TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 24, 2022 – 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: 828 7893 1150 Passcode: 857286

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	January 2022 Financial Statement Results	10 min.	CFO
6	New Business – a) Consideration to approve Resolution No. 809, a Resolution of Tri-City Healthcare District Board of Directors Authorizing Execution and Delivery of a Loan and Security Agreement, Promissory Note, and Certain Actions in Connection therewith for the California Health Facilities Financing Authority Non-designated Public Hospital Bridge Loan Program	10 min.	CFO
7	Old Business – None	--	--

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

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

	Agenda Item	Time Allotted	Requestor
8	Chief of Staff a) February 2022 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on February 22, 2022.	5 min.	COS
9	Consideration of Consent Calendar ***Requested items to be pulled require a second*** (1) Approval of Resolution 807, 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 (2) Administrative & Board Committees **A. Policies** **1. Patient Care Services Policies & Procedures** a. Abbreviations, Use of b. Administration of Vitamin K Injection and Erthomycin Ophthalmic, Intravenous Procedure c. Admixture, Intravenous Procedure d. Family Presence During Resuscitation Policy e. Hovermatt Air Transfer System Procedure f. Infusion Pump Syringe or PCA Module System with Guardrails Procedure g. Infusion Pumps, Intravenous Therapy Policy h. Medical Screening Exam to Rule out Labor Standardized Procedure i. Patient Rights and Responsibilities Policy j. Precipitous Vaginal Delivery Standardized Procedure k. Preventing Admissions and Procedures Beyond Medical Staff Privileges Policy l. Stroke Code, In-House m. Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC) Policy n. Video Laryngoscope Set-up & Cleaning Procedure (DELETE) **2. Administrative Policies & Procedures** a. Charity Care, Uncompensated Care, Community Service 285 b. Prior Authorizations for Non-Emergency Services for HMO PPO 213 **3. Unit Specific – Engineering** a. Managing Biological Agents to Prevent Waterborne Illness **4. Unit Specific Laboratory** a. Individualized Quality Control Plan Policy b. Laboratory Policy and Procedure Document Control c. Pathology Staff Professional Competency Policy **5. Unit Specific – Medical Staff** a. CPOE Power Plan Revisions – additions 8710-568 b. Surgical Assistance 8710-545		

	Agenda Item	Time Allotted	Requestor
	6. Unit Specific – NICU a. Criteria for Case Referrals to Morbidity and Mortality (M&M) Policy b. Donor Breast Milk Use Policy **7. Unit Specific – Pharmacy** a. Drug Supply Chain Security Act b. General and Concentrated Electrolytes Policy c. Licensure and Professional Services d. Pharmaceutical Representatives Policy e. Transdermal Fentanyl Patch Prescribing and Use f. Unlabeled Uses of FDA-Approved Medications **8. Unit Specific - Radiology** a. Patient Transport #135 (DELETE) b. Referrals not Scheduled – No Show Patient Canceled #136 (3) Minutes – Approval of: a) January 27, 2022, Regular Meeting b) January 27, 2022, Special Meeting (4) Meetings and Conferences – None (5) Dues and Memberships - None (6) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (January, 2022) (d) Reimbursement Disclosure Report – (January, 2022) (e) Seminar/Conference Reports – None		Standard
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 min	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1 hour	
16	Adjournment		

RESOLUTION NO. 809

RESOLUTION OF TRI-CITY HEALTHCARE DISTRICT BOARD OF DIRECTORS AUTHORIZING EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT, PROMISSORY NOTE, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR THE CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM

WHEREAS, Tri-City Healthcare District (the "Borrower") is a nondesignated public hospital as defined in Welfare and Institutions Code Section 14165.55, subdivision (l), excluding those affiliated with county health systems pursuant to Chapter 240, Statutes of 2021 (SB 170), Section 25; and

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed **$2,405,000.00** from the California Health Facilities Financing Authority (the "Lender"), such loan to be funded with the proceeds of the Lender's Nondesignated Public Hospital Bridge Loan Program; and

WHEREAS, the Borrower intends to use the funds solely to fund its working capital needs to support its operations;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby ratifies the submission of the application for a loan from the Nondesignated Public Hospital Bridge Loan Program.

Section 2. Steven L. Dietlin, CEO an ("Authorized Officer") is hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable in order to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan is hereby approved. The loan shall be in a principal amount not to exceed **$2,405,000.00,** shall not bear interest, and shall mature 24 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The Authorized Officer(s) is hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially said form that includes the redirection of up to 20% of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default, with such changes therein as the

Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with such changes therein as the Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

_____

Date of Adoption

SECRETARY'S CERTIFICATE

I, Gigi Gleason, Secretary of Tri-City Healthcare District, hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of Tri-City Healthcare District duly and regularly held at the regular meeting place thereof on the 24th day of February 2022, of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

AYES:

NOES:

ABSENT:

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

Dated:_____ By:_____

Gigi Gleason
Secretary

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
February 9, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/25/2022 – 1/31/2024)

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 2/25/2022 through 1/31/2024:

- **DANQUAH, Vanessa MD/Psychiatry (Array Behavioral Care)**
- **NIKANJAM, Mina MD/Oncology (UCSD)**
- **REINSCH, Caryl MD/OB/GYN (Kaiser)**
- **SHAMSINEJAD BABAKI, Arash MD/Internal Medicine (Sound Physicians)**
- **WALSH, John MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
February 9, 2022

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 03/01/2022 – 02/29/2024)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 03/01/2022 through 02/29/2024, 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:

- **ANAND, Neil, MD/Teleradiology/Provisional**
- **BAILEY, Romana, MD/Neonatology/Active**
- **BAROUDI, Sam, MD/Internal Medicine/Active**
- **BISHAY, Emad, MD/Internal Medicine/Active**
- **BLOOM, Irving, MD/Internal Medicine/Active**
- **CADMAN, Karen, MD/Internal Medicine/Refer and Follow**
- **DEVEREAUX, Christopher, MD/Gastroenterology/Active**
- **GOMEZ, Denise, MD/Internal Medicine/Refer and Follow**
- **GOODING, Justin, MD/Radiology/Active**
- **HANNA, Karen, MD/General Surgery/Active**
- **HOSSEINI, Puya, MD/Anesthesiology/Active Affiliate**
- **KROENER, John, MD/General and Vascular Surgery/Active**
- **PINNELL, Sean, MD/Radiology/Active**
- **PONEC, Donald, MD/Radiology/Active**
- **TRAN, Quoc, MD/Family Medicine/Active**
- **YUH, Theresa, MD/Teleradiology/Provisional**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
February 9, 2022

Attachment B

REINSTATEMENT: (Effective Dates 02/01/2021 – 01/31/2023)

Any items of concern will be "red" flagged in this report. The following application was recommended for reinstatement to the medical staff office effective 02/01/2021 through 01/31/2023, 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:

- **MATEO, Marie, CNM/Allied Health Professional**

RESIGNATIONS: (Effective date 02/28/2022 unless otherwise noted)

Automatic: None

Voluntary:

- **AL-TARIQ, Quazi, MD/Teleradiology**
- **BLAKE, Patrick, MD/Dermatology**
- **MEINEKE, Ryan, MD/Orthopedic Surgery**
- **WACLAWSKI, Richard, MD/Anesthesiology**
- **WONG, Darryl, MD/Dermatology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 09, 2022

PROCTORING RECOMMENDATIONS

Any items of concern will be "red" flagged in this report.

- **BAKSHI, Ankur, MD** — **Cardiothoracic Surgery**
- **HAWLEY, Daniel, MD** — **Radiology**
- **RUIZ, Lizette, MD** — **Emergency Medicine**
- **YUNG, Aaron, MD** — **Interventional Cardiology**

RESOLUTION NO. 807

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 February 24, 2022, by the following roll call vote:

AYES: Directors

NOES: Directors

ABSTAIN: Directors

ABSENT: Directors

_____

Rocky J. Chavez, President
Board of Directors

ATTEST:

_____

Gigi Gleason, Secretary
Board of Directors

ADMINISTRATION CONSENT AGENDA
February 15th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Abbreviations, Use of	– 3 year review, practice change	Forward To BOD For Approval
2. Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure	– 2 year review	Forward To BOD For Approval
3. Admixture, Intravenous Procedure	– 3 year review	Forward To BOD For Approval
4. Family Presence During Resuscitation Policy	– 3 year review, practice change	Forward To BOD For Approval
5. Hovermatt Air Transfer System Procedure	– 3 year review	Forward To BOD For Approval
6. Infusion Pump Syringe or PCA Module System with Guardrails Procedure	– 3 year review	Forward To BOD For Approval
7. Infusion Pumps, Intravenous Therapy Policy	– 3 year review	Forward To BOD For Approval
8. Medical Screening Exam to Rule out Labor Standardized Procedure	– 2 year review, practice change	Forward To BOD For Approval
9. Patient Rights and Responsibilities Policy	– 3 year review, practice change	Forward To BOD For Approval
10. Precipitous Vaginal Delivery Standardized Procedure	– 2 year review, practice change	Forward To BOD For Approval
11. Preventing Admissions and Procedures Beyond Medical Staff Privileges Policy	– 3 year review	Forward To BOD For Approval
12. Stroke Code, In-House	– 3 year review, practice change	Forward To BOD For Approval
13. Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC) Policy	– 3 year review	Forward To BOD For Approval
14. Video Laryngoscope Set-up & Cleaning Procedure	DELETE	Forward To BOD For Approval
Administrative 200s District Operations		
1. Charity Care, Uncompensated Care, Community Service 285	– 3 year review, practice change	Forward To BOD For Approval
2. Prior Authorizations for Non-Emergency Services for HMO PPO 213	3 year review	Forward To BOD For Approval
Engineering		
1. Managing Biological Agents to Prevent Waterborne Illness	– 3 year review, practice change	Forward To BOD For Approval
Laboratory		
1. Individualized Quality Control Plan Policy	– 2 year review	Forward To BOD For Approval
2. Laboratory Policy and Procedure Document Control	– 2 year review, practice change	Forward To BOD For Approval
3. Pathology Staff Professional Competency Policy	– 2 year review	Forward To BOD For Approval
Medical Staff		
1. CPOE Power Plan Revisions-Additions 8710-568	– 3 year review	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
February 15th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
2. Surgical Assistance 8710-545	– 3 year review, practice change	Forward To BOD For Approval
NICU		
1. Criteria for Case Referrals to Morbidity and Mortality (M & M) Policy	– 2 year review, practice change	Forward To BOD For Approval
2. Donor Breast Milk Use Policy	NEW	Forward To BOD For Approval
Pharmacy		
1. Drug Supply Chain Security Act	– 3 year review	Forward To BOD For Approval
2. General and Concentrated Electrolytes Policy	– 3 year review	Forward To BOD For Approval
3. Licensure and Professional Standards	– 3 year review	Forward To BOD For Approval
4. Pharmaceutical Representatives Policy	– 3 year review	Forward To BOD For Approval
5. Transdermal Fentanyl Patch Prescribing and Use	– 3 year review	Forward To BOD For Approval
6. Unlabeled Uses of FDA-Approved Medications	– 3 year review	Forward To BOD For Approval
Radiology		
1. Patient Transport #135	DELETE	Forward To BOD For Approval
2. Referrals Not Scheduled-No Show-Patient Canceled #136	– 3 year review	Forward To BOD For Approval

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/97 **SUBJECT: Abbreviations, Use of**

REVISION DATE: 5/02, 12/02, 5/03, 12/03, 3/04, 4/06, 08/06, 07/09, 06/15, 04/18

Department Approval:	~~02/18~~10/21
Clinical Policies & Procedures Committee Approval:	~~03/18~~11/21
Nursinge Leadership~~Executive Committee~~ Approval:	~~03/18~~12/21
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/18~~01/22
Administrative Approval:	02/22
Professional Affairs Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

A. **PURPOSE:**

1. To provide optimal safety for patients and clear understanding of written medical communication by eliminating the use of potentially dangerous abbreviations and dose designations.

B. **POLICY:**

1. Tri-City Medical Center (TCMC) has adopted the Neil-Davis Medical ~~Abbreviations~~ **Abbreviations.**
   a. In addition, Pharmacy has adopted the Institute for Safe Medication Practices (ISMP)'s Error-Prone Abbreviations, Symbols, and Dose Designations for medication orders.
2. Abbreviations identified as "Do Not Use Abbreviations" by the Joint Commission are prohibited for use in all orders and medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed orders.
3. Medication orders
   a. If an unapproved abbreviation is used on a medication order or other written communication for patient care, the ordering physician shall be contacted by the nurse or pharmacist for clarification. The clarified order shall be documented in the medical record.
   b. Medication orders containing unapproved abbreviations shall not be dispensed by pharmacy or administered by the nurse until clarified and the medication order re-entered.
4. Changes to abbreviation references will be approved by the Pharmacy and Therapeutics Committee (P&T), the Medical Executive Committee and the Board of Directors.

C. **RELATED DOCUMENTS:**

1. **Institute for Safe Medication Practices** (ISMP). **(2021)** ~~'s~~ List of Error-Prone Abbreviations~~, Symbols, and Dose Designations (2015)~~
2. **The** Joint Commission **Official** ""Do Not Use" List (20~~17~~20)

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

1. Neil-Davis Medical Abbreviation - http://www.medabbrev.com/

E. **REFERENCES:**

1. The Joint Commission. **(August, 2020**~~June 2017~~). ***Fact sheet. Offical "do no use" list. s*** ~~*about the Official "Do Not Use" List.*~~ Retrieved from ~~www.jointcommission.org on March 7th, 2018. https://www.jointcommission.org/facts_about_do_not_use_list/~~

Facts about the Official "Do Not Use" List of Abbreviations

June 9, 2017

The Joint Commission's "Do Not Use" List is part of the Information Management standards. This requirement does not apply to preprogrammed health information technology systems (for example, electronic medical records or CPOE systems), but this application remains under consideration for the future. Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	
U, u (unit)	
IU (International U	Unit"
Q.D., QD, q.d., qd (Q.O.D., QOD, q.o.d, q other day)	day"
Trailing zero (X.0 Lack of leading zero	
MS	fate"
MSO_4 and MgS	lfate"

[1] Applies to all orde uding free-text

***Exception:** A "traili f precision of the value being reported, s s, or catheter/tube sizes. It may entation.

Development of the "
In 2001, The Joint Com eviations. A year later, its Board of Comm ed organizations to develop and impleme created its "Do Not Use" List to meet that g nagement standards as elements
For more information, c te the Standards Online Question Submi

https://www.jointcommi
Retrieved March 7, 2018

DELETE

The Joint Commission

Official "Do Not Use" List

The Joint Commission
FACT SHEET

- This list is part of the Information Management standards
- Does not apply to preprogrammed health information technology systems (i.e. electronic medical records or CPOE systems), but remains under consideration for the future

Organizations contemplating introduction or upgrade of such systems should strive to eliminate the use of dangerous abbreviations, acronyms, symbols and dose designations from the software.

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

[1]Applies to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on pre-printed forms.

***Exception:** A "trailing zero" may be used only where required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

Development of the "Do Not Use" List
In 2001, The Joint Commission issued a *Sentinel Event Alert* on the subject of medical abbreviations. A year later, its Board of Commissioners approved a National Patient Safety Goal requiring accredited organizations to develop and implement a list of abbreviations not to use. In 2004, The Joint Commission created its "Do Not Use" List to meet that goal. In 2010, NPSG.02.02.01 was integrated into the Information Management standards as elements of performance 2 and 3 under IM.02.02.01.

For more information

- Complete the Standards Online Question Submission Form.
- Contact the Standards Interpretation Group at 630-792-5900.

8/20

Institute for Safe Medication Practices

ISMP's List of *Error-Prone Abbreviations, Symbols,* and *Dose Designations*

The abbreviations, symbols, and dose designations found in this table have been reported to ISMP through the ISMP National Medica… being frequently… medication erro… nicating medical information. This includes internal communications, telephone/verbal prescriptions, computer-generated …ministration …uter order

Abbreviation	…	…
pp		
AD, AS, AU		" or "each ear"
OD, OS, OU		," or "each eye"
BT		
cc		
D/C		…continue"
LJ		
IN		"
HS		…ening"
hs		
IU**		
o.d. or OD		
OJ		
Per os		r "orally"
q.d. or QD*		
qhs		
qn		…ne"
q.o.d. or QOD		
q1d		
qSPM, etc.		…i PM daily"
SC, SQ, sub		…neously"
ss		use "one-half" or
SSRI		…nsulin)"
SSI		
i/d		
TIW or tiw		
U or u**		
UD		

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Trailing zero after decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
"Naked" decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use zero before a decimal point when the dose is less than a whole unit
Abbreviations such as mg. or mL. with a period following the abbreviation	mg mL	The period is unnecessary and could be mistaken as the number 1 if written poorly	Use mg, mL, etc. without a terminal period

DELETE

ISMP's List of *Error-Prone Abbreviations, Symbols, and Dose Designations* (continued)

Dose Designations and Other Information	Intended Meaning	Misinterpretation	Correction
Drug name and dose run together (especially problematic for drug names that end in "l" such as Inderal40 mg; Tegretol300 mg)	Inderal 40 mg Tegretol 300 mg	Mistaken as Inderal 140 mg Mistaken as Tegretol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run togeth (e.g., 10mg, 100mL)	10 mg	The "m" is sometimes misread as two zeros, risking	tween the dose and
Large doses without properly placed comma (e.g., 100000 units; 1000000 units)			nits at or above as 100 " to improve
Drug Name Abbreviation			on
To avoid confusion, do			errors include:
APAP			
ARA A			
AZT			
CPZ			
DPT			
DTO			
HCl			unless expressed
HCT			
HCTZ			
MgSO4**			
MS, MSO4**			
MTX			
NaAC			
PCA			
PTU			
T3			
TAC			
TNK			
TPA or tPA			s
ZnSO4			
Stemmed Drug Names			on
"Nitro" drip			
"Norflex"			
"IV Vanc"			
Symbols			on
5			
ℿ			
x3d			
> and <			than"
/ (slash mark)	Separates two values in dosing; indicates "per"	Mistaken as the number 1 (e.g., 1.5 mg/kg/day misread as "15 units and 110" units)	Use "per" rather than a slash mark to separate doses
@	At	Mistaken as "2"	Use "at"
&	And	Mistaken as "2"	Use "and"
+	Plus or and	Mistaken as "4"	Use "and"
°	Hour	Mistaken as a zero (e.g., q2° seen as q 20)	Use "hr," "h," or "hour"
Ø or ø	zero, null sign	Mistaken as numerals 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words

DELETE

**These abbreviations are included on The Joint Commission's "minimum list" of dangerous abbreviations, acronyms, and symbols that must be included on an organization's "Do Not Use" list, effective January 1, 2004. Visit www.jointcommission.org for more information about this Joint Commission requirement.

ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations

The abbreviations, symbols, and dose designations in the **Table** below were reported to ISMP through the ISMP National Medication Errors Reporting Program (ISMP MERP) and have been misinterpreted and involved in harmful or potentially harmful medication errors. These abbreviations, symbols, and dose designations should **NEVER** be used when communicating medical information verbally, electronically, and/or in handwritten applications. This includes internal communications; verbal, handwritten, or electronic prescriptions; handwritten and computer-generated medication labels; drug storage bin labels; medication administration records; and screens associated with pharmacy and prescriber computer order entry systems, automated dispensing cabinets, smart infusion pumps, and other medication-related technologies.

In the **Table**, error-prone abbreviations, symbols, and dose designations that are included on The Joint Commission's "**Do Not Use**" list (Information Management standard IM.02.02.01) are identified with a double asterisk (**) and must be included on an organization's "**Do Not Use**" list. Error-prone abbreviations, symbols, and dose designations that are relevant mostly in handwritten communications of medication information are highlighted with a dagger (†).

