical status in the medical record.
2. Document placement of Dinoprostone (Cervidil) suppository in the medication record.
3. Document events, VS, and interventions associated with this procedure in the medical record.

I. **REFERENCES:**
1. Simpson, K. R., & Creehan, P. A. (20~~14~~**20**). AWHONN's Perinatal Nursing 4th ~~5~~**5th** Ed. Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins
2. ACOG Committee on Practice Bulletins- Obstetrics ACOG Practice Bulletin No 107: Induction of labor. Obstetrics and Gynecology 2009; 114:386.
3. Kennedy, B.B., Ruth, E.J., Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.) Lippincott Williams and Wilkins
4. Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.
5. Wing, D.A., Lockwood, C.J., Barss, V. Induction of labor. Retrieved from www.uptodate.com 08/12
~~5.~~**6. Ferring Pharmaceuticals. (2017). Cervidil. Retrieved from Ferring Pharmaceuticals Medical Information on 3/3/2020**

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**LAMINARIA**
Purpose:	To outline the nursing responsibilities in assisting the physician with the insertion and removal of Laminaria (Dilateria).
Supportive Data:	Laminaria is a sea grown plant, capable of absorbing fluids from uterine cervix. Gradual swelling of laminaria (up to 4 times its diameter) results in a gradual symmetrical dilation of the cervical canal and softens cervical tissue. Dilateria diameter swells the most within the first 4 to 6 hours after insertion. It should be removed within 24 hours to prevent infection.
Equipment:	1. Laminaria (Dilateria) 2. Vaginal speculum 3. Long ring forceps 4. Atraumatic tenaculum or a milex dilateria forceps (if available) 5. Antiseptic solution per physician preference 6. Cervical lubricant and sterile swabs 7. Light source 8. Sterile gloves 9. Gauze sponges

A. **INDICATIONS FOR USE:**

1. Cervical ripening for first and second trimester miscarriage/ abortion
2. Dilates cervix in preparation for Dilation and Curettage (D&C) procedure
3. **Term Vaginal Delivery**

B. **CONTRAINDICATIONS:**

1. Laminaria should not be used when vaginal, cervical and/or pelvic infection is suspected
2. Laminaria should not be used if there is concern that the patient will not follow-up appropriately, as the patient must return within 24 hours to have it removed.

C. **INSERTION:**

1. After the physician/Allied Health Professional (AHP) has ~~informed patient~~**informed patient** of reasons for use, risks and side ~~effects, the~~**effects, the** nurse should ~~verify the~~**verify the** patient's consent.
2. The nurse/ Obstetrical Technician (OB Tech) will ensure the necessary equipment is available to place the laminaria aseptically.
   a. A staff member will retrieve the laminaria from the supply pyxis for insertion
3. The patient should be encouraged ~~to void~~**to void** prior to the insertion
4. The nurse and/or OB Tech will be available to help the physician prepare the patient for laminaria insertion by.
   a. Positioning the ~~patient in~~**patient in** ~~lithotomy position~~**lithotomy position** ~~for vaginal~~**for vaginal** examination
   b. Having appropriate cleansing product available to perform a surgical preparation before laminaria insertion.
   c. Assisting physician during the procedure with equipment needs.
5. The nurse shall document the size and number of laminaria placed and how the patient tolerated the procedure in a clinical note.
6. The nurse ~~will complete~~**will complete** patient education which should include but is not limited to discussion about:
   a. Avoid bathing, douching, and intercourse while the laminaria is in place

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/03, 08/09, 06/16, **02/20**	02/13, 08/16, **06/21**	**n/a**	01/13, 11/16, , **07/21**	05/13, 11/16, **11/21**	**11/21**	06/13, 01/17, **n/a**	06/13, 01/17

b. The laminiaria needs to be removed within 24 hours. Patient must return to have it removed if is being sent home after the procedure
   i. If the laminaria falls out, notify her doctor
c. Discomfort similar to menstrual cramping after placement may be felt
d. Call her doctor immediately if develops a fever over 100 F, chills, pain or vaginal bleeding while laminaria is still in place.

D. **CAUTIONS:**

1. Cervical manipulation may cause a vaso-vagal reaction in the patient. She should be watched for unusual pallor, nausea vertigo or weakness after placement and it is best to have her remain recumbent for three to 10 minutes after placement.
2. If laminaria remains in place for greater than 24 hours, the physician should consider antibiotic prophylaxis.
3. The laminaria should not be forced into place during insertion. If the cervix is obstructed the physician may have to pre-dilate the cervix for placement.

E. **REMOVAL:**

1. The nurse and/**or** OB Tech shall have patient empty her bladder.
2. The nurse and/or OB Tech will help position patient in bed for the removal of laminaria.
3. The nurse and/or OB Tech will get the required equipment and supplies to assist provider with removal, to include having a clean drape available on which to place removed laminaria.
4. The nurse shall help get patient ready for surgery as needed.

F. **DOCUMENTATION:**

1. At insertion the nurse shall note number and size of laminaria placed by the physician.
2. At removal, the nurse shall note number of laminaria removed by the physician.

G. **REFERENCES:**

1. Sagiv, R, Mizrachi, Y.,Glickman, H., Kerner, R., Keidar, R., Bar, J. and Golan, A. (2015). Laminaria vs. vaginal misoprostol for cervical preparation before second trimester surgical abortion: a randomized trial. Contraception. May: 91 (5) 406-411.