Table. Error-Prone Abbreviations, Symbols, and Dose Designations

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Abbreviations for Doses/Measurement Units			
cc	Cubic centimeters	Mistaken as u (units)	Use mL
IU**	International unit(s)	Mistaken as IV (intravenous) or the number 10	Use unit(s) (International units can be expressed as units alone)
l **ml**	Liter Milliliter	Lowercase letter l mistaken as the number 1	Use L (UPPERCASE) for liter Use mL (lowercase m, UPPERCASE L) for milliliter
MM or M **M or K**	Million Thousand	Mistaken as thousand Mistaken as million M has been used to abbreviate both million and thousand (M is the Roman numeral for thousand)	Use million Use thousand
Ng or ng	Nanogram	Mistaken as mg Mistaken as nasogastric	Use nanogram or nanog
U or u**	Unit(s)	Mistaken as zero or the number 4, causing a 10-fold overdose or greater (e.g., 4U seen as 40 or 4u seen as 44) Mistaken as cc, leading to administering volume instead of units (e.g., 4u seen as 4cc)	Use unit(s)
µg	Microgram	Mistaken as mg	Use mcg
Abbreviations for Route of Administration			
AD, AS, AU	Right ear, left ear, each ear	Mistaken as OD, OS, OU (right eye, left eye, each eye)	Use right ear, left ear, or each ear
IN	Intranasal	Mistaken as IM or IV	Use NAS (all UPPERCASE letters) or intranasal

** On The Joint Commission's "**Do Not Use**" list

† Relevant mostly in handwritten medication information

List — continued on page 2 ▶

List — continued from page 1

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
IT	Intrathecal	Mistaken as intratracheal, intratumor, intratympanic, or inhalation therapy	Use intrathecal
OD, OS, OU	Right eye, left eye, each eye	Mistaken as AD, AS, AU (right ear, left ear, each ear)	Use right eye, left eye, or each eye
Per os	By mouth, orally	The os was mistaken as left eye (OS, oculus sinister)	Use PO, by mouth, or orally
SC, SQ, sq, or sub q	Subcutaneous(ly)	SC and sc mistaken as SL or sl (sublingual) SQ mistaken as "5 every" The q in sub q has been mistaken as "every"	Use SUBQ (all UPPERCASE letters, without spaces or periods between letters) or subcutaneous(ly)
Abbreviations for Frequency/Instructions for Use			
HS **hs**	Half-strength At bedtime, hours of sleep	Mistaken as bedtime Mistaken as half-strength	Use half-strength Use HS (all UPPERCASE letters) for bedtime
o.d. or OD	Once daily	Mistaken as right eye (OD, oculus dexter), leading to oral liquid medications administered in the eye	Use daily
Q.D., QD, q.d., or qd**	Every day	Mistaken as q.i.d., especially if the period after the q or the tail of a handwritten q is misunderstood as the letter i	Use daily
Qhs	Nightly at bedtime	Mistaken as qhr (every hour)	Use nightly or HS for bedtime
Qn	Nightly or at bedtime	Mistaken as qh (every hour)	Use nightly or HS for bedtime
Q.O.D., QOD, q.o.d., or qod**	Every other day	Mistaken as qd (daily) or qid (four times daily), especially if the "o" is poorly written	Use every other day
q1d	Daily	Mistaken as qid (four times daily)	Use daily
q6PM, etc.	Every evening at 6 PM	Mistaken as every 6 hours	Use daily at 6 PM or 6 PM daily
SSRI **SSI**	Sliding scale regular insulin Sliding scale insulin	Mistaken as selective-serotonin reuptake inhibitor Mistaken as Strong Solution of Iodine (Lugol's)	Use sliding scale (insulin)
TIW or tiw **BIW or biw**	3 times a week 2 times a week	Mistaken as 3 times a day or twice in a week Mistaken as 2 times a day	Use 3 times weekly Use 2 times weekly
UD	As directed (ut dictum)	Mistaken as unit dose (e.g., an order for "dil**TIAZ**em infusion UD" was mistakenly administered as a unit [bolus] dose)	Use as directed

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

List — continued on page 3

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Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Miscellaneous Abbreviations Associated with Medication Use			
BBA **BGB**	Baby boy A (twin) Baby girl B (twin)	B in BBA mistaken as twin B rather than gender (boy) B at end of BGB mistaken as gender (boy) not twin B	When assigning identifiers to newborns, use the mother's last name, the baby's gender (boy or girl), and a distinguishing identifier for all multiples (e.g., Smith girl A, Smith girl B)
D/C	Discharge or discontinue	Premature discontinuation of medications when D/C (intended to mean discharge) on a medication list was misinterpreted as discontinued	Use discharge and discontinue or stop
IJ	Injection	Mistaken as IV or intrajugular	Use injection
OJ	Orange juice	Mistaken as OD or OS (right or left eye); drugs meant to be diluted in orange juice may be given in the eye	Use orange juice
Period following abbreviations (e.g., mg., mL.)†	mg or mL	Unnecessary period mistaken as the number 1, especially if written poorly	Use mg, mL, etc., without a terminal period
Drug Name Abbreviations			
To prevent confusion, avoid abbreviating drug names entirely. Exceptions may be made for multi-ingredient drug formulations, including vitamins, when there are electronic drug name field space constraints; however, drug name abbreviations should NEVER be used for any medications on the *ISMP List of High-Alert Medications* (in Acute Care Settings [www.ismp.org/node/103], Community/Ambulatory Settings [www.ismp.org/node/129], and Long-Term Care Settings [www.ismp.org/node/130]). Examples of drug name abbreviations involved in serious medication errors include:			
Antiretroviral medications (e.g., DOR, TAF, TDF)	DOR: doravirine TAF: tenofovir alafenamide TDF: tenofovir disoproxil fumarate	DOR: Dovato (dolutegravir and lami**VUD**ine) TAF: tenofovir disoproxil fumarate TDF: tenofovir alafenamide	Use complete drug names
APAP	acetaminophen	Not recognized as acetaminophen	Use complete drug name
ARA A	vidarabine	Mistaken as cytarabine ("ARA C")	Use complete drug name
AT II and AT III	AT II: angiotensin II (Giapreza) AT III: antithrombin III (Thrombate III)	AT II (angiotensin II) mistaken as AT III (antithrombin III) AT III (antithrombin III) mistaken as AT II (angiotensin II)	Use complete drug names
AZT	zidovudine (Retrovir)	Mistaken as azithromycin, aza**THIO**prine, or aztreonam	Use complete drug name
CPZ	Compazine (prochlorperazine)	Mistaken as chlorpro**MAZINE**	Use complete drug name
DTO	diluted tincture of opium or deodorized tincture of opium (Paregoric)	Mistaken as tincture of opium	Use complete drug name

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

List — continued on page 4

List — continued from page 3

Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
HCT	hydrocortisone	Mistaken as hydro**CHLORO**thiazide	Use complete drug name
HCTZ	hydro**CHLORO**thiazide	Mistaken as hydrocortisone (e.g., seen as HCT250 mg)	Use complete drug name
MgSO4**	magnesium sulfate	Mistaken as morphine sulfate	Use complete drug name
MS, MSO4**	morphine sulfate	Mistaken as magnesium sulfate	Use complete drug name
MTX	methotrexate	Mistaken as mito**XANTRONE**	Use complete drug name
Na at the beginning of a drug name (e.g., Na bicarbonate)	Sodium bicarbonate	Mistaken as no bicarbonate	Use complete drug name
NoAC	novel/new oral anticoagulant	Mistaken as no anticoagulant	Use complete drug name
OXY	oxytocin	Mistaken as oxy**CODONE**, Oxy**CONTIN**	Use complete drug name
PCA	procainamide	Mistaken as patient-controlled analgesia	Use complete drug name
PIT	Pitocin (oxytocin)	Mistaken as Pitressin, a discontinued brand of vasopressin still referred to as PIT	Use complete drug name
PNV	prenatal vitamins	Mistaken as penicillin VK	Use complete drug name
PTU	propylthiouracil	Mistaken as Purinethol (mercaptopurine)	Use complete drug name
T3	Tylenol with codeine No. 3	Mistaken as liothyronine, which is sometimes referred to as T3	Use complete drug name
TAC or tac	triamcinolone or tacrolimus	Mistaken as tetracaine, Adrenalin, and cocaine; or as Taxotere, Adriamycin, and cyclophosphamide	Use complete drug names Avoid drug regimen or protocol acronyms that may have a dual meaning or may be confused with other common acronyms, even if defined in an order set
TNK	TNKase	Mistaken as TPA	Use complete drug name
TPA or tPA	tissue plasminogen activator, Activase (alteplase)	Mistaken as TNK (TNKase, tenecteplase), TXA (tranexamic acid), or less often as another tissue plasminogen activator, Retavase (retaplase)	Use complete drug names
TXA	tranexamic acid	Mistaken as TPA (tissue plasminogen activator)	Use complete drug name
ZnSO4	zinc sulfate	Mistaken as morphine sulfate	Use complete drug name
Stemmed/Coined Drug Names			
Nitro drip	nitroglycerin infusion	Mistaken as nitroprusside infusion	Use complete drug name
IV vanc	Intravenous vancomycin	Mistaken as Invanz	Use complete drug name
Levo	levofloxacin	Mistaken as Levophed (norepinephrine)	Use complete drug name

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

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Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Neo	Neo-Synephrine, a well known but discontinued brand of phenylephrine	Mistaken as neostigmine	Use complete drug name
Coined names for compounded products (e.g., magic mouthwash, banana bag, GI cocktail, half and half, pink lady)	Specific ingredients compounded together	Mistaken ingredients	Use complete drug/product names for all ingredients Coined names for compounded products should only be used if the contents are standardized and readily available for reference to prescribers, pharmacists, and nurses
Number embedded in drug name (not part of the official name) (e.g., 5-fluorouracil, 6-mercaptopurine)	fluorouracil mercaptopurine	Embedded number mistaken as the dose or number of tablets/capsules to be administered	Use complete drug names, without an embedded number if the number is not part of the official drug name
Dose Designations and Other Information			
1/2 tablet	Half tablet	1 or 2 tablets	Use text (half tablet) or reduced font-size fractions (½ tablet)
Doses expressed as Roman numerals (e.g., V)	5	Mistaken as the designated letter (e.g., the letter V) or the wrong numeral (e.g., 10 instead of 5)	Use only Arabic numerals (e.g., 1, 2, 3) to express doses
Lack of a leading zero before a decimal point (e.g., .5 mg)**	0.5 mg	Mistaken as 5 mg if the decimal point is not seen	Use a leading zero before a decimal point when the dose is less than one measurement unit
Trailing zero after a decimal point (e.g., 1.0 mg)**	1 mg	Mistaken as 10 mg if the decimal point is not seen	Do not use trailing zeros for doses expressed in whole numbers
Ratio expression of a strength of a single-entity injectable drug product (e.g., EPINEPHrine 1:1,000; 1:10,000; 1:100,000)	1:1,000: contains 1 mg/mL 1:10,000: contains 0.1 mg/mL 1:100,000: contains 0.01 mg/mL	Mistaken as the wrong strength	Express the strength in terms of quantity per total volume (e.g., **EPINEPH**rine 1 mg per 10 mL) **Exception:** combination local anesthetics (e.g., lidocaine 1% and **EPINEPH**rine 1:100,000)
Drug name and dose run together (problematic for drug names that end in the letter l [e.g., propranolol20 mg; TEGretol300 mg])	propranolol 20 mg **TEG**retol 300 mg	Mistaken as propranolol 120 mg Mistaken as **TEG**retol 1300 mg	Place adequate space between the drug name, dose, and unit of measure
Numerical dose and unit of measure run together (e.g., 10mg, 10Units)	10 mg 10 mL	The m in mg, or U in Units, has been mistaken as one or two zeros when flush against the dose (e.g., 10mg, 10Units), risking a 10- to 100-fold overdose	Place adequate space between the dose and unit of measure

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

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Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Large doses without properly placed commas (e.g., 100000 units; 1000000 units)	100,000 units 1,000,000 units	100000 has been mistaken as 10,000 or 1,000,000 1000000 has been mistaken as 100,000	Use commas for dosing units at or above 1,000 or use words such as 100 thousand or 1 million to improve readability **Note:** Use commas to separate digits only in the US; commas are used in place of decimal points in some other countries
Symbols			
℥ or ♏†	Dram Minim	Symbol for dram mistaken as the number 3 Symbol for minim mistaken as mL	Use the metric system
x1	Administer once	Administer for 1 day	Use explicit words (e.g., for 1 dose)
> and <	More than and less than	Mistaken as opposite of intended Mistakenly have used the incorrect symbol < mistaken as the number 4 when handwritten (e.g., <10 misread as 40)	Use more than or less than
↑ and ↓†	Increase and decrease	Mistaken as opposite of intended Mistakenly have used the incorrect symbol ↑ mistaken as the letter T, leading to misinterpretation as the start of a drug name, or mistaken as the numbers 4 or 7	Use increase and decrease
/ (slash mark)†	Separates two doses or indicates per	Mistaken as the number 1 (e.g., 25 units/10 units misread as 25 units and 110 units)	Use per rather than a slash mark to separate doses
@†	At	Mistaken as the number 2	Use at
&†	And	Mistaken as the number 2	Use and
+†	Plus or and	Mistaken as the number 4	Use plus, and, or in addition to
°	Hour	Mistaken as a zero (e.g., q2° seen as q20)	Use hr, h, or hour
Φ or ø†	Zero, null sign	Mistaken as the numbers 4, 6, 8, and 9	Use 0 or zero, or describe intent using whole words
#	Pound(s)	Mistaken as a number sign	Use the metric system (kg or g) rather than pounds Use lb if referring to pounds

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

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Error-Prone Abbreviations, Symbols, and Dose Designations	Intended Meaning	Misinterpretation	Best Practice
Apothecary or Household Abbreviations			
Explicit apothecary or household measurements may **ONLY** be safely used to express the directions for mixing dry ingredients to prepare topical products (e.g., dissolve 2 capfuls of granules per gallon of warm water to prepare a magnesium sulfate soaking aid). Otherwise, metric system measurements should be used.			
gr	Grain(s)	Mistaken as gram	Use the metric system (e.g., mcg, g)
dr	Dram(s)	Mistaken as doctor	Use the metric system (e.g., mL)
min	Minim(s)	Mistaken as minutes	Use the metric system (e.g., mL)
oz	Ounce(s)	Mistaken as zero or 0_2	Use the metric system (e.g., mL)
tsp	Teaspoon(s)	Mistaken as tablespoon(s)	Use the metric system (e.g., mL)
tbsp or Tbsp	Tablespoon(s)	Mistaken as teaspoon(s)	Use the metric system (e.g., mL)
Common Abbreviations with Contradictory Meanings	**Contradictory Meanings**		**Correction**
For additional information and tables from Neil Davis (MedAbbrev.com) containing additional examples of abbreviations with contradictory or ambiguous meanings, please visit: www.ismp.org/ext/638.			
B	Breast, brain, or bladder		Use breast, brain, or bladder
C	Cerebral, coronary, or carotid		Use cerebral, coronary, or carotid
D or d	Day or dose (e.g., parameter-based dosing formulas using D or d [mg/kg/d] could be interpreted as either day or dose [mg/kg/day or mg/kg/dose]; or x3d could be interpreted as either 3 days or 3 doses)		Use day or dose
H	Hand or hip		Use hand or hip
I	Impaired or improvement		Use impaired or improvement
L	Liver or lung		Use liver or lung
N	No or normal		Use no or normal
P	Pancreas, prostate, preeclampsia, or psychosis		Use pancreas, prostate, preeclampsia, or psychosis
S	Special or standard		Use special or standard
SS or ss	Single strength, sliding scale (insulin), signs and symptoms, or ½ (apothecary) SS has also been mistaken as the number 55		Use single strength, sliding scale, signs and symptoms, or one-half or ½

** On The Joint Commission's "**Do Not Use**" list
† Relevant mostly in handwritten medication information

While the abbreviations, symbols, and dose designations in the **Table** should **NEVER** be used, not allowing the use of **ANY** abbreviations is exceedingly unlikely. Therefore, the person who uses an organization-approved abbreviation must take responsibility for making sure that it is properly interpreted. If an uncommon or ambiguous abbreviation is used, and it should be defined by the writer or sender. Where uncertainty exists, clarification with the person who used the abbreviation is required.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF VITAMIN K INJECTION AND ERYTHROMYCIN OPHTHALMIC OINTMENT TO NEWBORNS

I. POLICY:

A. Function: To provide guidelines for Women and Newborn Services (WNS) nurses administering Vitamin K and Erythromycin Ophthalmic Ointment to newborns.

B. Circumstances:
   1. Setting: WNS

C. Consent:
   1. The RN shall obtain verbal parental consent prior to administration of the Vitamin K injection and the Erythromycin Ophthalmic Ointment to the newborn.
      i. If the parent or legal guardian declines the Vitamin K injection and Erythromycin Ophthalmic Ointment refer to documentation guidelines. In the Medication Administration Record (MAR) this will be documented as "refusal".

D. Administration/Documentation:
   1. The newborn's patient record
      i. Refer to Tri-City Medical Center Patient Care Services (PCS) policy Medication Administration.
      ii. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.
         a. Not required if a screening process triggers the order
      iii. Document given or "refused" in the MAR
         a. If refused complete Refusal of Newborn Eye Prophylaxis and/or Refusal of Vitamin K form(s), original to be kept with the patient chart and one copy to be given to the parent or legal guardian and notify Pediatrician of refusal(s).

II. PROCEDURE:

A. The RN will administer Vitamin K 1 mg IM and Erythromycin Ophthalmic Ointment to the newborn within two hours of birth.

III. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current unencumbered California RN license and working in WNS
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annually

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:

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Department of Pediatrics	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
6/05, 6/07, 9/09, 5/11, 07/13, 06/18. 10/20	6/07, 9/09, 07/13, 04/15, 07/18, 10/20	8/07, 11/09, 7/13, 4/15, 07/18, 12/20	05/15, 08/18	7/07, 12/09, 9/13, 05/15, 09/18, 05/21	8/07, 12/09, 09/13, 09/15, 10/18, 10/21	8/07, 2/10, 10/13, 09/15, 11/18, 01/22	01/19, 02/22	10/15, n/a	12/05, 8/07, 2/10, 6/11,10/15 , 01/19

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Administration of Vitamin K Injection and Erythromycin Ophthalmic Ointment to Newborns Standardized Procedure

VI. RELATED DOCUMENT(S):

A. Patient Care Services Policy: Medication Administration
B. Refusal of Vitamin K Form 6385-1012 English - Sample
C. Refusal of Vitamin K Form 6385-1014 Spanish - Sample
D. Refusal of Newborn Eye Prophylaxis Form 6385-1011 English - Sample
E. Refusal of Newborn Eye Prophylaxis Form 6385-1013 Spanish - Sample

SAMPLE

I, _____, have been advised and my physician, Dr. _____ (physician's name, printed) has recommended that my newborn receive a single intramuscular injection of .5-1.0 milligrams of vitamin K (phytonadione) within two hours of birth for prevention of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn).

Hemorrhagic Disease of the Newborn usually occurs in the first week of life, but can occur up to 3 months of age. Early warning signs of this disease include but are not limited to:

- skin bruising
- blood seepage from any body opening

Upon observing any such symptoms, a physician should be notified immediately.

Very minimal correlations between childhood leukemia and the use of vitamin K in infants have been reported. If the treatment is not provided, the following injuries could occur:

- onset of vitamin K deficiency bleeding (Hemorrhagic Disease of the Newborn)
- intracranial hemorrhage
- seizure
- death

I have read and I understand the above material. My physician has informed me of the nature of this medical treatment, the risks, benefits, and alternatives thereof, and the probable consequences of receiving and declining this treatment. All my questions have been answered. Despite this information, and the recommendation of my physician, I refuse to allow the hospital to administer a vitamin K injection to my infant. **I also understand that no circumcision will be performed on any male infant who has not received the vitamin K injection.**

I accept full responsibility for any detrimental effect my refusal may have on my infant. I, as an individual, and on behalf of my infant child, hereby release, indemnify and hold harmless Tri-City Medical Center, its agents, servants, and employees, including but not limited to anyone involved in my care and the delivery and care of my child, for any and all liability for any injury resulting from my refusal to allow treatment. I have made this decision of my own free will with full understanding and knowledge of the harm that may result to my child as a result of my decision not to allow my child to receive a vitamin k injection.

I understand that the physician named above and other physicians who provide services to me are not employees, servants or agents of the hospital but independent contractors.

Name: Patient/Representative	Signature: Patient/Representative	Date	Time
_____	_____	___/___/___	_____ AM/PM

If signed by a person other than the patient, indicate relationship to patient _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason _____

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
_____	_____	___/___/___	_____ AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language _____ ☐ Telephonic ☐ VRI ☐ Face-to-face ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time
_____	_____	___/___/___	_____ AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter: _____
Name and relationship to patient

Affix Patient Label

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

6385-1012
(Rev. 3/17)

REFUSAL OF VITAMIN K FORM

White - Medical Record Canary - Patient

SAMPLE

Fecha: _____.

Nombre de la madre: _____.

Yo, _____, he sido aconsejada y mi médico, el Dr./la Dra. (imprima/escriba en letra de molde el nombre del médico): _____ ha recomendado que mi recién nacido reciba una sola inyección intramuscular de entre 0.5 a 1.0 miligramos de vitamina K (fitonadiona) dentro de la primera hora de haber nacido para la prevención del sangrado por causa de la deficiencia de vitamina K (Enfermedad Hemorrágica del Recién Nacido). Hay una forma oral disponible de la vitamina K, pero no ha mostrado ser tan efectiva y pone a la criatura en riesgo de tener un sangrado tardío.

La Enfermedad Hemorrágica del Reclén Nacido usualmente ocurre en la primera semana de vida, pero puede ocurrir hasta los 3 meses de edad. Las señales de alerta o advertencia temprana de esta enfermedad incluyen pero no se limitan a:

- moretones en la piel
- sangre que filtra (sale) de cualquier abertura del cuerpo

Al observar cualquiera de estos síntomas, se le deberá notificar al médico inmediatamente.

Ha sido mínima la correlación que se ha reportado entre la leucemia infantil y el uso de la vitamina K en los recién nacidos. Si no se proporciona el tratamiento, las siguientes lesiones o daños pueden ocurrir:

- inicio de sangrado por deficiencia de la vitamina K (Enfermedad Hemorrágica del Recién Nacido)
- hemorragia intracraneal
- convulsiones
- muerte

He leído y comprendo el material/información anterior. Mi médico me ha informado acerca de la naturaleza de este tratamiento médico, los riesgos, los beneficios y las alternativas del mismo, y también acerca de las probables consecuencias de recibir y de rehusar este tratamiento. Todas mis preguntas han sido respondidas. A pesar de esta información y de la recomendación de mi médico, rehúso permitir al hospital administrarle una inyección de vitamina K a mi criatura. **Comprendo, además, que no circuncisión se realizará en ningún recién nacido que no haya recibido la inyección de vitamina K.**

Acepto completa y total responsabilidad por cualquier efecto perjudicial que mi rehúso pudiera tener en mi criatura. Yo, como individuo, y en nombre de mi criatura, por la presente libero, indemnizo, y exonero a Tri-City Medical Center, a sus agentes, servidores y empleados, incluyendo pero no limitándose a cualquier persona involucrada en mi atención médica, y en el parto y atención de mi criatura, de cualquier y toda responsabilidad por cualquier lesión/daño que resulte de mi rehúso a permitir el tratamiento. He tomado esta decisión por mi propia voluntad y con la completa comprensión y conocimiento del daño a mi criatura que podría resultar como consecuencia de mi decisión de no permitir que mi criatura reciba una inyección de vitamina K.

Comprendo que el médico mencionado anteriormente y otros médicos que me proporcionan servicios son contratistas independientes y no son empleados, servidores (dependientes) o agentes del hospital.

Firma: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**
(Madre o Padre)

Si se firma por alguien más que no sea la madre o el padre del paciente, imprima su nombre en letra de molde e indique la relación con el paciente:

Nombre: _____ **Relación:** _____.

Testigo: _____ **Fecha:** _____ **Hora:** _____ **AM / PM**

Affix Patient Label

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

6385-1014
(Rev. 01/14)

REFUSAL OF VITAMIN K
REHÚSO A LA VITAMINA K

White - Hospital Yellow - Patient

SAMPLE

I, _____, have been informed by my physician,
Dr _____ (physician's name, printed) that California State law[1] requires both of my newborn infant's eyes to be treated with efficient prophylaxis treatment approved by the California Department of Public Health. Erythromycin is the medication provided at Tri-City Medical Center.

The hospital intends to comply with California State law by administering an approved prophylactic agent to the newborn's eye within two hours after the infant's birth in order to prevent ophthalmia neonatorum and gonorrheal ophthalmia, which most commonly result from Sexually Transmitted Infections. Neither agent stings or otherwise irritates the eyes. If any other symptoms are observed, a physician should be notified immediately.

The most common side effects can last up to 24 hours and include
- blurred vision
- swelling, redness and/or puffiness to the eyelids

If the treatment is not provided, the following injuries could occur:
- severe eye infection up to and including permanent impaired vision or blindness
- other systemic infection with significant complications

I have read and I understand the above material. My physician has informed me of the nature of this medical treatment, the risks, benefits, and alternatives thereof, and the probable consequences of receiving and declining this treatment. All my questions have been answered. Despite this information, I refuse to allow the hospital to administer a prophylactic agent to my infant's eyes.

I accept full responsibility for any detrimental effect my refusal may have on my infant. I, on behalf of myself and my newborn infant, hereby release, indemnify and hold harmless Tri-City Medical Center, its agents, servants, and employees, including but not limited to anyone involved in my care and the delivery and care of my child, for any and all liability for any injury resulting from my refusal to allow treatment.

I understand that by signing this document I am agreeing not to have the treatment for my infant child and to assume full responsibility for the consequences for any civil or criminal action made against me as a result of my decision not to allow my infant child to undergo prophylactic-efficient treatment.

I understand that the doctor named above and other doctors who provide services to me are not employees, servants or agents of the hospital but independent contractors.

Name: Patient/Representative	Signature: Patient/Representative	Date	Time
		/ /	AM/PM

If signed by a person other than the patient, indicate relationship to patient _____
Examples: Spouse, Partner, Legal Guardian

If patient is unable to sign, state reason: _____

Witness – TCHD Representative (print name)	Signature • *Firma*	Date • *Fecha*	Time • *Hora*
		/ /	AM/PM

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language _____ ☐ Telephonic ☐ VRI
☐ Face-to-face ☐ I have accurately and completely reviewed this document in patient/patient's legal representative preferred language with _____ ☐ Patient ☐ Patient's legal representative

Interpreter ID number or Name	Interpreter Signature (if present)	Date	Time
		/ /	AM/PM

☐ Patient refuses TCHD's interpretation services and selects as interpreter _____
Name and relationship to patient

[1]The Business and Professions Code Section 551 requires the infant's eye be treated within two hours after birth with a prophylactic-efficient treatment to prevent ophthalmia neonatorum and gonorrheal ophthalmia.

Affix Patient Label

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

6385-1011
(Rev 5/17)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM

White - Medical Record Canary- Patient

SAMPLE

Fecha: _____

Nombre de la madre: _____

Yo, _____, he sido informada por mi médico, el Dr /la Dra _____ (nombre del médico en letra de molde) que la Ley Estatal de California[1] requiere que ambos ojos de mi recién nacido sean tratados con tratamiento profiláctico-eficiente aprobado por el Departamento de Salud Pública de California. Los agentes profilácticos aprobados por el Departamento de Salud Pública de California, incluyen (1) uno porciento de nitrato de plata en ampolletas de cera administradas sin irrigación con solución salina, o (2) pomadas oftálmicas o gotas conteniendo tetraciclina o eritromicina.

El hospital se propone cumplir con la Ley Estatal de California, administrándole un agente profiláctico aprobado a los ojos del recién nacido a menos de dos horas de haber nacido la criatura con el fin de prevenir la oftalmia neonatorum y la gonorrea oftálmica, los que más comúnmente resultan de las Infecciones Sexualmente Transmitidas. Ninguno de los agentes causan ardor o irritan de ninguna manera a los ojos. Si se observa cualquier otro síntoma, se debería notificar inmediatamente a un médico.

Los más comunes efectos secundarios pueden durar hasta 24 horas e incluyen:

- visión borrosa
- inflamación, enrojecimiento y o/hinchazón en los párpados

Si no se provee el tratamiento, los siguientes daños podrían ocurrir:

- infección severa de los ojos hasta llegar e incluir impedimento permanente de la vista o ceguera
- otras infecciones sistémicas con significativas complicaciones

He leído y comprendo el material anteriormente expuesto. Mi médico me ha informado acerca de la naturaleza de este tratamiento médico, los riegos, los beneficios, las alternativas de los mismos, y las probables consecuencias de recibir y de rehusar este tratamiento. Todas mis preguntas han sido respondidas. No obstante esta información, yo rehúso permitir que el hospital administre un agente profiláctico a los ojos de mi criatura.

Acepto completa responsabilidad por cualquier efecto detrimental (que causa daño) que mi rehúso pueda causar en mi criatura. Yo, en mi nombre y en nombre de mi criatura recién nacida, por este medio absuelvo, indemnizo y libero de toda responsabilidad a Tri-City Medical Center, a sus agentes, servidores, y empleados, incluyendo pero no limitándose a cualquier persona involucrada en mi cuidado y en el acto de lar a luz y en el cuidado de mi criatura, de cualquier y toda responsabilidad y obligación por cualquier daño resultante de mi rehúso a permitir el tratamiento.

Comprendo que, al firmar este documento, estoy aceptando a no tener el tratamiento para mi criatura y asumo total responsabilidad de las consecuencias de cualquier acción civil o criminal hecha contra mi como resultado de mi decisión de no permitir que mi criatura se someta al tratamiento profiláctico-eficiente.

Comprendo que el médico nombrado anteriormente y otros médicos que a mi me proveen servicios no son empleados, servidores o agentes del hospital, sino contratistas independientes.

_____

Firma del padre (madre/padre) Fecha / Hora

Si ha sido firmado por otra persona que no sea la madre o el padre del paciente, escriba el nombre en letra de molde e indique la relación o el parentesco con el paciente:

_____ _____

Nombre en letra de molde **Relación con el paciente**

Testigo _____

Representante del Hospital Fecha / Hora

[1]La Sección 551 del Código de Negocios y Profesiones de California requiere que el ojo de la criatura sea tratado en menos de dos horas de haber nacido con un tratamiento profiláctico-eficiente para prevenir la oftalmia neonatorum y la gonorrea oftálmica.

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

6385-1013

(Rev. 12/13)

REFUSAL OF NEWBORN EYE PROPHYLAXIS FORM
REHÚSO A LA PROFILAXIS OCULAR EN RECIÉN NACIDO

Affix Patient Label

White - Medical Record Canary - Patient

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	**ADMIXTURE, INTRAVENOUS**
Purpose:	To outline the responsibilities and technique for Registered Nurses (RNs) in compounding sterile intravenous admixture preparations in patient care areas to prevent harm that could result from microbial contamination (non-sterility), excessive bacterial endotoxins, and large content errors in strength of correct ingredients, and incorrect ingredients in compounded sterile preparations (CSP).
Supportive Data:	Aseptic technique refers to performing a procedure in a manner that minimizes the chance of contamination caused by the introduction of microorganisms. Because contaminants may be introduced from the environment, equipment, supplies, or personnel, it is essential to control these different sources of contamination at the time an aseptic procedure is performed. Touch contamination by the person performing a procedure is the most frequent cause of contamination, occurring when proper control over manipulation is not maintained. Good technique in the preparation of intravenous (IV) admixtures is critical to producing a sterile product. All objects that come in contact with the drug additive or IV solution must be sterile, or contamination will result.
Equipment:	1. Admixture (medication) 2. IV solution 3. Sterile syringe: appropriate size based on the volume of solution to be measured and the graduation marks on the syringe. (The smallest size syringe should be selected, but should not be filled to capacity or the plunger may become dislodged). Selecting the smallest size syringe allows the volume of solution to be measured most accurately. 4. Sterile needles for transfer; not less than 19 gauge recommended (*filtered needles or filter straws are needed to draw any medication from ampules)* 5. 70% alcohol swabs/wipes

A. **POLICY:**

1. Pre-mixed standard concentration infusions shall be utilized whenever possible.
2. Intravenous admixture of pharmaceutical products which require the measured addition of a medication to a 50 mL or greater bag or bottle of IV fluid must be compounded in the pharmacy except:
   a. Emergencies when nursing staff may need to prepare a dose of a sterile product for immediate use.
      i. Medications for immediate use shall have administration started within one hour of preparation. If administration is not started within one hour the dose must be discarded.
   b. Product stability is of short duration.
3. Compounding personnel must visually confirm that ingredients measured in syringes match the written order.
   a. All admixtures shall be visually examined for the presence of particulate matter and not administered or dispensed when such matter is observed.
4. All IV solutions mixed by nursing must be discarded within 24 hours of spiking.
5. All CSP labels shall include:
   a. Patient name
   b. Correct names and amounts or concentrations of ingredients
   c. Total volume
   d. Date and time of preparation
   e. Beyond use date (BUD) and time is 1 hour from time of preparation.
      i. Medication must be administered or have infusion initiated prior to BUD time.

Revision Dates	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
3/06, 9/08, 6/11, 4/12, 09/16	4/12, 10/16, 10/21	4/12, 01/17, 11/21	n/a	11/16, 02/17, 11/21	5/12, 03/17, 01/22	02/22	06/12, 04/17, n/a	06/12, 04/17

f. Initials of the compounding nurse

B. **DEFINITION(S):**

1. Admixture: One or more drugs are commonly added to the intravenous solution to prepare the final sterile product. The drug is referred to as the additive and the final product is referred to as the admixture. This does not include the drawing up of medication into a syringe and/or adding medication to a buretrol or intravenous line.

C. **PROCEDURE:**

1. Assess designated preparation area for cleanliness and gather all appropriate supplies prior to beginning admixture procedure. If admixture area is visibly soiled, clean with hospital-approved disinfectant.
2. Perform hand hygiene.
3. Use of Needle and Syringe for Transfer:
   a. Open the syringe and needle using proper aseptic technique, do not allow syringe package to come in contact with the syringe, since the outside surface is contaminated.
   b. Remove the protective cover over the syringe tip by twisting.
      i. When a needle is to be added to a syringe, the needle package must be opened before removing the protective cap.
   c. Remove the protective cover over the syringe tip by twisting.
   d. Insert the tip of the syringe into the hub of the needle. The needle may be held on by friction or by a locking mechanism. The finger should be held well back from the point of attachment of the needle to the syringe.
   e. Leave needle guard in place until just before use. To remove the guard, pull it straight off or twist very gently.
4. Use of Ampules: When preparing sterile products contained within an ampule container, special precautions should be taken to avoid glass fragments from entering the final sterile product. Even tiny glass fragments entering the circulatory system can cause great damage to vital organs or carry contaminants that cause infection.
   a. Tap or shake all the liquid into the bottom half of the ampule.
   b. Wipe the ampule neck with an alcohol swab and break it at a horizontal angle away from you. Discard the wipe and the ampule neck immediately to prevent accumulation of glass particles in the CSP area.
   c. Choose an appropriate size syringe and attach a *filter straw or filter needle.*
   d. Hold the ampule at a nearly horizontal angle to ensure proper airflow around the neck area. Tip the ampule downward as necessary to keep the tip of the straw below fluid level.
   e. Withdraw the contents of the ampule with the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand. Contamination of the medication can occur in some procedures if the plunger is touched with the fingers.
   f. Remove the filter needle or filter straw and replace it with a needle.
   g. Tap the air bubbles from the syringe barrel, bring the liquid to the correct volume, squirt any excess liquid into the ampule, and deliver the liquid.
5. Use of Vials:
   a. Remove the protective cap from the vial and scrub the diaphragm with alcohol swab, and allow to air dry before piercing the vial.
   b. Draw the volume of air equivalent to the volume of solution that will be withdrawn from the vial into the syringe. When pulling back the plunger of the syringe, the fingers should not come in contact with any part of the plunger except the flat knob at the end. The barrel of the syringe should be held in the other hand.
   c. Hold the vial and insert the needle at 45 degree angle with bevel up into the vial, taking care to prevent coring of the closure.
   d. Hold the vial in a vertical position (inverted) and force air into the vial, withdraw slightly more than the required amount of fluid.

e. With the vial in the vertical (inverted) position and the needle in the diaphragm, tap the barrel of the syringe to remove air bubbles and bring the syringe to the proper volume. Read the volume of solution by aligning the rubber end of the plunger with the graduation marks on the barrel of the syringe. Squirt excess liquid back into the vial.

6. To Reconstitute and Transfer a Drug from a Vial: Some drugs inside a vial may be in powder or liquid form. If the drug is in powder form, an extra step – reconstitution - must be performed before it can be added to the IV solution. Diluents such as sterile water for injection, bacteriostatic water for injection, or bacteriostatic 0.9% sodium chloride injection are usually used to reconstitute powdered drugs. The volume of a suitable diluent is specified in the package insert and frequently on the vial itself.
   a. Remove the protective tab and swab the top surface of the rubber closure of each vial with alcohol swab, and allow to air dry before piercing the vial.
   b. Determine the correct volume of suitable diluent to reconstitute the powdered drug.
   c. Inject a volume of air equal to the volume of solution to be removed from the diluent vial using a needle and syringe, and then remove the diluent from the vial. (Hold the diluent vial in an inverted position).
   d. Inject the diluent into the medication vial.
   e. Remove the needle and shake the vial until the drug is dissolved unless shaking is not recommended.
   f. Reinsert the needle and remove the proper volume of drug solution. Do not inject air before withdrawing the drug solution unless air was withdrawn before the needle was removed.
   g. Remove all air bubbles from the syringe so the volume can be read accurately.
7. Drug Transfer into a Plastic Bag: A syringe and needle are generally used to transfer a drug additive from a vial or ampule to a plastic bag. It is recommended the needle gauge be not less than 19 to ensure resealing of the protective rubber cover. The needle must be at least ½ inch long to penetrate the inner diaphragm.
   a. Remove the plastic IV from the outer wrap.
   b. Assemble the needle and syringe.
   c. Swab the medication vial or ampule with alcohol swab and withdraw the necessary amount of drug solution. If the drug is in powder form, reconstitute it with the recommended diluent. (See previous section of procedure).
   d. Swab the medication port of the plastic IV bag with an alcohol swab, and allow to air dry before piercing the port.
   e. Insert the needle into the medication port and through the inner diaphragm. The medication port should be fully extended to minimize the chance of going through the side of the port.
   f. Remove the needle and dispose of in appropriate sharps container.
   g. Shake and inspect the admixture.
8. In Emergency Situations:
   a. The RN may prepare the first infusion bag using aseptic technique for the following but not limited to: phenylephrine, nitroprusside, norepinephrine, epinephrine, epinephrine/calcium, diltiazem, aminocaproic acid, and labetolol.
   b. Label the compounded product appropriately

D. **REFERENCES:**

1. USP General Chapter. Pharmaceutical Compounding-Sterile Preparations. 797th ed: USP/NF,2004. Print
2. Buchanan, C.E., and P.J. Schneider. Compounding Sterile Preparations 2nd Ed.: American Society of Health-System Pharmacists, 2005. Print
3. Contianment Technologies Group, Pharmacopeal Form, August 2003. <http.//www.mic4.com/regulations/USP-797.pdf>

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 03/09 **SUBJECT:** **Family Presence During Resuscitation**

REVISION DATE: 01/12, 07/16, 06/19

Patient Care Services Content Expert Approval:	**~~03/19~~11/21**
Clinical Policies & Procedures Committee Approval:	**~~04/19~~11/21**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~04/19~~11/21**
Medical Staff Department or Division Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/19~~01/22**
Administration Approval:	**~~06/19~~02/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/19**

A. **DEFINITIONS:**

1. Family Presence **During Resuscitation (FPDR)**: The presence of family in the patient care area/**room during resuscitation efforts** ~~in a location that affords visual or physical contact with the patient during resuscitation events~~.
2. Resuscitation: A sequence of events, which are initiated to sustain life or prevent further deterioration of the patient's condition.
3. Family: A relative of the patient or any significant other with whom the patient shares an established relationship.
4. Family Support Person: Tri-City Healthcare District (TCHD) employees including:
   a. ~~Assistant~~ Nurse **Leader**~~Manager (ANM)~~
   b. Staff Registered Nurse (RN), **Supervisor, Charge Nurse**
   c. Chaplain
   d. Social Worker
   e. Administrative Supervisor or other designee who is assigned to the family of a patient during a resuscitation event and assumes no direct care responsibilities for the patient. During day shift hours the family support person role will be fulfilled by a chaplain or social worker, or if unavailable, the **Nurse Leader**~~ANM~~ or his/her designee. During night shift hours the family support person role will be fulfilled by the Administrative Supervisor, **Nurse Leader**~~ANM~~ or his/her designee.
5. **Trauma Intervention Program (TIP): Specially trained community volunteer that provides emotional and practical support to survivors immediately following a traumatic emergency situation in the Emergency Department (ED).**

B. **PURPOSE:**

1. To assure patient and families are provided care consistent with the philosophy of patient/family-centered care and established emergency care standards.
   a. Supportive data:
      i. The family is a constant in the patient's life. Family participation and involvement in the patient's health care promotes collaborative relationships among the patient, family and health care professionals. The strengths and coping strategies of the family are supported and incorporated into the care of the patient.