Tri-City Medical Center	~~Distribution:~~ Women and Newborn Services
PROCEDURE:	**OBSTETRICAL HEMORRHAGE**
Purpose:	To provide guidelines for the optimal response of the multidisciplinary team in the event of obstetric hemorrhage and to assist all care providers in recognizing patients at risk for hemorrhage, identifying stages of hemorrhage, and primary treatment goals.
Supportive Data:	~~Approximately one-third of maternal deaths are related to postpartum hemorrhage, which is defined as a blood loss greater than 500ml in the first 24 hours after delivery.~~ **Maternal hemorrhage is defined as a cumulative blood loss greater than or equal to 1,000 mL or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process.** Major causes of postpartum hemorrhage (PPH) include uterine atony, lacerations, hematomas, retained placental fragments, uterine inversion and blood coagulation disorders, (e.g., disseminated intravascular coagulation (DIC)).
Equipment:	1. Additional Intravenous (IV) fluid (e.g., normal saline, lactated ringers) 2. Additional IV tubing 3. Transfusion administration set 4. Foley catheter 5. Oxytocin 10 units per mL, uterotonic medications as ordered by provider 6. Infusion pump 7. Syringes for Intramuscular (IM) administration 8. Oxygen delivery equipment (e.g. simple mask) 9. OB Hemorrhage Cart & (Crash Cart, as needed) NOTE: Equipment for this procedure may vary, based on the clinical situation

A. **POLICY STATEMENTS:**

1. **An o**~~O~~ptimal response to obstetrical (OB) hemorrhage **should use a multidisciplinary and multifaceted approach that involves maintaining hemodynamic stability while simultaneously identifying and treating the cause of blood loss.**
2. **All births shall have active management and assessment practices in place to minimize OB hemorrhage.**
3. **The nursing unit, anesthesia, blood bank, operating room, and other appropriate services shall work together to mount an efficient and coordinated response to an OB hemorrhage.**
4. **The WNS department will maintain and have OB Hemorrhage Carts available for urgent hemorrhage management on Labor and Delivery (L&D), L&D Post Anesthesia Care Unit (PACU) and Post-Partum (PP).**
5. ~~1.~~**In the event of an OB hemorrhage, a CODE MATERNITY shall be initiated. Refer to Patient Care Services (PCS) Procedure; Code Maternity Team.**~~requires the coordination of effort of team members from multiple disciplines and departments.~~
   - ~~a. Births shall have active management & assessment practices in place to minimize OB hemorrhage~~
     - ~~i. Patients admitted for labor will have IV access which may be by normal saline lock. An 18 gauge IV catheter is desired.~~
     - ~~ii. Patients will be assessed and monitored for OB hemorrhage as follows:~~
       - ~~1) Completing a risk factor screen for hemorrhage risk, on admission, **30 minute s prior to delivery, 60 minutes post-delivery, on admission to the post partum unit, every shift, or if there is a change in patient condition.**~~
       - ~~2) Ongoing assessments for vaginal bleeding – during intrapartum period, 3rd stage/ recovery, admission to postpartum, and every shift until discharge.~~

Review/Revision Date	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/11, 05/15; **02/20**	07/12, 06/15, **06/21**	**n/a**	12/15, **07/21**	05/13; 02/16, **11/21**	**11/21**	06/13; 03/16, **n/a**	06/13; 03/16

~~3) Active management of the 3rd stage of labor to include:~~
~~a) Fundal massage immediately following the delivery of the placenta and then at regular intervals as defined in Women and Newborn Services (WNS) Standards of Care.~~
~~b) Patient receiving an oxytocin infusion of 230 units/10500 mL solution with rate adjustments made according to uterine tone OR if no IV, oxytocin 10 units IM, as ordered by provider (Obstetrician/ Physician/ Certified Nurse Midwife (CNM)).~~
~~4) Evaluation of vaginal bleeding amount, to include weight measurements, as ordered by provider.~~
~~5) Ongoing evaluation of vital signs (VS) during recovery and postpartum periods.~~

~~b. The nursing unit, anesthesia, blood bank, operating room, and other appropriate services shall work together to mount an efficient and coordinated response to OB hemorrhage.~~

~~c. The WNS department will maintain and have OB Hemorrhage Carts available for urgent hemorrhage management on Labor and Delivery (L&D), L&D Post Anesthesia Care Unit (PACU), and 2 South **and Post-Partum**.~~
~~i. Uterotonic medications shall be kept together in the Pyxis refrigerator, as an OB Hemorrhage Kit, which is supplied by the pharmacy.~~

~~d. In the event of an uncontrolled patient hemorrhage, a CODE MATERNITY shall be initiated. Refer to Patient Care Services (PCS) Procedure; Code Maternity Team Mobilization.~~

B. **DEFINITIONS:**

1. **Postpartum hemorrhage is defined as a cumulative blood loss greater than or equal to 1,000 mL or blood loss accompanied by signs or symptoms of hypovolemia within 24 hours after the birth process regardless of route of delivery.**~~General hemorrhage:~~
   - **a.** Vaginal birth:~~ estimated blood loss greater than 500 mL blood loss~~
     - **i. Stage 1: >500 mL blood loss~~l~~, with continued bleeding and/or Vital Sign (VS) instability~~ <1000 ml blood loss~~**
     - **ii. Stage 2: <1500 mL cumulative blood loss with continued bleeding or VS instability ~~1000-1500 ml Blood Loss~~**
     - **~~a.~~iii. Stage 3: >1500 mL cumulative blood loss, >2 units PRBCs given, VS unstable or suspicion for DIC. ~~Blood Loss > 1500 ml (massive hemorrhage)~~**
   - **b.** Cesarean birth:~~ estimated blood loss greater than 1000 mL blood loss~~
     - **i. Stage 1: >1000 mL blood loss, with continued bleeding and/or VS instability.~~ ml <1500 ml blood loss~~**
     - **ii. Stage 2: <1500 mL cumulative blood loss with continued bleeding or VS instability ~~1000-1500 ml Blood Loss~~**
     - **~~b.~~ Stage 3: >1500 mL cumulative blood loss, >2 units Red Blood Cells (RBC) given, VS unstable or suspicion for DIC.~~Blood Loss > 1500 ml (massive hemorrhage)~~**
     - **iii.** ~~2. Massive hemorrhage: greater than 1500 mL blood loss for ANY birth mode~~

3. **Vital Sign (VS) instability:**~~Additional Clinical Triggers:~~
   - a. Heart rate **>15% change or** ≥ 110
   - b. Blood pressure ≤ 85/45 ~~(> 15% drop)~~
   - c. O2 **saturation**~~sets~~ < 95%