C. **POLICY:**

1. Patient **and&** Family Assessment

a. Family members shall be assessed by the primary ~~Registered Nurse (~~RN~~)~~ or designee for the appropriate levels of coping, desires and needs.
   i. In addition, family members should demonstrate the absence of combative or threatening behavior, extreme emotional volatility, and behaviors consistent with an altered mental status related to drugs or alcohol.
      1) Family members demonstrating such behavior are not candidates for **FPDR**~~family presence~~.
   ii. Children must have an adult caregiver present to be allowed at the bedside.
b. Cultural customs shall be considered and assessed. Healthcare providers shall maintain an awareness of cultural variations and be sensitive to these factors and family needs.
c. Decision to initiate **FPDR**~~family presence~~ is dependent upon criteria consisting of three components:
   i. Patient's **pre-determined** desire to have family ~~with~~ **present**~~them~~
   ii. Family's desire to be present
   iii. Agreement of the direct care providers
d. Family members who do not wish to participate shall be supported in their decision without judgment and the family support person shall remain with them.
e. When a resuscitation event is announced a family support person shall be determined based on available staff.
f. The family support person shall identify the primary RN and ask if the family can be present.

2. Preparation/Participation of **FPDR**~~Family Presence~~
   a. The family support person shall explain the patient's appearance, treatments and equipment used in layman's language and shall prepare the family for entering the patient's room **by**~~, including~~:
      ~~i. Communicating that the patient is the priority.~~
      ~~ii.~~**i.** Explaining how many family members may enter the room safely, where they may stand initially, when they shall be able to move to the bedside and what not to touch to prevent injury.
      ~~iii.~~**ii.** Explaining and adhering to appropriate infection control measures if the patient is **on**~~in~~ isolation~~ or contact precautions~~.
      ~~iv.~~**iii.** Preparing family members for the sights and sounds of resuscitation.
      ~~v.~~**iv.** Clearly informing the family of the status of their loved one at all times.
      ~~vi.~~**v.** Explaining why the family may be asked to step out of the room and when they **may**~~can~~ leave the room.
      ~~vii.~~**vi.** Informing ~~the~~ health care providers of the presence of the family.
      ~~viii.~~**vii.** Remaining with the family at all times during the resuscitation.
      ~~ix.~~**viii.** Escorting the family from the bedside and/or out of the room if deemed necessary by the health care providers.

3. **TIP Volunteers**
   a. **May perform the following with family members:**
      i. **Sit quietly**
      ii. **Listen**
      iii. **Ask open ended questions**
      iv. **Escort family to see patients with prior approval by the primary RN**
   b. **May not perform or assist with the following:**
      i. **Patient care**
      ii. **Turn off cardiac monitors**
      iii. **Remove equipment attached to patients**
      iv. **Remove clothing or jewelry, or personal belongings from the patient**
      v. **Provide health information to family members**

~~3.~~**4.** Post-Code Follow-Up

a. Immediately following the resuscitation event, the family support person shall meet with and debrief the family regarding the circumstances of the resuscitation event and the outcome.
b. If the patient survives resuscitation efforts with good prognosis:
   i. Provide patient/family orientation to the Intensive Care Unit (ICU)
   ii. Explain procedures/test fully and update all parties per Primary Care RN/Primary Physician on an on-going basis.
   iii. Transfer to ICU
c. If the patient survives with poor prognosis:
   i. Discussion shall be initiated with family regarding comfort measures, hospice, etc.
      1) Hospitality cart ordered for family
      2) Chaplain Services as appropriate
      3) Open Visitation
   ii. Life sharing referral initiated
d. If the patient ~~E~~expires:
   i. Explain end of life process to family per primary care RN/ancillary staff (i.e., Chaplain, Social Worker, and Administrative Supervisor). See Patient Care Services Policy: End of Life (Comfort Care)
   ii. Notify Life-Sharing **per Patient Care Services Policy: Organ Donation, Including Tissue and Eyes** ~~of expiration~~.
   iii. Allow family private time in room.
   iv. Complete required documentation
   v. Offer dealing with grief information to family.

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: End of Life (Comfort Care)
2. **Patient Care Services Policy: Organ Donation, Including Tissue and Eyes**

E. **REFERENCE(S):**
1. American Association of Critical Care Nurses (AACN). (2016). Practice alert: Family Presence During Resuscitation and Invasive Procedures. Retrieved May 9,2016, from http://www.aacn.org/wd/practice/docs/practicealerts/family-presence-during-resusitation-and-invasive-procedures-pa-2015.pdf
2. Beesley, S.J., Hopkins, R. O., Francis, L., Chapman, D., Johnson, N., & Brown, S. M. (April 2016). Let Them In: Family Presence During Intensive Care Unit Procedures. American Thoracic Society.
3. **Brasel, K., MD, Entwistle III, J. MD, PhD, & Sade, R., MD. (2016, November). Should family presence be allowed during cardiopulmonary resuscitation? Ann Thorac Sug.102(5): 1438 - 1443. Doi: 10.1016/j.athrorcur.2016.02.011**
~~2.~~4. Davidson, J. E., Powers, K. S., Hedayat, K. M., Tieszen, M., Kon, A. A., Shepard, E., et al. (2007). Clinical practice guidelines for support of the family in the patient-centered intensive care unit. American College of Critical Care Medicine Task Force 2004-2005. Critical Care Medicine, 35(2), 605-622.
~~3.~~5. Emergency Nurses Association (2007). Presenting the Option for Family Presence (3rd Edition).
~~4.~~6. Guzzetta, C. E., Clark, A. P., & Halm, M. A. (2008). Family presence facilitation. In E. Ackley, G. Ladwid, B. A. Swan, & S. Tucker (Eds.), Evidence-based nursing care guidelines. Philadelphia: Elsevier.
~~5.~~7. Mian, P., Warchal, S., Whitney, S., Fitzmaurice, J., & Tancredi, D. (2007). Impact of a multifaceted intervention on nurses' and physicians' behaviors toward family presence during resuscitation. Critical Care Nurse, 27(1), 52-61.

~~6.~~**8.** Oczkowski, S.J.W., Mazzetti, I., Cupido, C., Fox-Robichaud, A. E. (July/August 2015). Family Presence During Resuscitation: A Canadian Critical Care Society Position Paper. Canadian Respiratory Journal, 22(4), 201-205.

9. Po wers, K., PhD, RN, CNE an d Re eve, C. L. PhD. (2020, November). Original research: Family presence during resuscitation: medical-surgical nurses• perceptions, self-confidence, and use of invitations. AJN, American Journal of Nursing: 120(11): 28-38 doi: 10.1097/OI.NAJ.0000721244.16344.ee

~~7.~~**10.** Porter, J. E., Cooper, S. J., Sellick, K. (2014). Family Presence During Resuscitation (FPDR): Perceived Benefits, Barriers and Enablers to Implementation and Practice. International Emergency Nursing, 22(2), 69-74.

11. Rublin, M.A., Tintin LG, Svensson, Herling, SF., Klauses, T.W., Moller, A.M., Jabre, P. (2020, May 35). Family presence during resuscitation. doi.org/10.1002/146518558.CD013619

12. Walker, W. and Gavin, C. (2019, August). Family presence during resuscitation: A narrative review of the practices and views of critical nurses. Intensive and Critical Care Nursing. 53: 15- 22. Doi.org/10.1016/j.iccn.2019.04.007

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HOVERMATT AIR TRANSFER SYSTEM**
Purpose:	To outline staff responsibilities and patient safety in the use of a lateral air transfer device.
Supportive Data:	Lateral air transfer devices assist with safe patient mobilization and movement techniques to ensure patient safety and reduce risk of injury to staff from patient mobilization tasks.
Equipment:	HoverMatt Air Transfer Mattress and HT-Air 1200 Air Supply

A. **INTENDED USE AND PRECAUTIONS:**

1. Intended Use
   a. The HoverMatt Air Transfer System is used to assist caregivers with patient transfers, positioning, turning and proning. The HoverTech Air Supply inflates the HoverMatt to cushion and cradle the patient, while air simultaneously escapes from the holes on the underside, reducing the force needed to move the patient by 80-90%.
2. Indications
   a. Patients unable to assist in their own lateral transfer
   b. Patient whose weight or girth poses a potential health risk for the care givers responsible for repositioning or laterally transferring the patient
3. Contraindications
   a. Patients who are experiencing thoracic, cervical or lumbar fractures that are deemed unstable, unless using in conjunction with a spinal board on top of the HoverMatt
4. Precautions with HoverMatt
   a. Caregivers must verify that all brakes **on both gurneys/beds** have been engaged prior to transfer.
   b. For safety, always use two people during patient transfer.
   c. Additional caregivers are recommended when moving a patient over 750 lbs/340kg.
   d. Never leave patient unattended on an inflated device.
   e. Never attempt to move a patient on an uninflated HoverMatt.
   f. Only use attachments and/or accessories that are authorized by HoverTech International.
5. Precautions with Air Supply
   a. Not for use in the presence of flammable anesthetics or in a hyperbaric chamber or oxygen tent.
   b. Route the power cord in a manner to ensure freedom from hazard.
   c. Avoid blocking the air intakes of the air supply.
   d. When using the HoverMatt in the MRI environment, a 25 ft. specialty MRI hose is required.

B. **PROCEDURE:**

1. Selecting the appropriate HoverMatt size:
   a. HoverMatts are available in 34 inch, 39 inch and 50 inch widths. The 34 inch width is the standard.
   b. All sizes have a weight capacity of 1200 pounds.
2. Instructions for Use
   a. A minimum of two (2) caregivers are required when transferring a patient. Caregivers need to be positioned so they can control patient positioning.
3. Positioning the HoverMatt underneath the patient:
   a. Patient should preferably be in a supine position.
   b. Place the HoverMatt under the patient using a "log-rolling" technique.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
05/13, 11/17, 10/21	06/13, 10/18, 11/21	06/13, 11/18, 12/21	n/a	n/a	11/18, 01/22	12/18, 02/22	07/13, n/a	07/13, 12/18

i. Make sure that the patient's head is located at the same end as the "HEAD" label on the HoverMatt topside.
ii. Roll the patient onto their side towards the staff member.
iii. Place the rolled edge of the HoverMatt against the patient.
iv. Roll the patient back towards the opposite side enough to unroll the HoverMatt.
v. Center the patient on the HoverMatt.

c. Attach the two (2) safety patient straps over the patient.
i. Straps should be loose.
ii. Do not pull on the safety straps to transfer the patient.

4. Connecting the blower unit to the HoverMatt:
a. The patient must be secured on the HoverMatt before starting the inflation process.
b. Make sure that the blower is off by seeing the standby light on.
c. Plug the power cord of the blower unit into the electric outlet on the wall.
d. Fully insert the other end of the flexible air hose into the HoverMatt sleeve into either two hose entries at the foot end of the HoverMatt and snap buckle into place.
e. Close the Velcro flap around the HoverMatt sleeve.
f. Use the air hose retention straps to secure the air hose to the HoverMatt.

5. Transfer of patient from one patient support platform to another:
a. Position one patient support platform alongside the other patient support platform as closely as possible.
b. Set the brakes to "ON" for both patient support platforms. Only use for patient transfers between fixed patient support surfaces that are level with one another.
c. Raise the patient support platform side rail located opposite the patient transfer.
d. If the space between the two patient support platforms is greater than three inches, use the transfer bridge to fill the gap.
e. Before turning the blower unit on, verify that the:
i. Side rails, accessories, or sharp object are not obstructing the path of the HoverMatt.
ii. Air hose is free to travel with the HoverMatt.
iii. Patient support systems, such as IV lines or oxygen tubing, are free to travel with the patient.
iv. Staff are positioned in the direction of the patient transfer, one on each side of the patient.
v. Never leave the patient unattended when the HoverMatt is inflated and the blower power unit is on.
f. To turn on, press the button corresponding to the HoverMatt size (size is printed at the bottom on the matt).
i. The "Adjustable" setting is a safety feature that can be used to ensure the patient is centered on HoverTech air-assisted devices and to gradually accustom a patient who is timid or in pain to both the sound and functionality of the inflated devices.
g. Wait approximately 10-15 seconds for the HoverMatt to fully inflate.
h. After the HoverMatt is fully inflated, grasp the extended pull handles of the HoverMatt while keeping your back in the neutral, ergonomic upright posture.
i. Push HoverMatt at an angle, either headfirst or feetfirst. Once half-way across, opposite caregiver should grasp closest handles and pull to desired location.
j. Patient must be centered on the new surface.
k. Press the "Standby" button to turn off.
l. Unplug the power cord from the wall and the blower unit.

C. **REFERENCE(S):**
1. HoverMatt Air Transfer System Use Manual (2018).

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INFUSION PUMP – SYRINGE OR PATIENT CONTROLLED ANALGESIC (PCA) MODULE INFUSION SYSTEM WITH GUARDRAILS**
Purpose:	To regulate intravenous (IV) infusion using an electronic control device.
Supportive Data:	The Alaris Intravenous Infusion Pump with Guardrails System provides medication error prevention software to protect patients at the point of infusion delivery.
Equipment:	1. Alaris administration set 2. Primary IV solution 3. Pump programmer point of care (POC) 4. Pump Syringe Module or Patient Controlled Analgesic (PCA) Module

A. **PROCEDURE:**

1. Syringe Module:
   a. Prior to the start of an infusion program, confirm syringe type and size. The system will provide a prompt for the programmer to select both the syringe type and size.
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
   b. Priming the Alaris Syringe Module:
      i. Prime tubing prior to attaching system to patient with normal saline.
      ii. Attach administration set to syringe and prime tubing with the medication that is ordered.
      iii. Once set is primed, close slide clamp.
   c. Loading the Alaris Syringe Module:
      i. Prior to loading syringe, close roller tubing clamp to prevent uncontrolled flow.
      ii. Open syringe barrel clamp until it clears syringe chamber.
      iii. Twist gripper control clockwise and raise device head to fully extended position.
      iv. Insert syringe barrel flange between barrel flange grippers.
      v. Lock syringe in place by closing barrel clamp.
      vi. Twist gripper control clockwise then lower drive head.
      vii. Lock plunger in place with plunger grippers.
   d. Programming Guardrails:
      i. See Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails
   e. Removing the Alaris Syringe Module:
      i. Silence alarm.
      ii. Close roller tubing clamp.
      iii. Open plunger grippers and syringe barrel clamp.
      iv. Remove syringe by applying downward pressure to remove disc.
   f. Near End of Infusion:
      i. The system will alternate between Near End and remaining volume to be infused (VTBI).
      ii. The audio prompt requires being silenced just once and will not reoccur following initial silencing.
2. PCA Syringe Module:
   a. Select syringe type and size.
   b. Prime tubing prior to attaching tubing to patient:
      i. Option One: Manually express air from the administration tubing set by:
         1) Prime tubing prior to attaching system to patient with normal saline.
         2) Attach administration set to syringe and prime tubing with the medication that is ordered.

3) Once set is primed, close slide clamp.

ii. Option Two: Prime tubing using Alaris PCA Module.

iii. The tubing may be primed from the Infusion Mode Screen prior to programming the PCA Module:

1) Select Options key.
2) Press Prime Set with Syringe.
3) Press and hold Prime key to prime tubing.
4) Press Exit when prime is complete.

c. After priming tubing, close slide clamp.

3. Initial Set-Up:
   a. Label syringe per the Patient Care Services Policy: Patient Controlled Analgesia (PCA).
   b. Load syringe with administration set attached.
   c. Press System On key.
   d. Select Yes or No to New Patient.
   e. Select appropriate profile.
   f. Press Channel Select key.
   g. Set key to Program position.
   h. Press Confirm time setting.
   i. Choose correct syringe type and size.
      i. Selecting the incorrect syringe type and size may cause under-infusion or over-infusion of solutions or medications to patient.
   j. Select correct medication and concentration.
   k. Enter the dose and time limits.
   l. Enter the total dosage patient may receive as ordered.
   m. Responds to appropriate clinical advisory.
   n. Close and lock door.
   o. Attach administration set tubing set to patient.
   p. Verify entered prescription with a second Registered Nurse (RN).
   q. Press Start to begin PCA Module.
   r. Document in the medical record per the Patient Care Services Policy: Patient Controlled Analgesia (PCA).
4. Changing Syringe:
   a. Press Pause.
   b. Close roller tubing clamp.
   c. Unlock door and remove old syringe.
   d. Press Silence.
   e. Date and time new syringe and attach to tubing.
   f. Load new syringe.
   g. Set key to Program position, close door.
   h. Press Channel Select.
   i. Select correct syringe type and size.
   j. Press Confirm.
   k. Press Restore.
   l. Verify entered drug, concentration, and settings.
   m. Lock door and open roller tubing clamp.
   n. Press Start.
5. Administering a Bolus:
   a. Press Channel Select.
   b. Set key to Program position and enter authorization code.
   c. Enter bolus dose amount and lock door.
   d. Press Confirm.
   e. Confirm settings and press Start.
   f. Document bolus in the medical record.
6. Reviewing History:

a. Review patient history at the beginning of the shift and every four hours.
b. Press Channel Select Key.
c. Press Options.
d. Press Patient History.
e. Review drug totals.
f. Press Zoom key to review time intervals.
g. Press Detail to collect average dose per hour.
h. Press Main History.
i. To clear patient history, press Clear History and select Yes.
    i. Clear patient history every four hours and prior to transferring a patient to another nursing unit.
j. To view 24 hours totals, select 24 h Totals.
k. Press Exit after viewing history.
l. Press Start to return to program.
m. Document patient history every four (4) hours in the patient's electronic **health**~~medical~~ record (E~~M~~HR).

7. Documentation:
    a. Document the start and change of syringes in the E~~M~~HR.
    b. A second RN must verify for accuracy the initiation, change in dosage or any boluses and document it in the electronic medication administration record (eMAR).

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

1. Patient Care Services Policy: Patient Controlled Analgesia (PCA)
2. Patient Care Services Procedure: Infusion Pump- Infusion System with Guardrails

C. **REFERENCE(S):**

1. Cardinal Health. (2010-2014). Alaris syringe module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf
2. Cardinal Health. (2010-2014). Alaris pca module v8: Quick reference guide. Retrieved from http://www.cardinal.com/alaris/brochure/spodfuAlarisSystemv8DFU.pdf

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES
POLICY

ISSUE DATE: 06/05

SUBJECT: Infusion Pumps, Intravenous (IV) Therapy

REVISION DATE: 04/07, 03/11, 07/15, 04/18

Department Approval:	~~01/18~~10/20
Clinical Policies & Procedures Committee Approval:	~~02/18~~12/20
Nursing Leadership~~Executive Committee~~ Approval:	~~03/18~~08/21
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~03/18~~09/21
Medical Executive Committee Approval:	~~03/18~~01/22
Administration Approval:	02/22
Professional Affairs Committee Approval:	~~04/18~~ n/a
Board of Directors Approval:	04/18

A. **PURPOSE:**

1. To establish standards at Tri-City Healthcare District (TCHD) for the management of intravenous (IV) administration sets, solutions, and medications in order to decrease the incidence of infections, complications, and errors.

B. **DEFINITION(S):**

1. Back flushing – A means to prime a secondary administration set in order to flush the secondary set of residual medication and/or to flush secondary tubing between the deliveries of incompatible medications.
2. Channel – The module attached to the programming module for the delivery of IV fluids or medications.
3. Channel Labels – Provides a hospital defined list of labels, which can be displayed in the channel message display allowing the user to identify the channel with the solution being infused (i.e., blood or chemotherapy), or the catheter location (i.e., pulmonary artery or intraperitoneal).
4. Drug Library – A drug dataset defines a list of up to 1500 drugs and concentrations appropriate for each Profile™. Programming via the drug dataset automates programming steps, including the drug name, drug amount and diluent volume, and represents established best practice Guardrails™ limit checking.
5. Epidural – Analgesia infusion delivered via the epidural space.
6. Flush solution – A solution used to provide a flush between or at the end of IV medications. The flush solution shall be compatible with the medications delivered.
7. Guardrails™ – The programming software within the Alaris Medley infusion system designed to help prevent programming errors by:
   a. Providing an advisory prompt if an out-of-limit entry is made at the time the device is programmed to infuse medications defined in the drug library
   b. Comparing user programming with the hospital-defined best practice guidelines
   c. Customizing device configurable settings to meet the need of the selected patient population
8. Intrathecal – Analgesia infusion delivered through the intrathecal space.
9. Point of Care (POC)/Programming Module – The module of the Alaris Medley medication safety system that contains the drug library and pump configurations. This module controls all of the solutions and medications delivered through the pumping modules. The programming module

cannot deliver any medication without a pumping module. Each programming module has the ability to control four pumping modules.

10. Priming Volume – The amount of fluid used to clear the administration set of air. The amount of priming volume varies by administration set. The amount of priming volume can be found on the administration set package.
11. Profile™ – Represents a specific patient population. Each profile contains drugs and instrument configurations that are appropriate for that patient population.

C. **INTRAVENOUS (IV) INFUSIONS:**

1. All solutions and medications administered via an IV route shall be administered using an IV infusion device except in the following situations:
   a. IV push administration.
   b. Surgery, under the direct supervision of an anesthesiologist.
   c. Emergent situations, under the direct supervision of the Registered Nurse (RN).
   d. Identified research studies when the research RN is present to monitor the infusion.
   e. High census, if there is a shortage of infusion pumps; plain solutions (without additives) at rates less than or equal to 75 mL/hour may be infused without an infusion pump.
2. Staff must utilize both the appropriate Profile™ with Guardrails™ features and the channel labels when programming the Alaris infusion system to enhance the safe delivery of IV medications and solutions.
   a. Intensive Care Unit (ICU)/Emergency Department (ED)/Operating Room (OR) shall be used by ICU, Post Anesthesia Care Unit (PACU), Cardiac Catheterization Lab, Interventional Radiology, and ED, Surgery.
   b. IMC/Telemetry shall be used by Telemetry and Progressive Care Unit.
   c. Acute Care shall be used by 1North, Acute Rehab, 2Pavilion, 3Pavilion, 4Pavilion, and the Forensic Unit.
   d. Neonatal Intensive Care Unit (NICU) shall be used by NICU and ED.
   e. Peds shall be used for pediatric patients.
   f. WCS shall be used by Labor and Delivery and Mother Baby.
   g. Oncology
3. Profiles and Channel Labels shall be checked by the licensed nurse at the beginning of each shift.
4. Profiles™ shall be checked and changed as needed when a patient is transferred to another patient care unit. The receiving unit RN shall be responsible to check and change the patient profile.
5. Channel labels shall be utilized for medications and/or solutions that are not a part of the drug data set.

D. **PRIMING AND FLUSHING:**

1. The priming volume shall be subtracted from the volume to be infused in order to ensure the medication and/or solution is infused over the prescribed rate as appropriate in NICU and Pediatrics.
2. To clear residual medication volume from the IV administration set, the back flushing technique shall be utilized. Approximately 20 mL of medication shall be flushed back into the empty bag or bottle. The flush solution is then infused at the same rate as the original rate of the medication.

E. **SMART SITE PORTS:**

1. Smart Site injection sites on the IV tubing are accessed only with a luer lock syringe.
   a. Note: Using a needle or blunt tip syringe will damage the valve and result in leaking. The valve may be secured by attaching a Smart Site valve cap.

F. **CARE AND CLEANING:**

1. One POC and channel shall be left in the patient's room at discharge and cleaned by Environmental Services (EVS). Extra POCs and channels shall be stored in a designated area on the unit or in the Sterile Processing Department (SPD).

a. The tubing and IV bag shall be removed and discarded by the unit's RN prior to EVS cleaning pump.
b. EVS shall not clean pump if tubing and/or IV bag have not been removed.
c. EVS shall attempt to locate the **Nursing Leader**/~~Assistant Nurse Manager (ANM) shift supervisor~~/designee and request the tubing and IV bag be removed. If the **Nursing Leader**~~ANM, shift supervisor~~/designee cannot be located, or the tubing/IV bag is not removed in a timely manner, cleaning the pump shall be nursing's responsibility.

2. Cleaned infusion pumps shall be covered with a plastic bag.
3. Cleaning needs of the Infusion Pump during patient care shall be the responsibility of the RN caring for the patient.
   a. They shall be wiped down with a hospital approved disinfectant weekly and when visibly soiled. (Refer to Infection Control Policy: Cleaning and Disinfection - IC 9)
   b. To avoid damage to the connectivity points never spray cleaning solutions directly onto the pump.
   c. Spray cleaning solution onto a cloth and wipe the pump with the moistened cloth.
4. Greater than 70% alcohol solutions are damaging to equipment surface, and shall not be used.
5. Infusion pumps shall be kept plugged into an electrical outlet at all times.
   a. Cleaned infusion pumps not in use shall be stored in the patient's room or designated storage area.
   b. SPD shall make rounds (Monday-Friday) to maintain a minimum supply in SPD.
      i. Exception: **Progressive Care**~~Forensic~~ Unit**, Emergency Department**

G. **RELATED DOCUMENTS**

1. Infection Control Policy: Cleaning and Disinfection IC 9

Tri-City Medical Center
Oceanside, California

STANDARDIZED PROCEDURES MANUAL

STANDARDIZED PROCEDURE: MEDICAL SCREENING EXAM TO RULE OUT LABOR

I. **POLICY:**

A. Function: Performance of a medical screening exam on pregnant patients who complain of "contractions" who have had prenatal care. All unassigned patients (those with no prior prenatal care) will be seen by the obstetrician on "unassigned call".

B. Circumstances:

1. Setting: Tri-City Medical Center, Labor ~~And~~**and** Delivery unit.
2. Supervision: None required.
3. Patient condition: Pregnant and complaining of **"contractions or rule out labor concerns".** ~~"contractions.".~~

II. **DEFINITION:**

A. Medical Screening Exam (MSE): An assessment of the patient consisting of specific subjective and objective symptom evaluation and prenatal history review performed by the labor and delivery nurse for patients who present to labor and delivery with "contractions or rule out labor concerns."

B. Emergency Medical Treatment and Labor Act (EMTALA): requires **Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of** ~~that a~~ patients **in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status,** ~~**national origin, race, creed, or color**~~ **race, color, religion, ancestry, national origin, disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, citizenship, primary language, or immigration status.**~~be stabilized within the hospital's capabilities~~

1. ~~All laboring patient are~~ **A woman in labor is** considered unstable **from the latent phase through delivery of the placenta**~~, if~~**. If there is inadequate time to safely transfer her to another hospital before delivery, or if that transfer may pose a threat to her or her fetus's health or safety,** ~~and are~~ **she is** thereby deemed to have an emergency condition. ~~until labor is ruled out or the infant and placenta are delivered.~~
2. The **Medical Screening Exam** allows the nurse**, certified nurse-midwife, nurse practitioner, physician assistant, or physician** to collect data to determine if the patient is in active labor**. Triage is followed by the complete evaluation of the woman and the fetus by a health care provider with** ~~**skills**~~**skills and training appropriate to evaluate the** ~~**eissues**~~**issues identified during triage.** ~~and meets criteria for admission verses outpatient evaluation.~~

III. **PROCEDURE:**

A. Obtain the following information by reviewing patient's prenatal record as available or interviewing the patient:

1. Pregnancy Summary

a. Estimated due date

b. Prior pregnancy history

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8/03, 5/06, 10/09, 3/10;6/13, 01/20	03/10;6/13, 01/20	04/10;6/13, 02/20	06/21	08/10;7/13, 07/21	08/10;10/13, 10/21	08/10; 10/13, 01/22	02/22	n/a	8/03, 2/08, 8/10;10/13

2. Past medical and surgical history
3. Allergies
4. Current Medications
5. Significant risk factors identified or health problems during this pregnancy

B. Subjective Data
1. Brief history of current condition/reason for exam
2. Report of fetal movement
3. Uterine contractions
   a. Time contractions started
   b. Frequency
4. Leaking of fluid
   a. Date and time when leaking started
   b. Color of fluid
5. Vaginal bleeding
   a. Bleeding amount
6. Pre-Eclampsia/Hypertension Symptoms

~~A.~~C. Objective Data
~~Brief history of the woman's presenting condition~~
~~1. Report of Fetal Movement~~
~~2. Any vaginal discharge to include bleeding or leakage of fluid~~
~~3. When contractions/ abdominal pain started~~
~~4. Frequency, and duration and intensity of contractions, if known~~
~~5. Pain rating using number scale~~
~~Description of pain~~
~~6. Complaints of rectal or perineal pressure~~
~~Pregnancy course to date, including gestational age determination and past gynecological and obstetrical history~~
~~Past medical and surgical history~~
~~Allergies~~
~~7. Current Medications, substance use~~
~~8. Subjective Data to include:~~
~~9. Objective Data to include:~~
~~a. Date of last menstrual period~~
~~b. Estimated date of confinement (EDC)~~
~~c. Number of times patient has been pregnant (gravida)~~
~~d. Number of viable deliveries (para)~~
~~e. Number of children born alive~~
~~f. Number of abortions (spontaneous/therapeutic) and stillbirths~~
~~10. Significant risk factors identified or health problems experienced during this pregnancy~~
~~11. Review prenatal record/information, lab and other diagnostic studies as available.~~
~~12. Signs of severe distress, e.g., cardiac, respiratory~~

1. Obtain Vital Signs
   a. Pulse
   b. Respiratory rate
   c. Blood pressure
   d. Temperature
   e. Current numerical pain level
      i. Target numerical pain level
      ii. Location of pain
      iii. Quality of pain
      iv. Pattern of pain
2. Signs of acute respiratory or cardiac distress.
3. Collect a clean catch urine sample, if patient is able to void, for a urine dip stick screening

~~13.~~

~~14. Obtain Urine Sample, if patient is able to provide, for urine dip stick screening~~

~~15.~~4. **Assess fetal heart rate (FHR) and uterine contractions for a minimum of 20 minutes, per Fetal Heart Rate (FHR) Surveillance/Monitoring Procedure.** ~~Place patient on Electronic Fetal Monitor to obtain an evaluation of the fetal heart rate and contraction pattern per Unit Specific Fetal Surveillance and Non-Stress Test Procedures.~~

a. If patient is less than 24 weeks gestation, may obtain and document FHR via Doppler. ~~with intermittent monitoring, but c~~ Continuous **contraction monitoring with** toco placement **is needed** to rule out premature contractions/preterm labor.

b. **Notify the provider i**If patient is less than 34 weeks gestation and ~~contracting~~ **having** more than ~~6~~ **six contractions** ~~times~~ in an hour ~~of~~ **or if** contraction pattern noted **to be less than ten** ~~<10~~ minutes apart. ~~, notify the provider.~~

~~16. Assess fetal heart rate and uterine contractions for a minimum of 20 minutes, per Unit Specific Fetal Surveillance and Non-Stress Test Procedures.~~

~~17. Patient must have a Reactive NST to be discharged home~~

~~18. A Non-Reactive NST requires provider notification.~~

~~B. For suspected rupture of membranes complete nitrizine screening, as appropriate, and notify provider of the results. Other tests like the AmniSure may be requested by the provider.~~

~~C. For vaginal bleeding, more than bloody shows notify the provider. DO NOT PERFORM a sterile vaginal exam.~~

~~D.~~5. If the patient reports no vaginal bleeding or leakage of fluids and is greater than 34 weeks gestation, perform a vaginal exam (VE). Note at a minimum: Cervical dilation, effacement, station, and presenting part.

a. For gestational age <34 weeks, DO NOT complete a VE, unless ordered by the provider. VE can interfere with some premature labor screening tools.

~~1.~~6. **For vaginal bleeding, more than bloody show, or placenta previa notify the provider. DO NOT PERFORM a vaginal exam.**

D. **Provider Notification for:**

1. **FHR tracing that are a Category II or Category III immediately.**
2. **Initial assessment data, and one-hour re-assessment data findings.**
3. **Obtain additional orders/instructions as appropriate.**

E. **Admission**

~~E.~~1. Notify the provider and start the admission process for the patient presenting with:

~~1.~~a. Positive rupture of membrane status

b. Greater than 34 weeks EGA, regular contractions with cervical exam of 4 cm or greater.

F. **Discharge**

1. **Patients of term gestation will have the following documented prior to discharge:**
   a. **Category I FHR**
   b. **Absence of active labor.**
   ~~2.~~c. **Provider order for discharge.** ~~.~~

~~F. Patients to be discharged home with physician order with term gestations will have documented evidence of the following:~~

~~1. Reactive FHR tracing and/or Category 1 tracing~~

~~2. Absence of active labor: Irregular contractions / > 5 minutes apart and/or cervical exam < 4 cm or no change in VE over two hour period.~~

~~3. Vital Signs and /or urine results within normal limits~~

~~G. Provider notification:~~

~~1. Notify provider for any fetal heart rate tracings that are a Category II or Category III findings immediately Notify patient's provider of initial assessment data, and one hour re-assessment data examination findings, and obtain orders/instructions as appropriate.~~

~~2. Obtain provider order for further evaluations, treatments as needed.~~

~~H.~~G. **Patient instructions/education:**

1. Review discharge ~~information with~~**instructions with the** patient and ~~significant other~~ **support person (if present)**~~as appropriate and~~, provide a copy of the discharge follow-up instructions and appropriate educational material.

IV. DOCUMENTATION:

A. Document discharge instructions ordered by the provider on the OB Patient Triage and add appropriate educational material during the depart process. Topics for consideration can include: Labor Precautions, Fetal Movement Counts

B. Document patient disposition (admission to labor and delivery, discharge, transfer) on the OB Patient Triage .

V. REQUIREMENTS FOR RN:

A. **Current unencumbered California RN license**

B. Education and training: At least six (6) months experience as a full time labor and delivery RN.

C. Experience: If less than six (6) months full time experience as L&D RN, nurse must consult with L&D shift charge nurse or designee prior to conversation with the provider and prior to the discharge of patient. Documentation shall be ~~co-signed~~ ~~reviewed by~~**reviewed by the** consulting RN.

VI. RNs AUTHORIZED TO DIRECT AND PERFORM MEDICAL SCREENING EXAM TO "RULE OUT LABOR"

A. Designated registered nurses who have been trained and maintain the annual requirements.

VII. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: Developed and approved by authorized representative of administration, nursing, medicine, and quality resource services.

B. Review: every two years.

VIII. REFERENCES:

1. ~~AAP & ACOG. (2007). Guidelines for Perinatal Care, 6th Edition~~**AAP, C. O. F. A. N., & ACOG, C. O. O. P. (2017). *Guidelines for perinatal care.* Retrieved from https://ebookcentral-proquest-com.ezproxy.liberty.edu**

2. ~~Emtala Laws and Regulations (2009). Retrieved from http://emtala.com/laws/regs.htm on June~~**EMTALA Fact Sheet. (2019). Retrieved November 12, 2019, from https://www.acep.org/life-as-a-physician/ethics-- lcgal/cmtala/emtala-fact-sheet/**

3. Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.) Lippincott Williams and Wilkins

4. ~~Schecter, J.C. (2009). *Cobra Laws and EMTALA.* EMedicine Emergency Medicine. Retrieved from http://emedicine.medscape.com on 6/8/2009.~~

5.4. Tucker, S.M., Miller, L.A., Miller, D.A. (2009). Fetal Monitoring and Assessment (5th ed.), Mosby: Elsevier.

6.5. Lyndon, A. & Ali, L. (2009) AWHONN Fetal Heart Monitoring Principles and Practices (4th ed), Kendall Hunt Professional.

6. **Committee Opinion No. 667: Hospital-Based Triage of Obstetric Patients. (2016). *Obstetrics & Gynecology*, 128(1). doi: 10.1097/aog.0000000000001524**

7. **Troiano, N. H., Witcher, P. M., & Baird, S. M. M. (2019*). High-risk & critical care obstetrics* (4th ed.). Philadelphia, PA: Wolters Kluwer.**

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/97 **SUBJECT: Patient Rights and Responsibilities**

REVISION DATE(S): 04/00, 05/02, 12/02, 12/03, 01/06, 05/07, 07/08, 02/09, 02/11, 06/14 07/17, 08/18

Patient Care Services Content Expert~~Department~~ Approval:	**~~07/18~~10/21**
Clinical Policies & Procedures ~~Committee~~ Approval:	**~~07/18~~11/21**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~07/18~~12/21**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/18~~01/22**
Administration Approval:	**~~08/18~~02/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/18**

A. **PURPOSE:**

1. To describe Tri-City Healthcare District's (TCHD) process of informing patients of their rights and responsibilities while receiving care, treatment, or services.
   a. To ensure TCHD **Workforce Members**~~staff~~ are aware of and their conduct supports patient's rights.
   b. To set forth behavioral guidelines for patients and families to ensure safe delivery of care, treatment, and services.

B. **DEFINITION(S):**

1. Patient Rights: **Basic rules of conduct between patients and medical caregivers. They are culturally and legally specified rights, claims, powers, privileges and remedies due to a person receiving health care services.** ~~A standard belief that patients deserve care, treatment, and services that safeguard their personal dignity and respect their cultural, psychosocial, gender identity, sexual orientation and spiritual values. These values often influence the patient's perceptions and needs. By understanding and respecting these values, providers can meet care, treatment, and service preferences~~.
2. **Notice of Patients' Rights: A list of patient's rights posted in "appropriate places" within a hospital.**
~~1.~~3. **Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**

C. **POLICY:**

1. TCHD facilitates the fulfillment of patient's responsibilities by ensuring that each patient, as appropriate to his/her condition, is a partner in the healthcare process.
2. Care is provided in a manner that respects and fosters dignity, autonomy, positive self-image, cultural values, and involvement in care decisions.
3. Care is individualized to incorporate cultural, psychosocial, gender identity, sexual orientation and spiritual values.
4. Upon admission, each patient is given a copy of the Patient's Bill of Rights and Patient Responsibilities located in the Patient Guide.
   a. The Patient's Bill of Rights is also printed on the TCHD Conditions of Admissions Form and is acknowledged by the patient's signature.
5. The "Patient's Bill of Rights" is posted (in both English and Spanish) in each patient care area and Registration.

D. RELATED DOCUMENT(S):

1. Behavior Health Services Policy: Patient Rights
2. Conditions of Admission – Sample
3. Justice Involved Patient's Rights and Responsibilities – Sample
4. Patient Rights Poster - Sample

E. REFERENCE(S):

1. California Hospital Association Consent Manual 20~~17~~20
~~1.~~**2. California Title 22§70707**

F. Conditions of Admission – Sample

CONDITIONS OF ADMISSION

1. CONSENT TO HOSPITAL PROCEDURES: The patient consents to the medical and surgical procedure, which may be performed during this hospitalization or on an outpatient basis, including emergency treatment or services. These may include but are not limited to laboratory tests, x-ray examinations, medical or surgical treatment or procedures, anesthesia, photographic/video records or hospital services rendered to the patient under the general and special instructions of the physician or surgeon. The attending physician must verbally inform the patient that telehealth may be used, and obtain verbal consent from the patient for this use. The verbal consent must be documented within the patient's medical record by the attending physician. The exception for this consent is for any patient that is under the jurisdiction of the Department of Corrections or any other correctional facility.