4. Risk **factor** assessment **for OB hemorrhage will be assessed on admission, within 30 minutes of delivery, 60 minutes post-delivery, admission to the postpartum unit and at each patient handoff/shift change for 24 hours after delivery. If high risk or hemorrhage after current delivery continue to assess every handoff/shift change until discharge.**

~~**interventions**: Recognition and screening for risk factors upon admission and throughout the intrapartum and postpartum period is essential in hemorrhage management anticipation.~~

~~a. Low Risk: Type and Rh upon admission~~

~~b. Medium Risk: Type and Screen~~

~~High Risk: Type and Crossmatch 2 units Red Blood Cells (RBC).~~

a. **Risk factor interventions:**
   i. **Low Risk: Type and Rh upon admission**
   ii. **Medium Risk: Type and Screen**
   iii. **High Risk: Type and Crossmatch 2 units of PRBCs**

~~i.~~

C. PROCEDURE AND RESPONSIBILITIES:

1. **The registered nurse (RN) will complete fundal and vaginal bleeding checks as indicated in WNS Standards of Care- Intrapartum and WNS Standards of Care- Postpartum.**
2. **If patient is having increased/continued bleeding or VS instability or greater than 500 mL blood loss, Notify Charge Nurse and call a Code Maternity for more assistance.**
   a. **See attached document: Obstetric Hemorrhage Emergency Management Plan to guide patient care during the OB Hemorrhage.**
3. **Notify provider, obtain and administer Intravenous (IV) Fluids as ordered.**
   a. **If patient's provider is a Certified Nurse Midwife (CNM), co-management with a physician is recommended for Stage 1 and required for Stage 2 and Stage 3.**
4. **Bring the OB Hemorrhage Cart into the patient room.**
5. **Monitor VS, level of consciousness (LOC) every 5 minutes.**
6. **Quantify blood loss (QBL) with scale. Calculate and record every 15 minutes.**
7. **Assure patients family/support person is updated regarding patient's status.**
   a. **If the WNS Social Worker is available, they can provide support to the family/support person.**
8. **Ensure an Operating Room (OR) is available for possible exam, repair, D&C or hysterectomy.**
9. **Consider transfusion on clinical criteria (not waiting for lab test results).**
10. **Prepare uterotonic medications. See Uterotonic Agents for Postpartum Hemorrhage.**

D. BLOOD BANK CONSIDERATIONS:

1. **Anticipate transfusion of blood products by having the patient Type and Crossmatched for 2 units of Packed Red Blood Cells (PRBC) during Stage 1 of an OB Hemorrhage.**
   a. **Infuse blood products per the Blood Products Administration Procedure.**
      i. **Suggested ratios may include**
         1) **1:1 ratio of PRBC/FP during acute hemorrhage management**
         2) **6:4:1 ratio of PRBC/FP/Platelets**
         3) **4:4:1 ratio of PRBC/FP/Platelets**
2. **If continued bleeding after administration of the initial 2 PRBC then activate the Massive Transfusion Protocol (MTP) Procedure.**
   a. **The units will be prepared in multiples of five (5) RBC units and five (5) Thawed Frozen Plasma (FP) units at a 1:1 ratio followed by one (1) unit of Plateletpheresis (PLPH).**
3. **If the patient has unresponsive coagulopathy after 8-10 units of PRBC and coagulation factor replacement, Physician may consider risk/benefit of Factor VIIa, to be provided by pharmacy (ext. 3012).**
   a. **Provisional dosing range 60-90 units/kg**
4. **The Physician may consider transfer of the patient to the Intensive Care Unit (ICU) if the patient receives MTP.**

5. Notify Blood Bank of patient stabilization and blood product adjustments/requirements per provider order.

C. PROCEDURE FOR HEMORRHAGE MANAGEMENT- STAGE 1 (VAGINAL Delivery >500 ml <1000 ml blood loss. CESAREAN Delivery : >1000 ml <1500 ml blood loss):

1. ASSESSMENT
   a. Complete fundal and vaginal bleeding checks as indicated in WNS Standards of Care. Notify provider, obtain and administer PPH/Uterine atony medication, as ordered by provider.
      i. If patient's provider is a CNM, co-management with a Physician is recommended.
   b. Notify Charge Nurse of hemorrhage concern.
   Monitor VS**, level of consciousness** and apply O2 saturation monitor. Begin more frequent vital sign monitoring, at a minimum every 5-15 minutes.
   c. **Weigh materials using QBL worksheet located in hemorrhage binder, calculate and record cumulative blood loss every 15 minutes**
   d. Review delivery history and consider possible causes for hemorrhage to include the four T's:
      i. Uterine Atony (TONE)
      ii. Retained placenta (TISSUE)
      iii. Vaginal vault or cervical lacerations (TRAUMA) or
      iv. Coagulopathy issues (THROMBIN).
2. MEDICATIONS/PROCEDURES
   a. Establish IV access, (16-18 gauge, preferred), per provider order.
   b. Increase IV fluid rates (Lactated Ringers preferred) and increase oxytocin infusion rate as ordered by provider (500 ml/hour of 20-40**30** units/10**5**00 mL normal saline (NS).
   c. Provider may provide vigorous bimanual fundal massage.
   d. Administer Uterotonic drugs, as ordered by provider:
      i. Misoprostol (Cytotec) **per provider order**
      ii. Methylergonovine (Methergine) **0.2mg IM every 2-4 hours**
         1) NOT recommended, if patient is hypertensive **or has cardiovascular disease**
      iii. Carboprost (Hemabate) **250mcg IM every 15-90 minutes not to exceed 8 doses in 24 hours**
         1) NOT recommended, if patient has hepatic disease, asthma, or active cardiac/pulmonary disease
   e. Administer oxygen via face mask to maintain oxygen saturation >95%.
   f. Assess patient's bladder, provider may order a Foley catheter placement. (Consider one with an urimeter, if hourly output monitoring is expected).
   g. Keep the patient head of the bed flat to increase perfusion to the brain/heart and keep patient warm **with forced air body warmer**.
   h. Have charge nurse notify the Blood Bank, via RED PHONE, that patient condition is Hemorrhage STAGE 1 and order Type & Cross match for 2 Units RBCs, if not already done and per provider's request.
3. BLOOD BANK CONSIDERATIONS:
   a. Type and Crossmatch for 2 units RBC STAT, per provider request.
4. If patient stabilizes, provide increased postpartum surveillance.