   The patient consents to the taking of pictures of his/her medical or surgical condition or treatment, and the use of the pictures for purposes of diagnosis or treatment or for the hospital's operations, including peer review and education or training programs conducted by the hospital.

2. CONSENT TO BLOOD TESTING: In the event of an exposure of blood or body fluids to a health care worker, I acknowledge that the patient's blood will be tested for bloodborne viruses including Human Immunodeficiency Virus (HIV). The results of the test are necessary to determine whether the exposed health care worker needs immediate preventive treatment. The physician will inform the patient of the accidental exposure, test completion and results.
   _____ Initials

3. NURSING CARE: The patient understands that this hospital provides only general duty nursing unless, upon orders of the physician, the patient is provided more intensive nursing care. If the patient's condition requires a special duty nurse, the patient agrees that it must be arranged by the patient or their legal representative. The hospital will not be responsible for failure to provide the same and is released from any liability arising there from.

4. TRAINING AND EDUCATION: The hospital participates in the training of residents, medical students, students nurses and other healthcare personnel. I agree that they may participate in my care to the extend deemed appropriate by the Medical Staff or Hospital personnel, and I consent to the demonstration, observation and administration of treatment or procedures by such persons under the supervision of the members of the Medical Staff or Hospital personnel.

5. MEDICATIONS: The patient understands and agrees not to bring any medications (including non-prescription, prescription, and herbals) into the hospital. This applies to both inpatient and outpatient services. Patient agrees to provide hospital with a list of all medications (including non-prescription, prescription and herbals) that he/she is currently taking.
   _____ Initials

6. PERSONAL VALUABLES: The patient understands and agrees that the hospital maintains a safe for the safekeeping of money and other valuables, and that the hospital shall not be liable for the loss of such valuables unless they are deposited with the hospital for safekeeping. Liability of the hospital for loss or damage is limited by statute to five hundred dollars. The patient understand that he/she is responsible for personal effects, including personal grooming articles, jewelry, clothing, documents, medication, eye glasses, hearing aids, dentures and other prosthetic devices.
   _____ Initials

7. NON-SMOKING HOSPITAL: The patient understands that no smoking is permitted within the hospital except in designated places.

8. PATIENT RIGHTS AND RESPONSIBILITIES: The hospital retains a patient representative who the patient may contact regarding concerns about care and treatment. The patient/agent has received a copy of Patient Rights and Responsibilities.
   _____ Initials

9. RELEASE OF INFORMATION: To obtain payment for service, the patient/agent authorizes the hospital/provider to disclose to the patient's insurance carrier, health service plan, workers compensation carrier, or rendering physician any and all medical and basic information including name, location and general condition. If the patient doesn't want such information released, he/she may make a written request for such information to be withheld. A separate form is available for this purpose upon request. How Tri-City Medical Center may further use or disclose patient identifiable medical information about you, including disclosures for purposes of treatment, payment and health care operations is described in the Notice of Privacy Practice. The undersigned acknowledges having been offered a copy of the Notice and may request an additional copy at this time or access at www.tricitymed.org.
   _____ Initials

10. I authorize TRI-CITY MEDICAL CENTER, its service providers (including service providers contacting me about obtaining financial assistance for my account(s) and/or for collection services) and their successors, assigns, affiliates, or agents to contact me at any telephone number associated with my account(s), including wireless telephone numbers or other numbers that result in charges to me, whether provided in the past, present or future. I agree that methods of contact may include using pre-recorded or artificial voice messages and/or an automatic telephone dialing system, as applicable.

11. FINANCIAL AGREEMENT: It is agreed, whether signed as agent or patient, that in consideration of the services to be rendered to the patient he/she individually obligates him/herself to pay the account of the hospital in accordance with regular rates and terms of the hospital including its financial assistance policies. Should the account be referred to an attorney or collection agency for collections, the undersigned shall pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate.

12. ASSIGNMENT OF BENEFITS: The patient or agent, hereby authorizes direct payment to the hospital/provider, any insurance benefits, including but not limited to third party liability payable to or on the patient's behalf for this hospitalization or for these services, including emergency services if rendered, at a rate not to exceed the hospital's billed charges. It is agreed that payment to the hospital by an insurance company shall discharge the insurance company of all obligations under a policy to the extent of such payment.

The patient understands that he/she is financially responsible for charges not covered by this assignment. This assignment is irrevocable.

13. PHYSICIANS ARE INDEPENDENT CONTRACTORS: All physicians and surgeons furnishing services to the patient, including the radiologist, pathologist, anesthesiologist, the emergency department physician and the like, are independent contractors and are not employees or agents of the hospital. Some of these physicians will bill separately for their services and may not have agreements with same insurance plans as the hospital. The undersigned acknowledges receipt of the Patient Notification Form and may request an additional copy at this time. _____ Initials

The patient is under the care of and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered to the patient under the general and special instructions of the physician.

14. HEALTH PLAN OBLIGATION: This hospital maintains a list of health plans with which it contracts. A list of such plans is available upon request from Patient Financial Services. The hospital has no contract, express or implied with any plan that does not appear on the list. The undersigned agrees that he/she is individually obligated to pay the full charges of all covered services rendered to him/her by the hospital if he/she belongs to a plan, which does not appear on the above-mentioned list.

The undersigned certifies that he/she has read the foregoing, received a copy, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

15. VISITORS: You have the right to visitors of your choice, including spouse, domestic partner (including same sex domestic partners), another family member or a friend.

_____ _____ ___/___/___ ___:___ AM/PM

Name: Patient/Legal Representative | Signature: Patient/Legal Representative | Date (m/d/y) | Time

If signed by other than patient, indicate relationship:

☐ Parent ☐ Spouse ☐ Partner ☐ Relative _____ ☐ Conservator ☐ Tutor/Legal Guardian

If patient is unable to sign, state reason: _____

☐ Interpretation provided: Language: _____

☐ Telephonic ☐ VRI _____

Interpreter: Name or ID No.

☐ Face-to-face interpreter Signature: _____

_____ _____

Witness/Representative of Tri-City Medical Center (print name) | Signature

Financial Responsibility Agreement by Person Other Than the Patient or Patient's Legal Representative.

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement, Assignment of Insurance Benefits and Health Plan Obligation provisions above.

Signature: _____ _____

(Financially responsible party) *(print name)*

Date/Time: _____

Witness: _____ _____

(TCMC representative) *(print name)*

Date/Time: _____

Affix Patient Label

Tri-City Medical Center

4002 Vista Way • Oceanside • CA • 92056

8560-4011

(Rev. 8/15)

CONDITIONS OF ADMISSION

Justice Involved Patient's Rights and Responsibilities – Sample

JUSTICE INVOLVED PATIENT'S RIGHTS & RESPONSIBILITIES

A patient's rights and responsibilities shall include but not be limited to:
(a patient shall have the right to:)

1. Exercise these rights without regard to sex or culture, economic, educational, or religious background or the source of payment for care.
2. Considerate and respectful care, including privacy in treatment and in care of personal needs, when not in conflict with security and custodial policies.
3. Receive information about the illness, the course of treatment and prospects for recovery in terms that the patient can understand and to be afforded the opportunity to discuss medical treatment.
4. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or nontreatment and the risks involved in each.
5. Participate in the consideration of ethical issues that arise in the provisions of the patient's care. A Bio-Ethics Committee exists for the purpose of addressing ethical issues which may arise the care of the patient. To gain access to the Bio-Ethics Committee, please notify the unit charge nurse or nursing administrator.
6. Confidential treatment of all communications and records pertaining to the care and the stay in the hospital. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with the care or who is outside the correctional treatment center, except in case of transfer to another health care facility, or as or required by law.
7. Reasonable responses to any reasonable requests made for services.
8. To give informed consent or to refuse any treatment or procedure or participation in experimental research.
9. Be informed of continuing health care requirements following discharge from the hospital.
10. Know which hospital rules and policies apply to the patient's conduct while a patient.

A patient's responsibilities shall include but are not limited to:
(A patient shall have the responsibility to/for:)

1. Following the recommended treatment plan.
2. Her/his actions if the patient refuses treatment or fails to follow the practitioner's instructions.
3. Following hospital rules and regulations affecting patient care and conduct.
4. Considering the rights of other patients and hospital personnel. The patient is responsible for being respectful of the property of other persons and the hospital.

Received by _____ Date / Time _____

Witness _____ Date / Time _____

Affix Patient Label

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

7085-1016
(Rev 07/16)

JUSTICE INVOLVED PATIENT'S
RIGHTS & RESPONSIBILITIES

Patient Rights Poster - Sample

Patient Rights

As a Patient at Tri-City Medical Center, you have the right to:

1. Considerate and respectful care, personal dignity and to be made comfortable. You have the right to respect for your cultural, psychosocial, spiritual, and personal values, beliefs and preferences. You have the right to pastoral or spiritual services.
2. Have a family member (or other representative of your choosing) and your own physician notified promptly of your admission to the hospital.
3. Know the name of the physician who has primary responsibility for coordinating your care and the names and professional relationships of other physicians and non-physicians who will see you.
4. Receive information about your health status, diagnosis, prognosis, course of treatment, prospects for recovery and outcomes of care (including unanticipated outcomes) in terms you can understand. You have the right to effective communication which addresses any vision, speech, hearing, language or cognitive impairment, including the provision of interpretation and translation services free of charge, and to participate in development and implementation of your plan of care. You have the right to participate in ethical questions that arise in the course of your care, including issues of conflict resolution, withholding resuscitative services, and forgoing or withdrawing life-sustaining treatment.
5. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. You may include family and others in your decision making process. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
6. Request or refuse treatment, to the extent permitted by law. However, you do not have the right to demand inappropriate or medically unnecessary treatment or services. You have the right to leave the hospital even against the advice of physicians, to the extent permitted by law.
7. Be advised if the hospital/personal physician proposes to engage in or perform human experimentation affecting your care or treatment. You have the right to refuse to participate in such research projects.
8. Reasonable responses to any reasonable requests made for service.
9. Appropriate assessment and management of your pain, information about pain, pain relief measures and to participate in pain management decisions. You may request or reject the use of any or all modalities to relieve pain, including opiate medication, if you suffer from severe chronic intractable pain. The doctor may refuse to prescribe the opiate medication, but if so, must inform you that there are physicians who specialize in the treatment of severe chronic pain with methods that include the use of opiates.
10. Formulate advance directives. This includes designating a decision maker if you become incapable of understanding a proposed treatment or become unable to communicate your wishes regarding care. Hospital staff and practitioners who provide care in the hospital shall comply with these directives. All patients' rights apply to the person who has legal responsibility to make decisions regarding medical care on your behalf.
11. Have personal privacy respected. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be told the reason for the presence of any individual. You have the right to have visitors leave prior to an examination and when treatment issues are being discussed. Privacy curtains will be used in semi-private rooms. You have the right to request access to a place and phones to conduct private phone conversations.
12. Confidential treatment of all communications and records pertaining to your care and stay in the hospital. You will receive a separate "Notice of Privacy Practices" that explains your privacy rights in detail and how we may use and disclose your protected health information.
13. Receive care in a safe setting, free from mental, physical, sexual or verbal abuse and neglect, exploitation or harassment. You have the right to access protective and advocacy services including notifying government agencies of neglect or abuse.
14. Be free from restraints and seclusion of any form used as a means of coercion, discipline, convenience or retaliation by staff.
15. Reasonable continuity of care and to know in advance the time and location of appointments as well as the identity of the persons providing the care.
16. Be informed by the physician, or a delegate of the physician, of continuing health care requirements and options following discharge from the hospital. You have the right to be involved in the development and implementation of your discharge plan. Upon your request, a friend or family member may be provided this information also.
17. Know which hospital rules and policies apply to your conduct while a patient.
18. Designate visitors of your choosing, if you have decision-making capacity, whether or not the visitor is related by blood or marriage, unless:
    - No visitors are allowed.
    - The facility reasonably determines that the presence of a particular visitor would endanger the health or safety of a patient, a member of the health facility staff or other visitor to the health facility, or would significantly disrupt the operations of the facility.
    - You have told the health facility staff that you no longer want a particular person to visit.

    However, a health facility may establish reasonable restrictions upon visitation, including restrictions upon the hours of visitation and number of visitors.

    The health facility must inform you (or your support person, when appropriate) of your visitation rights, including any clinical restrictions or limitations. The health facility is not permitted to restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation or disability.
19. Have your wishes considered, if you lack decision-making capacity, for the purposes of determining who may visit. The method of that consideration will comply with federal law and be disclosed in the hospital policy on visitation. At a minimum, the hospital shall include any persons living in your household and any support person pursuant to federal law.
20. Examine and receive an explanation of the hospital's bill regardless of the source of payment.
21. Exercise these rights without regard to sex, economic status, medical condition, educational background, race, color, religion, ancestry, national origin, disability, sexual orientation or marital status or the source of payment for care.
22. File a grievance. If you want to file a grievance with this hospital, you may do so by writing or by calling Tri-City Medical Center, Attention Administration, 4002 Vista Way, Oceanside, CA 92056 (760) 940-7466.

    The grievance committee will review each grievance and provide you with a written response within 10 days. The written response will contain the name of a person to contact at the hospital, the steps taken to investigate the grievance, the results of the grievance process, and the date of completion of the grievance process. Concerns regarding quality of care or premature discharge will also be referred to the appropriate Utilization and Quality Control Peer Review Organization (PRO). If you are a Medicare patient, and have concerns regarding quality of care or premature discharge, you may call or e-mail the Quality Improvement Organization (QIO) at Health Services Advisory Group 1-800-880-8749, TDD Hearing Impaired: 1-800-881-5960, or www.hsag.com. You can exercise this right without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care, treatment and services.
23. File a complaint with the state Department of Health Services regardless of whether you use the hospital's grievance process. The state Department of Health Service's phone number and address is: 7575 Metropolitan Drive, Suite # 104, San Diego, CA 92108 (619) 278-3700.
24. File a complaint with The Joint Commission regardless of whether you use the hospital's grievance process. The Joint Commission's phone number is 1-800-994-6610 or by email complaint@jointcommission.org.

Patient Responsibilities

As a patient of Tri-City Medical Center, you have the responsibility to:

1. Provide accurate information. Patient/patient's representative must provide to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalization, medications and matters relating to their health. Patient/patient's representatives must report perceived risks in their care and unexpected changes in their condition.
2. Ask questions. Patient/patient's representative must ask questions when they do not understand their care, treatment, and service or what they are expected to do.
3. Follow instructions. Patient/patient's representative must follow the care, treatment and service developed. They should express their concerns about their ability to follow the proposed care plan or course of care, treatment, and services. The hospital makes every effort to adapt the plan to the specific needs and limitations of the patients. When such adaptations to plan are not recommended, patients and their families are informed of the consequences of the plan alternatives and not following the proposed course.
4. Accept consequences. Patient/patient's representative is responsible for the outcomes if they do not follow the care, treatment or service.
5. Follow the rules and regulations. Patient/patient's representative must follow the hospital rules and regulations.
6. Show respect and consideration. Patient/patient's representative must be considerate of the hospital's staff and property as well as other patients and their property.
7. Meet your financial commitments. Patient/patient's representative should promptly meet any financial obligation agreed to with the hospital.

[illegible]

Tri-City Medical Center

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PRECIPITOUS VAGINAL DELIVERY

I. **POLICY:**

A. Function: To provide guidelines for Labor and Delivery Registered Nurses performing unexpected spontaneous vaginal emergency deliveries.

B. Delivering a baby without the Obstetrical (OB) provider in attendance may be due to these situations:

1. Delivery is imminent and the OB Provider (Obstetrician or Allied Health Professional is not immediately available, attending another delivery, performing surgery, etc.).
2. Patient's contraction pattern gets closer and more intense very quickly.
3. Patient has a history of rapid delivery.
4. Rapid descent of the fetus occurs unexpectedly.
5. Patient may have a small baby.
6. ~~Rapid descent of fetus and preparation for potential of a stressed newborn.~~

II. **PROCEDURE:**

A. Provider Notification:

1. Notify the patient's provider or designee **of imminent delivery**.
2. STAT overhead page for any OB provider **and call OB Physicians call room for any available provider.** ~~(during the day)~~. If unavailable, contact the Emergency Department (ED) Charge Nurse (ext. 3509) and request an ED physician attend the delivery.

B. Patient assessment may include these signs and symptoms:

1. Increased bloody show.
2. Bulging perineum.
3. Separation or parting of the labia.
4. **Abnormal or rapid** ~~i~~increase in contraction frequency and strength.
5. Strong urges to push or to bear down with contractions.
6. Feelings expressed by the mother that "the baby is coming".
7. Sudden nausea and retching may occur as cervix reaches full dilation.

C. Remain with the patient:

1. Summon assistance.
2. Have a Precipitous Delivery Pack ("Precip" Pack) brought to the bedside.
   a. May use a delivery table if available.
3. ~~a.~~ **If time allows, obtain as much history as possible including but not limited to frequency of contractions, rupture of membranes or leaking of fluid, bleeding, presence of fetal movement, estimated due date, prior births and complications.**

D. Reassure the patient and give clear, concise instructions.

E. Don gloves and other personal protective equipment, and use universal precautions.

F. Position the patient **in the dorsal lithotomy position on her back with her hips and knees flexed and legs abducted**.

G. If time permits, cleanse the perineum with recommended aseptic diluted povidone iodine solution.

H. For a~~n occipital~~ **cephalic precipitous** delivery:

1. As the head begins crowning:
   a. Tear amniotic sac if still intact
   b. Instruct the patient to pant or feather blow.
2. It is important to control/support the fetal head during delivery to protect the perineum.

Patient Care Services ContentDepartment Review	Clinical Policies & Procedures	Nursing Executive Council	Department of OB/GYN	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/06, 8/09, 8/12, 11/14, 12/19	8/12, 12/14, 01/20	08/12, 12/14, 02/20	06/15, 06/21	09/12, 09/15, 07/21	10/12, 01/16, 10/21	11/12, 01/16, 01/22	02/22	02/16, n/a	12/12, 02/16

a. Support the perineum with a sterile towel or sponges if available.

3. In the groin area adjacent to the perineum, place the thumb on one side and fingers on the opposite. Exert pressure by drawing the thumb and fingers together. This action is aimed at trying to create a pouch of the perineum.
4. Instruct the woman when to feather blow and when to push.
5. Using a cupped hand or the pads of the fingers, gently maintain pressure on the fetal head to control delivery. Assist extension by raising the head as the forehead comes over the perineum.
6. Inspect for a nuchal cord as soon as the head has delivered.
   a. If a loose cord is felt around the baby's neck, gently pull a loop down over the baby's head.
   b. If a tight cord is felt, **place** ~~put~~ two clamps on the umbilical cord approximately one inch apart, cut between the clamps and unwind the cord.
7. **If able, w**~~W~~ipe the baby's face to remove excess mucous or meconium. ~~Use a bulb syringe or a De Lee trap to suction mouth, oropharynx, and nasal passages as needed.~~
8. Support the fetal head as restitution (external rotation) occurs.
9. Place one hand on each side of the head and exert gentle, downward pressure until the anterior shoulder emerges under the symphysis pubis.
10. As soon as the anterior shoulder delivers, apply gentle upward pressure to deliver the posterior shoulder **and remainder of the fetus.**
11. Hold the baby securely while the rest of the body delivers.
    a. Cradle baby's head and back in one hand and the buttocks in the other

12. Hold the baby's head down slightly, and keep the body level with the uterus.

~~12.~~**13. Place the baby directly on the mother's chest or abdomen and initiate skin-to-skin contact covering the baby and mother with warm towels or a warm blanket.**

~~13.~~**14.** Double clamp the umbilical cord **approximately 3 cm distal to the insertion**. Cut the cord between the clamps.

~~14. Place the baby directly on the mother's chest or abdomen and initiate skin-to-skin contact covering the baby and mother with warm towels or a warm blanket.~~

~~15. Dry the baby thoroughly and stimulate.~~

~~16.~~**15.** Immediately following birth, follow Neonatal Resuscitation Program Guidelines.
   ~~17.~~**a.** If the baby shows signs of distress, provide intervention and **activate** ~~call~~ **Team NICU** ~~transport the baby to the nursery.~~

16. If a provider is still not available, assist with delivery of the placenta by keeping gentle, steady, downward traction on the cord as the other hand supports the uterine fundus. The mother can assist by bearing down when she feels a contraction.
   a. Be alert for signs of placental separation which can include:
      i. Sudden gush of blood
      ii. Lengthening of the umbilical cord
      iii. Firming of the uterus.
   b. Do not pull or tug on the umbilical cord. Delivery of placenta may take up to 30 minutes after the delivery of the fetus.
   c. Once the placenta is delivered, it should be examined to assess whether it appears intact.

~~18. Be alert for signs of placental separation which can include:~~
~~a. Slight~~ **Sudden** ~~gush of blood~~
~~b. Lengthening of the umbilical cord~~
~~c. Change in uterine shape from oval to globular~~ **Firming of the uterus**

~~19. Do not pull or tug on the umbilical cord.~~ **Delivery of placenta may take up to 30 minutes after the delivery of the fetus**

~~20. If physician still not available,~~ Aassist with delivery of the placenta by keeping ~~gentle, steady, downward traction on the cord as the other hand supports the~~

~~uterine fundus. The mother can assist by bearing down when she feels a contraction. Gently ease out the placental membranes~~

~~21.~~17. Gently massage the uterus to stimulate contractions and firm the uterus. Assess the uterine tone and amount, color of lochia expressed. ~~and placenta.~~

18. After the placental delivery, administer the following:

a. **20 units oxytocin in 1000 mL NS intravenous (IV) via mainline. Administer 500 mL bolus (10 units) once over 30 minutes, then set rate to 125 mL/hour (41.67 milliunits/minute)**

~~22.~~b. **Administer 10 units oxytocin via Intramuscular injection if there is no IV access**

~~a. 20 units oxytocin in 1000 mL NS intravenous (IV) via mainline. Administer 500 mL bolus (10 units) once over 30 minutes, then set rate to 125 mL/hour (41.67 milliunits/minute)~~

~~i. Administer 10 units oxytocin via Intramuscular injection if there is no IV access~~

~~23.~~19. Inspect the perineum and labia for lacerations and bleeding.

~~24.~~20. Clean the patient's perineum and other areas.~~, and change linen as needed.~~

~~25.~~21. Facilitate bonding.

~~26.~~22. Monitor condition of mother and baby until the provider arrives.

III. **DOCUMENTATION:**

A. Maternal-infant identification bands.
B. Labor and Delivery Summary, Delivery Record, and patient record.

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

A. Current **unencumbered** California RN license
B. Education: Orientation to Labor and Delivery nursing role
C. Initial Evaluation: Orientation to Labor and Delivery
D. Ongoing Evaluation: Annual skills assessment exam/evaluation/observation

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

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

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

A. All healthcare providers who have successfully completed requirements as outlined above are authorized to direct and perform PRECIPITOUS VAGINAL DELIVERY Standardized Procedure.

VII. **REFERENCES:**

A. Kennedy, B.B, Ruth, D.J., Martin, E.J. (2009) Intrapartum Management Modules (4th ed.) Lippincott Williams and Wilkins

B. A. Bohart, Joelle, and Bavolek, Rebecca A. Emergency Medicine Clinics of North America. www.emed.theclinics.com. Consulting Editor AMAL MATTU. May 2019. Volume 37, Number 2

~~A.~~**C. Borhart, Joelle, and Voss, Kathryn. Emergency Medicine Clinics of North America. www.emed.theclinics.com. May 2019. Volume 37, Issue 2, Pages 265-276**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/02

SUBJECT: **Preventing Admissions and Procedures Beyond Medical Staff Privileges**

REVISION DATE(S): 6/03, 8/05, 5/08, 05/11, 02/15, 11/18

Patient Care Services Content Expert Approval:	**~~07/18~~07/21**
Clinical Policies & Procedures Committee Approval:	**~~08/18~~11/21**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~09/18~~11/21**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/18~~01/22**
Administration Approval:	**~~10/18~~02/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/18**

A. **PURPOSE:**

1. Consistent with the **Tri-City Healthcare District (TCHD)**~~Hospital~~'s and Medical Staff's obligation, this policy provides the mechanism for personnel to ensure that practitioners seeking to admit, treat, or perform procedures on patients at ~~Tri-City Healthcare District (~~TCHD~~)~~ have current Medical Staff membership and/or appropriate privileges. In addition, to ensure the current clinical privileges and proctoring requirements for all Medical Staff members are available to the nursing units and hospital departments.

B. **POLICY:**

1. Personnel responsible for scheduling admissions are responsible for verifying the admitting physician has been appointed to the Medical Staff with admitting privileges or has been granted temporary admitting privileges.
2. If a request for admission is made by a physician without Medical Staff privileges, admission of the patient must be denied. If the physician still wishes to hospitalize the patient, personnel should recommend patient care be transferred to a physician who has Medical Staff admitting privileges.
3. Personnel responsible for scheduling surgery shall verify the surgeon, anesthesiologist and/or surgical assistant(s) has privileges to perform the designated procedure(s), and whether proctoring is required. If the practitioner does not have privileges to perform the procedure(s), personnel shall not schedule the procedure and shall follow his/her department process for follow up. If proctoring is required, personnel shall obtain the name of the proctor from the practitioner.
4. Personnel in charge of the labor & delivery **(including operating rooms), main** operating rooms, nursery, various treatment rooms or any area where special procedures or treatment shall be carried out, are responsible for verifying the practitioner has the specific privilege(s) to perform the requested procedure(s), and whether proctoring is required. If the practitioner does not have privileges to perform the procedure(s), personnel shall not allow the procedure to be performed and shall follow his/her department process for follow up. If proctoring is required, personnel shall obtain the name of the proctor from the practitioner.
5. The Manager of Medical Staff Office and Manager of Risk shall be notified immediately of any incident involving a practitioner performing a procedure for which he/she has no privileges including a description of the circumstances surrounding the incident.

6. Privileges to admit or perform the procedure(s) shall be verified on the Tri-City Medical Center Intranet as follows.
   a. Log onto Tri-City Intranet
   b. Click on Essentials
   c. Click on Applications & Resources
   d. Click on E-PRIV
   e. Select search criteria (either "Search by Name" or "Search by Specialty")
   f. Click on appropriate practitioner to view privileges
7. In the event the TCMC Intranet is not accessible, the unit/department requiring information regarding a practitioner's privileges shall contact the Medical Staff Office.
8. The Medical Staff Office maintains a current hardcopy of each practitioner's privileges, including proctoring status.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**STROKE CODE, IN-HOUSE**
Purpose:	To outline the procedure for prompt recognition and interventions for a patient with signs and symptoms of stroke or worsening stroke
Supportive Data:	Rapid response is critical for a prompt diagnosis and appropriate intervention.
Equipment:	Stroke Admission Packet

A. POLICY:

1. The primary Registered Nurse (RN) shall call the Rapid Response Team (RRT) if a patient is experiencing new or worsening "stroke-like" symptoms and will obtain a blood glucose level via point of care blood glucose meter prior to RRT arrival.
2. The RRT will do a patient assessment with the National Institute of Health Stroke Scale (NIHSS) detailed stroke scale assessment on the patient when they arrive on the unit.
3. The RRT will initiate the in-house stroke code by dialing 66 from the patient's room and inform the Public Branch Exchange (PBX) operator that there is an in-house stroke code on the unit and will give the patient's room number.
4. The RRT or designee will order the In House Stroke Code power plan
5. PBX Operator:
   a. The operator shall call a stroke code overhead and will page the Stroke Team which consists of the following staff members:
      i. ~~Computerized~~ **Computed Tomography** technologist
      ii. Lab phlebotomist
      iii. Stroke coordinator
      iv. Radiology technologist
6. The primary nurse or designee will contact the on call hospitalist at (760) 966-2499 and inform the hospitalist of the in-house stroke code.
7. The hospitalist will come assess the patient and if the hospitalist agrees with the stroke code, the hospitalist will contact the neurologist on call at (760)940-3002
   a. The Stroke Code will continue unless cancelled by the hospitalist on call.
   b. If the hospitalist does not arrive to assess the patient in a timely manner, the RRT will page the neurologist and continue on with the stroke code.
      i. RRT to give the on call Neurologist the patient's NIHSS score and patient assessment details so the neurologist can verify the stroke code is appropriate and any further orders.
8. The RRT and/or Stroke Coordinator serve as the team leader:
   a. Evaluates timeline (time from symptom onset to intravenous thrombolytic administration should be less than 4.5 hours). Determines eligibility for thrombolytics in collaboration with Neurologist
   b. Performs patient NIHSS and patient assessment
   c. Orders necessary tests/labs –
      i. In House stroke code order set which includes:
         1) STAT ~~Computerized~~ **(Computed** Tomography) ~~(~~CT~~)~~ ~~Stroke Code without Contrast, CT Stroke Code Angio COW (Circle of WILLIS), and CT Angio Carotid~~**Brain/Head Stroke Alert and CT Angio Brain and Neck.**
            a) No need to wait for creatinine level or GFR prior to scans
         2) Prothrombin Time (PT), Partial Thromboplastin Time (PTT), International Normalized Ratio (INR), Chemical Panel (Chem 12) and Complete Blood Count (CBC)
   d. Discusses possible treatment options that may be ordered by physician with patient/family

Department Review	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Division of Neurology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
8/15	05/14, 9/15, 05/17, 08/21	05/14, 09/15, 05/17, 10/21	11/14, 04/18	n/a	11/14, 05/18, 01/22	02/22	01/15, 06/18, n/a	01/15, 06/18

e. Accompanies monitored patient to CT scanner as indicated by acuity
f. Administers thrombolytic agent if ordered
g. Monitors for signs/symptoms of bleeding, neurologic deterioration, changes in vital signs

9. The Neurologist shall collaborate with RRT and the attending physician when available during the stroke code.
10. Primary nursing:
    a. Administers supplemental oxygen as ordered
    b. Assesses vital signs
    c. Monitors cardiac ~~rhythm~~**rhythm** (in monitored areas) and pulse oximetry
    d. Ensures intravenous (IV) access (prefer 18-20 g in antecubital or forearm)
    e. Considers/secures second IV as indicated for thrombolytic administration
    f. Administer thrombolytics as ordered
11. Lab Phlebotomist:
    a. Draws stat blood tests as ordered, draws PT/INR, PTT, Chem 12 and CBC
    b. Immediately delivers to lab and hands off to technologist
12. Laboratory technologist:
    a. Performs testing
        i. If specimen hemolyzes, immediately initiate redraw. Notify RRT 760-802-3727 or physician of delay.
    b. Call results directly to the RRT (760)802-3727, and document the communication in Cerner.
        i. Time from order to communication of results should be less than 45 minutes
13. Pharmacist:
    ~~a. RRT or designee will notify pharmacy of possible tPA candidate~~
    ~~b. Pharmacy will verify inclusion/exclusion criteria and weight while awaiting tPA orders from Neurologist~~
    ~~c. When tPA ordered pharmacy will prepare and send tPA to RRT RN~~
    ~~d.~~**a. RRT or designee will notify pharmacy at extension ~~X~~3012 possible tPA candidate, Pharmacy then contacts ICU/ED Pharmacist based on their shift and availability.**
    ~~e.~~**b. Pharmacy will verify inclusion/exclusion criteria and weight while awaiting tPA orders from the Neurologist.**
    ~~f.~~**c. Pharmacist to contact the provider as soon as possible to clarify any exclusions.**
    ~~14.~~**d. When tPA is ordered, pharmacy will prepare and send tPA to RRT RN**
    e. In case of emergency, the stroke team will override tPA from Emergency Department's ADC and mix it based on Tri-City Medical Center (TCMC) policy and procedure.
~~15.~~**14.** Assigned radiology transporter:
    a. Transports patient to CT scanner
~~16.~~**15.** Radiology technologist:
    a. Verifies with RN that Stroke Code notification was received.
    b. Prepares the CT scanner for emergent head CT as per imaging protocol
    c. Performs the CT.
        i. Time from order to completion of test should be less than 25 minutes for patients eligible for thrombolysis.
    d. CT alerts Radiologist to stroke code
~~17.~~**16.** Radiologist:
17. **a.** Reads CT immediately and contacts the on-call neurologist with results: (Time from completion of test to communication with Neurologist should be less than 20 minutes for patients eligible for thrombolysis.)
18. **Care of the patients eligible for thrombolytics per physician orders:**
    a. Continuous cardiac monitoring
    b. Place second peripheral IV.
    c. Monitor blood pressure every~~Q~~ 15 minutes.

i. **Acceptable blood pressure obtained prior to administration of tPA is a systolic blood pressure less than (<) 185 and diastolic blood pressure of less than (<) 110.**

d. **If patient is eligible for tPA treatment informed consent will be obtained by the Neurologist.**
   i. **Signed consent is not required for administration of tPA.**

19. **Administer tPA per physician order:**
   a. **Recommended TOTAL dose of tPA is 0.9 mg/kg, not to exceed 90 mg.**
   b. **Reconstitute and administer tPA as follows:**
      i. **Reconstitute tPA with 100 mL of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.**
      ii. **With a second Registered Nurse, verify the weight based dose of tPA.**
      iii. **Remove from the vial any quantity drug in excess of that specified for patient treatment**
      iv. **Withdraw the bolus amount (bolus dose is 10% of total dose) and administer IVP over 1 minute.**
      v. **Program the infusion pump to deliver the remaining dose over 60 minutes.**
      vi. **Once the chamber is near empty, hang 50 ml normal saline and infuse at the same rate to ensure the patient receives the complete dose.**

20. **Monitoring During and Post Thrombolytic Administration:**
   a. **Continuous cardiac monitoring.**
   b. **Monitor blood pressure:**
      i. **Every 15 minutes for 2 hours**
      ii. **Then every 30 minutes for 6 hours**
      iii. **Then every 1 hour for 16 hours.**
      iv. **Notify Physician immediately for systolic blood pressure greater than (>) 180 and/or diastolic blood pressure greater than (>) 105.**
   c. **Monitor neurological status every:**
      i. **15 minutes for 2 hours**
      ii. **Then every 30 minutes for 6 hours**
      iii. **Then every 1 hour for 16 hours.**
      iv. **Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria.**
      v. **If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify Physician immediately.**
      vi. **Monitor temperature and maintain normothermia.**
      ~~i.~~vii. **Monitor blood sugar and maintain euglycemia.**

~~18.~~21. The ~~(ANM) Assistant~~ Nursinge LeaderManager/designee shall assist RRT to assure patient is placed on the appropriate nursing unit.
   a. Patients receiving tPA shall be assigned to a bed in the Intensive Care Unit (ICU)
   b. All other patients, are assigned based on acuity or physicians order, to 4P or Telemetry
   c. Whenever possible patients must be in the monitored/camera beds on 4P

~~19.~~22. Post-Stroke Code Care; per ~~CPOE~~ Stroke Care Set (unless superseded by physician orders):
   a. Continuous cardio respiratory monitoring
   b. Blood pressure recording
   c. Monitor temperature
   d. Monitor neurological status: NIH Stroke Scale and neuro checks
   e. Monitor peripheral circulation and end-organ perfusion (skin temperature, capillary refill, peripheral pulses, and urinary output).
   f. Monitor for signs of bleeding or other complications if tPA administered.
   g. Maintain two (2) intravenous lines (if tPA administered).

h. Monitor blood studies.
i. Measure intake and output

~~20.~~**23.** Documentation:

a. RRT shall document events in the patient's medical record. (NOTE: Obtaining CT scan and labs have highest priority and should not be delayed unless absolutely necessary for patient safety.)

C. RELATED DOCUMENT(S):

1. Stroke Code; In-House Algorithm

D. REFERENCES:

1. **Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association Powers, WJ, Rabinstein AA, Ackerson, T, Adeoye, OM et al. Originally published30 Oct 2019Stroke. 2019;50:e344–e418**~~Guidelines for Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association /American Stroke Association. 2018:49e46-e99;44:870-947~~
2. Scientific Rationale for the Inclusion and Exclusion Criteria for Intravenous Alteplase in Acute Ischemic Stroke. Stroke 2016;47:581-641

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/14

SUBJECT: **Transferring and Receiving Patients from Outside Tri-City Medical Center (TCMC)**

REVISION DATE(S): 06/14, 01/18

Patient Care Services Content Expert Approval:	**~~08/17~~09/21**
Clinical Policies & Procedures Committee Approval:	**~~04/18~~11/21**
Nursinge Leadership ~~Executive Committee~~ Approval:	**~~04/18~~01/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/18~~01/22**
Administration Approval:	**~~10/18~~02/22**
Professional Affairs Committee Approval:	**~~10/18~~ n/a**
Board of Directors Approval:	**11/18**

A. **PURPOSE:**
   1. To ensure safe and appropriate inter-facility patient transfers.

B. **POLICY:**
   1. Patient safety, infection control, and requests shall be considered in all transfer decisions.
   2. Inter-facility transfers are indicated when continuing medical care provided by other medical facilities or alternate acute care facilities are required.
   3. An inter-facility transfer requires a physician order and an accepting physician **at the receiving facility**.
      a. Skilled Nursing Facilities (SNF) may designate a staff physician.
         i. The Case Manager or Administrative Supervisor shall coordinate Inter-facility transfers to acute care hospitals, or intermediate care facilities.
         ii. The Social Worker or Case Manager shall coordinate transfers to assisted living or board and care facilities, and SNF.

C. **PROCEDURE FOR TRANSFERRING PATIENTS OUTSIDE TCMC:**
   1. The attending physician communicates with a physician at the receiving acute care facility and documents the acceptance of the patient by that physician.
   2. The attending physician completes discharge orders and appropriate orders for medications and treatments for transfer to any facility.
   3. The attending physician dictates a transfer summary with all appropriate information about the patient's course in the hospital, including but not limited to diagnosis, medications, treatments, dietary requirement, rehabilitation potential, known allergies and treatment plan, and the summary shall be signed by the physician.
      a. A copy of the summary shall be sent with the patient.
         i. If the summary is not available at time of discharge, copies of physician orders must accompany the patient.
   4. The RN shall contact the receiving facility and provide hand-off communication.
   5. The Inter-Facility Transfer Form shall be completed by the primary nurse.
   6. Copies of orders, medical summary, progress notes, MAR, therapy notes, lab and radiology reports may accompany the patient as requested by the receiving facility.
   7. The unit secretary/designee shall arrange transportation.

8. The patient agrees to transfer.
9. Patients' families may transfer a child from the ED to a children's hospital via personal vehicle under these conditions:
    a. Parents/legal guardian agree
    b. Risks and benefits are explained and documented
    c. ED physician determines the patient is stable for transfer by privately owned vehicle (POV)
        i. Patient may be transported with Physician order by POV with intravenous (IV) access in place and appropriate dressing, with instructions to go directly to children's hospital.
        ii. Patient cannot be transported by POV if they have received IV pain medication with the last 20 minutes
    d. Directions have been provided and the parents/responsible party reiterates understanding
    e. Children's hospital is in agreement
10. The healthcare provider shall attempt to notify the patient's spouse/family/significant other of transfer arrangements and scheduled departure time.
    a. Document notification/attempt in the electronic health record.
11. The primary nurse shall ensure all patients personal belongings are either transported with the patient or given to spouse/family/significant other see Patient Care Services Policy: Patient Valuables Liability and Control.
12. The transferring physician shall verify that the primary physician has been notified of the transfer.