D. PROCEDURE FOR MASSIVE HEMORRHAGE- STAGE 2 (1000-1500 ml Blood Loss):

1. ASSESSMENT
   a. Call Physician to the bedside.
   b. Notify Charge Nurse of continued hemorrhage concern and Initiate "Code MATERNITY" (Refer to PCS Procedure; Code -Maternity Team Mobilization).
   Request that**Bring** OB Hemorrhage Cart brought to the patient room.

c. **Record events on Code Maternity Record sheet**
d. Continue to monitor VS every 5-10 minutes.
e. Weigh bloody materials on gram scale (1 gm = 1 mL) **to calculate cumulative blood loss every 5-10 minutes.**
f. Anticipate Physician may perform a complete evaluation of the vaginal wall, cervix, placenta and uterus.
g. Draw and send additional labs per Physician's request: H&H with Platelet Count (purple top tube), DIC Panel (blue tube for PT, PTT, and Fibrinogen), and electrolytes with Liver Function Tests (ALT, AST, and uric acid green top tube).
   i. May repeat labs every 30-60 minutes, per Physician order.
   ii. WNS Charge Nurse to contact Lab ext 7913, if blood draw results not entered into computer within 30 minutes of being drawn.
h. Monitor intake and output (I&O)'s **by placing indwelling catheter**

2. MEDICATIONS/ PROCEDURES
   a. Administer Uterotonic drugs, as ordered by Physician.
   b. Establish second IV access with at least an 18 gauge, as ordered by Physician.
      i. Second IV site should be used for blood product administration
   c. Continue to assess uterine tone.
   d. Be prepared to transfuse 2 units of RBCs per patient's clinical signs and Physician order.
      i. Do NOT wait for lab results
      ii. Utilize blood tubing and blood warmer for transfusion.
      iii. Refer to Tri City Medical Center Patient Care Services (PCS) procedure: Blood Products Administration
   e. Consider moving the patient to the L&D Operating Room (OR)/ L&D PACU per Physician direction.
   f. Ask Charge Nurse to update the Blood Bank of Hemorrhage Stage 2 via RED PHONE.
3. BLOOD BANK CONSIDERATIONS
   a. Prepare 2 units of RBCs for transfusion per order request.
      i. Two units O negative blood or group specific (if known) and available should be ready for transfusion, as soon as possible.
      ii. A request may be made for a "keep ahead" order for 2-4 units per Physician order.
   b. Consider thawing **2-4** Fresh Frozen Plasma (FFP), if transfusing >2 units of RBCs.
   c. Determine availability of additional RBCs, FFP, and cryoprecipitate and notify WNS Charge Nurse.
   d. Anticipate the possibility of massive hemorrhage and obtain laboratory support as needed.
4. If patient stabilizes, anticipate increased monitoring requirements postpartum.
5. Notify Blood Bank of patient stabilization and blood product adjustments/requirements per Physician order.

E. PROCEDURES FOR MASSIVE HEMORRHAGE- STAGE 3 (Blood Loss > 1500 ml/ >2 units RBC's given, VS unstable OR suspicion for DIC exists:
1. ASSESSMENT
   a. Patient may be transferred to the L&D OR or the Main OR, per the direction of the Physician.
   Physician may consider consulting/gaining assistance from: Advanced GYN surgeon, 2nd anesthesia provider, OR staff, and an Adult Intensivist.
   Continue Code Maternity Record Sheet
   b. **Anesthesia to document vital signs while in OR**
   c. Continue to monitor patency of IV lines, blood administration process, VS and strict I&O.

~~d. Repeat labs per Physician order: H&H, Platelet Ct, DIC panel electrolytes with Liver Function Tests (ALT, AST, and uric acid). Repeating lab work every 30-60 minutes, should be considered.~~

~~e. Charge Nurse should consider~~**will** ~~consulting a Social Worker to provide family support.~~

~~2. MEDICATIONS/ PROCEDURES~~

~~**Initiate Massive Transfusion Protocol by calling blood bank at x7904**~~

~~a. Physician may consider performing:~~

~~i. Laparotomy: B-lynch Suture, uterine artery ligation, hysterectomy, and/or administering vasopressor support.~~

~~Prepare to circulate in the OR~~

~~b. **In OR, nurse or anesthesiologist to announce Vital Signs and Cumulative Blood Loss every 5-10 minutes**~~

~~c. Physician may consider selective embolization (Interventional Radiology).~~

~~i. Prepare patient for transport~~

~~d. Anesthesiologist may consider~~

~~i. Placing a Central/Arterial line~~

~~ii. Obtaining an arterial blood gas (ABG)~~

~~iii. Intubation~~

~~iv. Providing perfusion support by utilizing~~

~~1) Fluid warmer and rapid infuser~~

~~2) Upper body warming device~~

~~3) Sequential compression stockings.~~

~~e. Charge Nurse shall notify the Blood Bank via RED PHONE to indicate a massive transfusion protocol has been initiated.~~

~~3. BLOOD BANK CONSIDERATIONS~~

~~a. Anticipate alternating the following transfusion products, as ordered by Physician:~~

~~i. PRBCs and Fresh Frozen Plasma (FFP) 5 units of each are to be prepared for immediate distribution with a "keep ahead 2 units" request..~~

~~ii. 5-10 units cryoprecipitate, pooled as needed. (indicated for decreased fibrinogen levels)~~

~~iii. 1- unit Apheresis platelet consideration for every 6 units of RBCs/FFP infused~~

~~b. Prepare to transfuse aggressively with varied products, per provider order. Suggested ratios may include:~~

~~i. Consider: 1:1 PRBC/FFP during acute hemorrhage management~~

~~ii. Either 6:4:1 PRBCs/FFP/Platelets~~

~~iii. Or 4:4:1 PRBCs/FFP/Platelets~~

~~4. If patient has unresponsive coagulopathy after 8-10 units of PRBCs and coagulation factor replacement, Physician may consider risk/benefit of Factor VIIa, to be provided by pharmacy (Ext. 3012).~~

~~a. Provisional dosing range 60 – 90 units/kg~~

~~5. When patient stabilizes, Physician may consider~~ **will** ~~transferring patient to Intensive Care Unit.~~

~~6. Notify Blood Bank of patient stabilization and blood product adjustments/requirements per provider order~~

~~F.~~**E. SPECIAL CONSIDERATAIONS:** ~~-~~JEHOVAH'S WITNESSES AND OTHERS WHO MAY DECLINE BLOOD PRODUCTS~~:~~

1. There is a wide range of acceptable blood interventions within the Jehovah's Witness community and 50% will actually take some form of blood transfusions.
2. It is imperative that the provider and health care team review all possible options with the patient refusing to receive blood products.

~~2.~~**a. Labor and Delivery**

~~a. Use of the specific Jehovah's Witness Blood Product and Technique Informed Consent Checklist form should be given to the patient and reviewed on admission.~~

~~b.~~**i.** Anesthesia shall be consulted when the patient is admitted.

~~c.~~**ii.** The OB provider shall review surgical ~~options and~~**options and** other specific techniques for consideration to manage hemorrhage concerns to include but not limited to:

~~i.~~**1)** Early Interventional Radiology involvement

2) Use of Fibrin/ Thrombin glues

b. Postpartum

i. Maintain volume with crystalloids

ii. **Aggressively treat anemia**

~~G.~~F. DOCUMENTATION:

1. Document assessment findings and interventions provided in patient medical record.
2. Document all medications, IV & blood products on eMAR and I/O forms in patient electronic medical record, as appropriate.
3. Complete documentation requirements for blood transfusion per Patient Care Services (PCS) procedure: Blood Products Administration.
4. May use Code MATERNITY report sheet to document events when Code MATERNITY is initiated, see PCS Procedure; Code Maternity -Team Mobilization.

~~H.~~G. REFERENCES:

1. California Maternal Quality Care Collaborative (CMQCC). (2015). *Obstetric Hemorrhage Version 2.0 Toolkit.* Retrieved on: ~~3/24/2015~~**02/20/2020**~~:~~
2. Elmer, J, Wilcox, S. R. &Raja, A. S. (2013). Massive transfusion in traumatic shock. Journal of Emergency Medicine, 44(4): 829-838.
3. Sheilds, L., Chagolla, B., Fulton, J., Pelletreau, B. (2013). Comprehensive maternal hemorrhage protocols reduce utilization of blood products and improve patient safety. American Journal of Obstetrics and Gynecology. 208; S49-50.
4. Simpson, K. and Creehan, P. (~~2014~~**2020**). Perinatal Nursing **5**4th Edition. Philadelphia, PA
5. **Belfort, M. (2019). Overview of postpartum hemorrhage. Retrieved from www.uptodate.com 2/20/2020. *WoltersKluwer***

Obstetric Hemorrhage Emergency Management Plan:

	Assessments	Meds/Procedures	Blood Bank
Stage 0	**Every woman in labor/giving birth**		
Stage 0 focuses on risk assessment and active management of the third stage.	• Assess every woman for risk factors for hemorrhage • Measure cumulative quantitative blood loss on every birth	Active Management 3rd Stage: • Oxytocin IV infusion or 10u IM • Fundal Massage- vigorous, 15 seconds min.	• If Medium Risk: T& Scr. • If High Risk: T&C 2 U • If Positive Antibody Screen (prenatal or current, exclude low level anti-D from RhoGam): T&C 2 U
Stage 1	**Blood loss: >500mL vaginal or >1000mL Cesarean, or VS changes (by >15% or HR ≥ 110, BP ≤ 85/45, O2 sat <95%**		
Stage 1 is short: activate hemorrhage protocol, initiate preparations and give Methergine IM.	• Activate OB Hemorrhage Protocol and Checklist • Notify Charge nurse, OB/CNM, Anesthesia • VS, O2 Sat q5' • Record cumulative blood loss q5-15' • Weigh bloody materials • Careful inspection with good exposure of vaginal walls, cervix, uterine cavity, placenta	• IV Access: at least 18gauge • Increase IV fluid (LR) and Oxytocin rate, and repeat fundal massage • Methergine 0.2mg IM (if not hypertensive) May repeat if good response to first dose, BUT otherwise move on to 2nd level uterotonic drug (see below) • Empty bladder: straight cath or place foley with urimeter	• T&C 2 Units PRBCs (if not already done)
Stage 2	**Continued bleeding with total blood loss under 1500mL**		
Stage 2 is focused on sequentially advancing through medications and procedures, mobilizing help and Blood Bank support, and keeping ahead with volume and blood products.	OB back to bedside (if not already there) • Extra help: 2nd OB, Rapid Response Team, assign roles • VS & cumulative blood loss q5-10 min • Weigh bloody materials • Complete evaluation of vaginal wall, cervix, placenta, uterine cavity • Send additional labs, including DIC panel • If in Postpartum: Move to L&D/OR • Evaluate for special cases: -Uterine Inversion -Amn. Fluid Embolism	2nd Level Uterotonic Drugs: • Hemabate 250 mcg IM or • Misoprostol 800 mcg SL 2nd IV Access (at least 18gauge) Bimanual massage Vaginal Birth: (typical order) • Move to OR • Repair any tears • D&C: r/o retained placenta • Place intrauterine balloon • Selective Embolization (Interventional Radiology) Cesarean Birth: (still intra-op) (typical order) • Inspect broad lig, posterior uterus and retained placenta • B-Lynch Suture • Place intrauterine balloon	• Notify Blood Bank of OB Hemorrhage • Bring 2 Units PRBCs to bedside, transfuse per clinical signs – do not wait for lab values • Use blood warmer for transfusion • Consider thawing 2 FFP (takes 35+min), use if transfusing >2u PRBCs • Determine availability of additional RBCs and other Coag products
Stage 3	**Total blood loss over 1500mL, or >2 units PRBCs given or VS unstable or suspicion of DIC**		
Stage 3 is focused on the Massive Transfusion protocol and invasive surgical approaches for control of bleeding.	• Mobilize team -Advanced GYN surgeon -2nd Anesthesia Provider -OR staff -Adult Intensivist • Repeat labs including coags and ABG's • Central line • Social Worker/ family support	• Activate Massive Hemorrhage Protocol • Laparotomy: -B-Lynch Suture -Uterine Artery Ligation -Hysterectomy • Patient support -Fluid warmer -Upper body warming device -Sequential compression stockings	Transfuse Aggressively Massive Hemorrhage Pack • Near 1:1 PRBCs: FFP • 1 PLT apheresis pack per 4-6 units PRBC's Unresponsive Coagulopathy: After 8-10 units PRBCs and full coagulation factor replacement: ma consult re rFactor VIIa risk/benefit

Uterotonic Agents for Postpartum Hemorrhage:

Drug	Dose	Route	Frequency	Side Effects	Contraindications	Storage
Pitocin (Oxytocin) 10 units/ml	10-40 units per 500-1000ml, rate titrated to uterine tone	IV infusion	Continuous	Usually none Nausea, vomiting, hyponatremia ("water intoxication") with prolonged IV admin. Decreased BP and increased HR with high doses, esp. IV push	Hypersensitivity to drug	Room temp
Methergine (Methylergonivine) 0.2 mg/ml	0.2 mg	IM (not to be given IV)	-Q 2-4 hours -If no response after first dose, it is unlikely that additional doses will be of benefit	Nausea, vomiting Severe hypertension, esp. if given IV, which is not recommended	Hypertension, Preeclampsia, Cardiovascular disease Hypersensitivity to drug Caution if multiple doses of ephedrine have been used, may exaggerate hypertensive response w/possible cerebral hemorrhage	Refrigerate
Hemabate (15-mthyl PG F2a) 250 mcg/ml	250 mcg	IM or intra-myometrial (not given IV)	-Q 15-90 min -Not to exceed 8 doses/24 hrs -If no response after several doses, it is unlikely that additional doses will be of benefit	Nausea, Vomiting, Diarrhea, Fever (transient), Headache, Chills, shivering, hypertension, bronchospasm	Caution in women with hepatic disease, asthma, hypertension, active cardiac or pulmonary disease Hypersensitivity to drug	Refrigerate
Cytotec (Misoprostol) 100 or 200 mcg tabs	600-1000 mcg	Sublingual, oral, or per rectum (PR)	One time	Nausea, vomiting, diarrhea, shivering, fever (transient), Headache	Rare Known allergy to prostaglandin Hypersensitivity to drug	Room temp

Tri-City Medical Center
Oceanside, California

DELETE Policy-Does not need replaced.

WOMEN AND NEWBORN SERVICES POLICY MANUAL

ISSUE DATE: 10/94 **SUBJECT:** Shift Change Responsibilities

REVISION DATE: 01/00, 06/03, 07/06, 06/13

Department Approval:	~~03/16~~10/21
Department of OB/GYN Approval:	n/a
Division of Neonatology Approval:	n/a
Department of Pediatrics Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	11/21
Professional Affairs Committee Approval:	~~01/17~~ n/a
Board of Directors Approval:	01/17

~~A. **ASSIGNMENT SHEET:**~~
~~1. Patient care assignments are made by the charge nurse for the oncoming shift.~~
~~a. The names of nursing personnel working in labor and delivery (L&D), and mother-baby unit are listed on the assignment sheet for women and newborn services (WNS).~~
~~b. Support staff and management personnel assigned to each of the areas is also documented.~~
~~2. The assignment sheets are maintained by the charge nurse.~~
~~a. Nurses may obtain their assignments from the unit census boards.~~
~~3. Updates to the assignment sheet, indicating admissions and/or discharges are made by the charge nurse on an ongoing basis during the shift.)~~

~~B. **SHIFT REPORT:**~~
~~1. Nursing staff, unlicensed staff, and management personnel receive report from the off-going shift.~~
~~a. This report is given verbally and if possible at the patient's bedside.~~
~~b. Report is to be given in a manner that protects patient confidentiality.~~
~~2. Management report is given in an in-person verbal format at 0700 and 1900 between the oncoming and off-going charge nurses.~~
~~3. During report, specific patient condition information and anticipated needs are discussed.~~
~~a. All concurrent and prospective interventions are based on the plan of care for each patient.~~

~~C. **PLAN OF CARE:**~~
~~1. The plan of care is formulated by the nurse using information gathered from the patient history and current clinical assessment.~~
~~a. The plan of care is and interventions are reviewed and discussed with the patient and should reflect items to help the patient meet established outcomes.~~
~~b. The plan of care should be curtailed to meet the needs of the patient and may change during the patient's stay.~~
~~2. Interventions for problems identified are evaluated and/or updated at least every 24 hours.~~
~~3. All care planning is coordinated by the registered nurse.~~
~~a. Acute Care Technicians (ACT's) or Certified Nursing Assistants (CAN's) assist the by providing data gathering tasks and duties assigned to him/her by the registered nurse.~~

~~D. **ROLES OF SUPPORT PERSONNEL:**~~
~~1. OB Technicians (Techs):~~

a. Function as support personnel to the medical and nursing staff and perform tasks that are assigned to them which can include but is not limited to:
   i. Surgical scrub technician role
   ii. Assist with delivery room set up, management, and any equipment preparations
   iii. Instrument cleaning preparations
   iv. Sterile processing department duties
   v. Patient transfer/transport
   vi. Supply and room stocking role

2. Unit Secretaries:
   a. Provide clerical support to nursing staff and medical staff in the areas that comprise WNS.

3. Peri-Operative Aides:
   a. Function as housekeeping support personnel to the L&D unit and perform tasks that are assigned to them which can include but is not limited to:
      i. All housekeeping duties to include operating room terminal cleaning
      ii. Patient transfer/ transport
      iii. Specimen transport

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

October 28, 2021 – 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 October 28, 2021.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Leigh Anne Grass
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Jennifer Paroly, Foundation President
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
Dr. Jamie Johnson, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky J. Chavez, called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Coulter to approve the agenda as presented. Director Younger Seconded the motion. The motion passed unanimously (7-0).

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Chavez read the Public Comments section listed on the October 28, 2021 Regular Board of Directors Meeting Agenda.

Kathy Cronce requested to speak under Public Comments.

5. September, 2021 Financial Statements – Ray Rivas, Chief Financial Officer

Mr. Rivas reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $83,981
- Operating Expense - $88,868
- EBITDA - $607
- EROE ($2,644)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 150
- Adjusted Patient Days – 27,403
- Surgery Cases – 1,684
- ED Visits – 12,797

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $28,690
- Operating Expense - $30,187
- EBITDA - $340
- EROE ($733)

Mr. Rivas reported on the current month Key Indicators as follows:

- Average Daily Census – 159
- Adjusted Patient Days – 9,572
- Surgery Cases – 563
- ED Visits – 4,106

- Net Patient Accounts Receivable - $51.4
- Days in A/R – 63.9

6. New Business

a) External Affairs Update – Aaron Byzak, Chief External Affairs Officer

Mr. Aaron Byzak, Chief External Affairs Officer provided a detailed presentation on the Community Outreach and Support through Active Leadership (COASTAL) Commitment project. He reviewed the following:

- Impact – Nearly 60 community partners with $185,865.00 in annual financial support through 85 programs addressing priority health needs and social determinants of Health;
- Awards which have included Carlsbad's Business Achievement & Distinction Awards winner; Heroes of Oceanside and Camp Pendleton; National Association for the Advancement of Colored People; San Diego's Best;

SD500 – The Most Influential People in San Diego; and Health Care Communicators of Southern California, to name a few;
- Student Opportunities for Care Awareness and Learning (SOCAL); and
- Website Design

Mr. Byzak's presentation also included "The Big Reveal" which includes renaming the towers to Carlsbad, Oceanside and Vista Pavilions as well as a History Wall, Healthcare Heroes Poster campaign, new way-finding signage and photographic art.

Mr. Byzak also commented on the hospital's 60th Anniversary Video and the Birthday BBQ and Heroes Shirt Distribution.

In closing, Mr. Byzak discussed the upcoming Phase II of Interior Updates which will include the following as well as the Coastal Commitment Expansion:

- Additional Wayfinding and Dimensional Lettering
- ADA Signage Updates
- Further Art Installations/Museum Tags
- Additional painting including accent walls
- NICU Wall of Hope

The Coastal Commitment Expansion (with over 50 volunteers thus far) will include expanded data collection and reporting.

7. Old Business – None

8. Chief of Staff

a) Consideration of the October 2021 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on October 25, 2021.

Dr. Jamie Johnson, Chief of Staff presented for the Board's consideration the Initial Appointments, Reappointments, Non-Reappointment Status modifications, and Proctoring report for both the Medical Staff and Allied Health Professionals.

It was moved by Director Grass to approve the September, 2021 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on September 27, 2021. Director Younger seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Gleason, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

9. Consideration of Consent Calendar

Director Gleason pulled item 10, September 30, 2021 Regular Board Meeting minutes.

It was moved by Director Gleason to approve the Consent Calendar minus the item pulled. Director Coulter seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Gleason, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**None**

10. Discussion of items pulled from Consent Calendar

Director Gleason stated she wished to abstain from the September Regular Board Meeting Minutes due to her absence from the meeting. Director Chaya stated she also wished to abstain from the minutes.

It was moved by Director Coulter to approve the September 30, 2021 Regular Board Meeting Minutes. Director Sanchez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Coulter, Grass, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**Chaya, Gleason**
ABSENT:	**Directors:**	**None**

11. Comments by Members of the Public

Chairperson Chavez recognized Kathy Cronce, RN.

Ms. Crone commented on staffing concerns.

Chairperson Chavez recognized Alyce Budde, RN

Ms. Budde commented on staffing concerns and wages.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported Tri-City currently has 15 COVID positive inpatients, however during the height of the Delta variant we were seeing numbers in the high 30's and have since stabilized at 15-20. Throughout the pandemic Tri-City has seen over 1,000 COVID positive inpatients. Mr. Dietlin stated although we are seeing the Delta variant number come down, the acuity of patients is very high which is reflected in the length of stay. The average daily census is also higher since the pandemic due to the fact that patients are staying longer.

Mr. Dietlin stated the work force has been an issue throughout the pandemic and even more so now than at the height of the pandemic. County-wide, state-wide and across the United States, the number one challenge in healthcare facilities is staffing. He explained we have incentive and recruitment programs in place and want to provide the best care for our community.

From a vaccination standpoint, Mr. Dietlin reported Tri-City has been providing vaccination clinics and boosters based on the demand. Tri-City continues to coordinate with the county to provide vaccines to those who are homebound and in nursing homes. All vaccination appointments can be made through the Tri-City website and on My Turn.

Mr. Dietlin reported in October Tri-City completed their Stroke Certification Survey. Mr. Dietlin stated the surveyors were highly complementary of the entire team and spoke of their exemplary performance. Mr. Dietlin stated we are very proud of our Stroke program and congratulated everyone on the Stroke Team from entry to exit.

Mr. Dietlin provided an update on the partnership with the County of San Diego for a Psychiatric Health Facility (PHF). He stated things have slowed down somewhat during the pandemic but we are excited about moving forward the PHF. Tri-City is coordinating with the city and county on licensing and permitting and expects to break ground in 2022. Mr. Dietlin estimated build time would take approximately 12 months. Although many mental health programs were suspended or closed through the COVID-19 pandemic, Tri-City continued to operate its intensive Outpatient Mental Health program and there will be an improvement in the continuum of care with the Crisis Stabilization sites in Oceanside and Vista along with the new PHF that will be built.

13. Board Communications

Director Chaya encouraged everyone to protect themselves and those around you as COVID-19 is a beast of a virus.

Director Chaya also commented on the Gala which was an absolute hit. She thanked everyone who joined and supported the Gala.

Director Gleason thanked the speakers for sharing their concerns. She also expressed her appreciation to Mr. Byzak for an amazing presentation. The cosmetic improvements are beyond impressive.

Lastly, Director Gleason congratulated Ms. Paroly on the success of the Gala as well as the Foundation Board, the sponsors and Director Chaya for chairing the event.

Director Sanchez echoed fellow Board member comments. She also expressed her appreciation for staff's continued efforts and the wonderful services Tri-City provides.

Lastly, Director Sanchez commented on the upcoming Turkey Trot.

Director Coulter congratulated everyone on the successful Stroke Survey. He also commented on Mr. Byzak's presentation and stated he is impressed with what has been done to beautify the hospital.

Director Younger commented on the incredible gala. She also commented on Mr. Byzak's presentation and the beautiful pictures that now line the hospital's hallways.

Director Younger thanked the nurses who spoke today and encouraged looking at "out of the box" solutions.

Lastly Director Younger wished everyone a Happy Thanksgiving.

Director Grass congratulated Mr. Aaron Byzak and his team on the outstanding presentation and expressed her appreciation for their dedication. She commented on the stunning photography and what an incredible change it has made to the interior of the hospital.

Director Grass also congratulated the Foundation Board on the success of the gala as well as Ms. Paroly and her team's efforts in preparation for the gala.

Lastly, Director Grass stated October is Breast Cancer Awareness month and encouraged all women over 45 to get their mammogram.

14. Report from Chairperson

Chairperson Chavez stated the Gala was a great event.

Chairperson Chavez reported that every ten years boundaries are redrawn for congressional seats among other things. Based on the preliminary maps, our District could conceivably have three Assembly Members and two Senators and the possibility of multiple congressional members which will be affecting the District as far as governance.

Chairperson Chavez stated he appreciated the comments from the nurses who spoke today, however it is important to keep in mind that we do not want to put ourselves in a place where the hospital is not a viable entity.

Chairperson Chavez commented on the improvements made to the hospital as reflected in Mr. Byzak's presentation. He stated there are also infrastructure upgrades that are needed and a bond will be necessary to make those upgrades. Chairperson Chavez stated he hopes all entities will come together for the betterment of our community.

Lastly, Chairperson Chavez encouraged everyone to get their flu vaccine.

15. Move to adjourn

It was moved by Director Younger and seconded by Director Sanchez to adjourn the meeting. The motion passed unanimously (7-0).

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16. There being no further business Chairperson Chavez adjourned the meeting at 4:30 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Tracy M. Younger, 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
FY22	63.3	63.8	64.7	68.2									65.0	48-52
FY21	51.1	50.9	52.7	50.7	50.9	50.7	55.4	54.6	50.9	53.0	62.4	60.9	51.3	

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
FY22	102.6	96.5	99.7	93.7									98.1	75-100
FY21	107.1	103.1	101.1	99.6	99.6	92.7	93.9	94.6	94.0	100.5	103.5	98.1	102.7	

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
FY22	($900)	($1,011)	($733)	$132									($2,512)	($4,789)
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)	$210	($554)	$4,682	$4,774	($2,835)	

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
FY22	-3.24%	-3.67%	-2.55%	0.43%									-2.19%	-4.40%
FY21	-6.12%	-3.74%	-3.60%	1.78%	-0.64%	-3.12%	4.13%	-0.92%	0.73%	-1.89%	14.69%	15.52%	-2.74%	

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
FY22	$190	$76	$340	$1,190									$1,797	$ (94)
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935	$1,383	$422	$5,782	$5,855	$2,140	

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
FY22	0.69%	0.28%	1.19%	3.85%									1.56%	-0.09%
FY21	-0.78%	1.18%	1.17%	6.09%	3.22%	1.18%	8.73%	3.50%	4.79%	1.44%	18.14%	19.03%	2.07%	

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
FY22	5.73	5.35	4.97	5.28									5.32	5.57
FY21	5.38	5.66	5.40	5.87	5.25	5.75	5.10	5.61	6.18	6.33	5.64	5.83	5.58	

TCHD Liquidity $ in Millions (Cash + Available Revolving Line of Credit)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
FY22	$81.4	$76.9	$71.5	$57.3								
FY21	$59.5	$57.4	$83.5	$76.9	$71.3	$68.5	$71.4	$75.4	$83.2	$67.3	$59.6	$86.8

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending October 31, 2021

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)	48,472.27	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)	35,117.58	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)	20,197.50	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)	17,002.20	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)	7,169.67	04/01/20	03/31/22	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Appox 4,508	$1.75	(a)	14,104.49	09/01/21	08/31/31	TCMC Primary Care Medical Group 115 N EL Camino Real, Suit A Oceanside, CA 92058	7090
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	13,026.85	07/01/21	06/30/26	**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)	40,211.40	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)	14,026.32	06/01/21	05/31/26	**OSNC 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	10/31/21	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**213,082.28**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Education & Travel Expense
Month Ending October 2021

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8510	YR END CLASS FOR PAYROLL	100621EDU	525.00	8021	ALCAZAR, ARTURO
8613	HCCA CONF	42921 EDU	1,045.00	83989	CARAPIA MARIA
8740	MASTERS NURSING	100721 EDU	2,367.00	83088	TROSTRUD, RACHEL
8740	PEDIATRIC LIFE SUPPORT	101421 EDU	185.00	83922	JENNIFER HA
8750	NAHG CERT	92321 EDU	175.00	82501	MANTA MED-JOHNSON
8740	IMAGING COURSES	102221 EDU	133.32	77058	PALMIERI SHELLY
8740	ETHICS CLASS	100721 EDU	124.98	81645	SIDHU, CAROLYN
8740	ONS ONCC	101421 EDU	103.00	82644	FRETHEL LEE D ABREA

**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.