D. **PROCEDURE FOR RECEIVING PATIENTS FROM OUTSIDE FACILITIES**:

1. All incoming transfer requests must be processed through the Administrative Supervisor (at phone number 760-644-6968).
    a. Requests for ST-segment elevation myocardial infarction (STEMI) admissions will be received by the Mobile Intensive Care Nurse (MICN) via the dedicated phone line in the radio room.
    b. For Women's and Newborn Services (WNS), admission requests are processed through the WNCS charge nurse.
    c. For NICU see NICU Transfer of Neonates and Infants Policy.
2. Upon receipt of transfer request, the Administrative Supervisor (AS) shall:
    a. Enter request into the bed tracking system under Transfer Services.
        i. Once physician accepts the transfer, a bed request is sent to bed board for placement.
        ii. Once bed is assigned a communication notice to registration is to be sent by the AS or Unit Secretary of unit.
    b. Assess bed and resource capabilities.
        i. Transfers may not be accepted if TCHD does not have the capability or capacity to accept patients.
            1) Document reason TCHD is unable to accept transfer in the bed board tracking system.
        ii. Verify insurance information by sending face sheet from sending facility to Registration to verify insurance. All transfer must meet TCHD's insurance eligibility criteria.
    c. Inform transferring facility/physician they must:
        i. Contact the accepting physician regarding patient's transfer to TCHD.
        ii. Provide face sheet including insurance information, and history and physical if available.
    d. Contact appropriate accepting physician to confirm acceptance of incoming patient transfer including:

i. Name of facility/physician requesting transfer
ii. Direct phone number of requesting facility/physician
iii. Description of patient
iv. Reason for transfer
v. If unable to determine which physician to contact, contact AS for guidance.

e. The AS/ shall obtain an admit level of care/service from the accepting physician.
i. If accepting physician denies transfer, request reason for transfer denial and document in the bed board tracking system.

3. TCHD ED physicians are available as a resource to help with the incoming transfer request process.

E. SPECIAL CONSIDERATIONS FOR CCS ELIGIBLE PATIENTS:

1. Definitions
   a. Pediatric Intensive Care Unit (PICU): A PICU is a unit within a California Children's Services (CCS) approved Tertiary or Pediatric Community Hospital that has the capability of providing definitive care for a wide range of complex, progressive, rapidly changing, medical, surgical and traumatic disorders, requiring a multidisciplinary approach to care for patients between 37 weeks gestation and/or two **(2)** kilograms (kg) and those under 21 years of age who meet CCS medical eligibility criteria.
   b. Tertiary Hospital: For the purpose of CCS, a tertiary hospital is a referral hospital providing comprehensive, multidisciplinary, regionalized pediatric care to children from birth up to 21 years of age which includes the provision of a full range of medical and surgical care for severely ill children, pediatric residency training with 24-hour CCS-paneled pediatrician coverage, an organized pediatric research program, and community outreach.
2. Criteria for transfer of persons up to the age of 21 or younger include, but are not limited to:
   a. Depressed or deteriorating neurologic status
   b. Severe respiratory distress responding inadequately to treatment and accompanied by cyanosis, retractions, apnea, stridor, grunting/ grasping respirations, status asthmaticus, and/or respiratory failure
   c. Children requiring endotracheal intubation and/or ventilatory support
   d. Serious cardiac rhythm disturbances
   e. Heart Failure
   f. Status post cardiopulmonary arrest
   g. Shock
   h. Severe hypothermia or hyperthermia
   i. Hepatic failure
   j. Near drowning
   k. Severe dehydration
   l. Severe metabolic disturbances
   m. Severe electrolyte imbalances
   n. Exposure or ingestion to a toxic substance
   o. Status epilepticus
   p. Services not provided at Tri-City Healthcare District (TCHD)
   q. Acute Trauma
   r. Any condition likely to require pediatric specialty intervention/assistance during hospitalization.
3. CCS-eligible clients who should be transferred to a CCS-approved tertiary hospital or CCS-approved PICU if the CCS-eligible client has:
   a. Acute hepatic failure OR
   b. Immediate dialysis requirements because of renal failure.
   c. See NICU Policy: Transfer of Neonates And Infants.

4. For CCS eligible inpatients, the medical care of patients between 14 and 21 years of age, shall be under the direction of a CCS-paneled physician appropriate for the medical condition. Adolescents 14 up to 21 years of age with the following conditions will be transferred to facilities meeting CCS Standards for Special Care Centers for further diagnostic work-up, treatment services and/or follow-up care as indicated. The conditions include:
   a. Complex congenital heart disease
   b. Inherited metabolic disorders
   c. Chronic renal disease
   d. Chronic lung disease
   e. Malignant neoplasm
   f. Hemophilia
   g. Hemoglobinopathies
   h. Craniofacial anomalies
   i. Myelomeningocele
   j. Endocrine disorders
   k. Immunologic and infectious disorders including HIV infection
5. Upon receipt of a physician order to facilitate a patient transfer to tertiary care facility, the Case Manager or Administrative Supervisor (after hours) will contact that facility's "Transfer Center" to initiate the transfer request.

F. **RELATED DOCUMENT(S):**
1. NICU Policy: Transfer of Neonates and Infants
2. Patient Care Services Policy: Patient Valuables Liability and Control

Tri-City Medical Center	Patient Care Services~~Emergency~~
PROCEDURE:	**~~VIDEO LARYNGOSCOPE SET-UP & CLEANING~~**
Purpose:	~~To establish a standard of care when setting up~~
Supportive Data:	~~The video laryngoscope is an instrument used b~~ ~~standard to difficult intubations. The video laryn~~ ~~of the vocal cords through the use of advanced~~ ~~sterile product that is reusable and requires proper cleaning between patients.~~
Equipment:	~~Video laryngoscope system and the Steris sterilizer machine (located in the Operating Room).~~

DELETE – follow manufacturer's instructions for use

A. ~~**INDICATIONS FOR USE:**~~

1. ~~Physicians may request the Video Laryngoscope for any intubation.~~

B. ~~**SET-UP:**~~

1. ~~See manufacturer's recommendation for the video laryngoscope system.~~

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

~~After the procedure is completed:~~

~~**Remove disposable blade from cable and disgard blade.**~~

~~**Wipe cable and machine with hospital approved cleansing wipe.**~~

~~**Drape machine with plastic and place "clean" sticker on plastic.**~~

~~**Spray soiled stylet at bedside and place in dirty instrument bin.**~~

1. ~~**Transport soiled stylet in dirty instrument bin to the Sterile Processing Department.**~~

a. ~~Remove the video laryngoscope handle (including cable if applicable) from the monitor.~~

b. ~~Ensure the video laryngoscope has the rubber protective cap inserted thoroughly into the handle port, if applicable, prior to any cleaning being done to prevent damage to the electronic connector~~

c. ~~Transport the used video laryngoscope handle to the Sterile Processing Department (SPD) in a closed biohazard container with a patient label on the outside of the container~~

i. ~~The scope is usually ready for pick-up within one hour.~~

ii. ~~Surgical Services will clean the video laryngoscope, and cord if attached, in the department.~~

d. ~~Wipe down the video laryngoscope monitor with a hospital approved cleansing wipe.~~

Department Review	Clinical Policies & Procedure	Nursinge Leadership ~~Executive Committee~~	Infection Control Committee	Pharmacy and Therapeutics	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
1/06; 02/11; 10/14, **10/20**	11/16, **12/20**	01/17, **08/21**	**04/17, 11/21**	n/a	01/15, 05/17, **01/22**	**02/22**	**06/17, n/a**	06/17

Tri-City Medical Center
Oceanside, California

Administrative Policy Manual
District Operations

ISSUE DATE: 09/96

SUBJECT: Charity Care, Uncompensated Care, Community Service

REVISION DATE: 08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15, ~~9/20~~06/17

POLICY NUMBER: 8610-285

Administrative Content Expert Approval Approval:	~~03/17~~06/21
Administrative Policies and Procedures Committee Approval:	~~04/17~~08/21
Finance, Operations and Planning Committee Approval:	~~06/17~~12/21
Administrative Approval:	02/22
Board of Directors Approval:	06/17

A. **PURPOSE:**

1. The Hospital desires to have a clear, well-communicated and documented financial assistance policy consistent with its mission and values, and in compliance with government accounting standards, Federal and State regulations.
2. California acute care Hospitals must comply with Health & Safety Code Section 127400 et. seq. hereinafter referred to as the California Fair Pricing Law, including requirements for written policies providing discounts and charity care to financially-qualified patients. This policy is intended to exceed the legal requirements detailed in the California Fair Pricing Law.

B. **POLICY:**

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual, orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.
4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by or for the patient, will be confidential and the dignity of the patient will be maintained during this process.
5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage garnishments or a lien on the patient's primary residence if the patient or the patient's legal representative are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.
6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital

7. All collection agencies working on behalf of the Hospital shall comply with the California Fair Pricing Law.
8. Without the completion of an application for financial assistance, the Hospital, at its discretion, may approve financial assistance outside the scope of this policy. Discretionary full or partial charity write-offs include, but are not limited to, a history of non-payment on the patient account balance, where referral to an outside collection agency would not result in a payment on the patient account, the social situation of the patient, and patients/guarantors who cannot be located

C. DEFINITIONS AND ELIGIBILITY:

1. Charity – Financial assistance to qualifying insured and uninsured patients, in whole or in part, to relieve them of their financial obligation for health care services. For individuals who meet the Hospital's charity criteria, charity care results from the Hospital's mission to provide free health care services. Charity care is measured based on revenue forgone, at full established rates. Charity care does not include contractual write-offs, courtesy discounts, prompt pay discounts, employee discounts, or friends and family discounts.
2. Charity care does not include bad debt resulting from a patient's unwillingness to pay or from a failure to meet the definitions in this financial assistance policy.
3. Definitions of Charity include:
   a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost. All charges are eligible for consideration under the Hospital's definition of High Medical Cost.
   b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
   c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
   d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
   e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
      i. Bankruptcy,
      ii. Patient without a residential address (homeless), or reasonable efforts are made to locate and contact the patient, and such attempts have been unsuccessful,
      iii. Deceased patients without an estate,
      iv. MediCal/Medicaid denials – patients who are eligible for MediCal/Medicaid are also presumed to qualify for full charity care. This definition includes patient's whose MediCal/Medicaid coverage is limited or restricted, TAR denials, medical necessity denials, billing denials (i.e. untimely filing)
      v. Charges for days exceeding a length-of-stay limit for patients enrolled in MediCal/Medicaid or other state or county indigent care programs,
      vi. Non-covered services for MediCal/Medicaid eligible patients,
      vii. The patient has coverage from an entity that does not have a contractual relationship with the provider; this would include Medicaid out of state patients, or situations where the insurance carrier is not under contract with the Hospital and denies the claim.
   f. Patient Obligations for deductible and coinsurance amounts, non-covered services, or services provided to a patient where the patient's benefits are exhausted, where the insured patient qualifies for full or partial charity care are included in the definition of charity care.

~~1. Charity – Health services for which the Hospital policies determine the patient is unable to pay. Charity care results from the Hospital's policy to provide health care services free of charge, or in circumstances where the patient has insurance, the self-pay balance free of charge to individuals who meet the hospital's charity criteria. Charity care is measured on the basis of revenue forgone, at full established rates. Charity care does not include contractual write-offs.~~

~~Definitions of Charity include:~~

~~a. Catastrophic Charity Care – 100% write-off of the patient's liability for a patient with High Medical Cost.~~

~~b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.~~

~~c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.~~

~~d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.~~

~~e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:~~

~~i. Bankruptcy – patients who are in bankruptcy for self-pay balances.~~

~~ii. Homeless patients – reasonable efforts have been made to locate and contact the patient and such efforts have been unsuccessful.~~

~~iii. Deceased patients without an estate.~~

~~iv. MediCal/Medicaid denials – patients who qualify for MediCal/Medicaid are also presumed to qualify for full charity care. This includes patient's whose MediCal/Medicaid coverage is limited or restricted. This does not include Share of Cost (SOC) amounts. SOC amounts must be paid by the patient before the patient is eligible for MediCal/Medicaid.~~

~~1.~~4. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

~~2.~~5. High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or reached a lifetime limit, non-covered relating to services not medically necessary) High medical costs means:

a. Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceeds 10 percent of the patient's family income in the prior 12 months.

b. Annual out-of-pocket medical expenses by the patient that exceeds 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

~~3.~~6. Patient's Family and Determination of Family Income – For persons 18 years of age and older: Spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.

~~4.~~7. Reasonable payment formula - monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.

a. "Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

~~5.~~8. **Self-pay discount – discounts are provided to uninsured patients or to insured patients where the payer does not cover the services provided, or where the insured patient has exhausted their benefits. The discount provided to uninsured patients is the difference between the charges and 125% of the Medicare reimbursement. This excludes self-pay discounts for OB services, which are based upon the type of delivery and the length of stay**

D. **PROCEDURES:**

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to

i. pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels:

Income Level	Discount Amount
Up to 350% of FPL	100% Discount
351% to 500% FPL	75% Discount
Over 500% of FPL	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

b. All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Patient Financial Assessment Form (PFAF). If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre- arranged with the Hospital financial counselor. Charity determinations over $25,000 require the approval of the Chief Financial Officer or his/her designee.

c. All patients with a self -pay balance of $25 or less and an age of greater than 120 days will be written off to charity.

2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a PFAF should be completed.
   a. Family Members – Patient will be required to provide the number of family members in their household.
   b. Income Calculation – Patient will be required to provide their household's yearly gross income. Adult patient's yearly income on the PFAF means the sum of the total yearly gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the PFAF means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.
   c. Income verification – Patients will be required to verify the income set forth in the PFAF. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.
   d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:
      i. Expired patients: Expired patients may be deemed to have no income.
      ii. Written Attestation: Patient can sign the PFAF attesting to the accuracy of the income information provided.
      iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.
3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patients will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.
4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient who is eligible for partial charity to pay over an extended period of time. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" formula to determine the payment plan.

5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or County-funded health coverage program.
6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.
7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt that the external agency will adhere to the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. **NOTICE:**

1. Timeframe - There is no rigid limit on the time when the charity determination will be made. In some cases, a patient eligible for charity care may not be identified prior to the initiation of external collection action. The Hospital's collection agencies shall be made aware of this procedure so that the agencies know to refer back to the Hospital patient accounts that may be eligible for charity care.
2. Once a full or partial charity determination has been made, a written notification will be sent to the applicant advising them of the Hospital's decision.

F. **COMMUNICATION:**

1. Information provided to patient – During registration, or as soon thereafter as practicable, the Hospital shall provide:
   a. All uninsured patients with written information regarding the Hospital's charity care policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.
   b. At the request of the patient, the Charity application will be provided.
   c. Patient statements to patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or County- funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications. Further, this information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, to the extent possible, these communications will be in the primary language of the patient.
   d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physicians. The statement will include contact information for the emergency room physician who treated the patient.
2. Postings and Other Notices – Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

G. **FORMS/RELATED DOCUMENTS:**

1. Patient Financial Assessment Form - Sample

H. **REFERENCE:**

1. California Health and Safety Code, Section 127400, et. Seq
2. ACA provisions, IRC §501(r)

Patient Financial Assessment Form - Sample

PATIENT FINANCIAL ASSESSMENT REQUEST FORM

Tri-City Medical Center

Date:_____

PATIENT NAME: LAST	FIRST	MIDDLE
PATIENT ADDRESS:		MEDICAL RECORD #
CITY, STATE & ZIP	PATIENT SOCIAL SECURITY #	FAMILY SIZE (REQUIRED)
MAIDEN NAME OR OTHER:		PHONE #: ( )
NEXT OF KIN NAME:	PHONE #: ( )	WORK PHONE ( )
EMERGENCY PHONE	PATIENT DOB	CELL PHONE: # ( )

RESPONSIBLE PARTY		SPOUSE	
NAME	OCCUPATION	NAME	OCCUPATION
EMPLOYER (IF SELF EMPLOYED DESCRIBE)	SOCIAL SECURITY #	EMPLOYER (IF SELF EMPLOYED DESCRIBE)	SOCIAL SECURITY #
ADDRESS		ADDRESS	
SUPERVISOR NAME		SUPERVISOR NAME	
PHONE	YEARS	PHONE	YEARS
INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY		INCOME (REQUIRED) $_____ ☐ HOURLY ☐ BIWEEKLY ☐ MONTHLY	

ASSETS		LIABILITIES	
CASH ON HAND	$_____	REAL ESTATE PAYMENTS	$_____
CHECKING ACCOUNT	$_____	INSURANCE PREMIUMS (AUTO/MED/HOME)	$_____
SAVINGS ACCOUNT	$_____	TAXES	$_____
CREDIT UNION ACCOUNT	$_____	UTILITIES	$_____
PROPERTY OWNED VALUE	$_____	AUTO PAYMENTS	$_____
MOTOR VEHICLES OWNED	$_____	FOOD	$_____
MAKE: _____	YEAR _____	HOUSE PAYMENT IF RENTING	$_____
MAKE: _____	YEAR _____	OTHER LIABILITIES: (ATTACH SEPARATE SHEET IF NECESSARY)	
HOME OWNER ESTIMATED VALUE	$_____	DESCRIBE / PAYMENT / BALANCE	
OTHER SOURCES/ (STOCK BONDS)	$_____		

BANK BRANCH(S) & ACCOUNT NUMBERS

I/WE HEREBY DECLARE THE FOREGOING TO BE TRUE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA.

_____ SIGNATURE(S) _____ DATE

FOR PA USE ONLY

350% FPL_____ APPROVED: ☐ YES ☐ NO BY WHOM: _____

IF PARTIAL AMOUNT: $_____

Rev (2/10)

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 07/92

SUBJECT: Prior Authorizations for Non-Emergency Services for HMO/PPO Patients

REVISION DATE(S): 07/94, 06/01, 10/05, 11/08, 09/10, 01/11, 02/15, 02/18

POLICY NUMBER: 8610-213

Administrative Content Expert Approval~~Department Review~~:	~~01/18~~07/21
Administrative Policies & Procedures Committee Approval:	~~01/18~~08/21
Finance & Operations Committee Approval:	~~02/18~~12/21
Administrative Approval:	02/22
Board of Directors Approval:	02/18

A. **PURPOSE:**

1. To set forth guidelines to ensure Tri-City Healthcare District's (TCHD) control and compliance with the utilization policies of Health Maintenance Organization (HMO) and Preferred Provider Organization (PPO) payers and to reduce the number of denied services due to the lack of required authorization.
2. It is the intention of this policy to ensure prior-authorization is received from all payers for all services performed at TCHD.

B. **PROCEDURE:**

1. The Director or designee of each department that schedules non-emergency services which require prior authorization from either the HMO/PPO or physician groups will ensure that said services shall not be scheduled prior to receipt of an authorization number either by telephone, fax, or mail.
    a. In the event that a physician, physician's office, patient, patient's family, HMO/PPO staff or any other party or agent requests to be scheduled for a service that requires prior authorization but cannot provide the authorization number, he/she shall be referred to the referral specialist's office or to the patient's primary care physician.
        i. If a patient who presents for a scheduled service and TCHD does not have a record of the required authorization number, then the patient's service will be postponed until said authorization is obtained.
        ii. The Access Management Manager, Supervisor or designee will phone physician's office to inform them of the information.
        iii. The Patient Access Director/Manager or designee can approve the scheduling of a procedure with a pending authorization based on patient's condition and service.

C. **CLARIFICATION:**

1. For clarification of this policy, contact the TCHD's Main Registration, extension 3151.

Tri-City Medical Center
Oceanside, California

ENGINEERING
INFECTION CONTROL

SUBJECT: **Managing Biological Agents to Prevent Waterborne Illness**

ISSUE DATE: 04/16
REVIEW DATE(~~S~~):
REVISION DATE(~~S~~):

Department Approval ~~Date(s)~~:	~~08/15,~~ 03/20
Environmental Health and Safety Committee Approval ~~Date(s)~~:	~~10/15,~~ 04/20
Infection Control Committee Approval ~~Date(s)~~:	~~03/16~~11/21
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	02/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/16~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/16

A. **POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) Engineering Department to maintain~~,~~ and treat ~~and test~~ open water ~~and potable water~~ systems to minimize pathogenic biological agents.

B. **PURPOSE:**

1. Equipment that operates with water that can be aerosolized (e. g., cooling towers, ~~faucets, showers,~~ fountains, pools, spas) may become contaminated with potentially infectious biological agents even though the equipment is operated within the manufacturer's guidelines. Regular maintenance and cleaning of the equipment and proper treatment of the water will be performed to ensure that the risks of hazards are minimized to the staff, patients and visitors of TCHD.
2. Treatment & General Cleaning
   a. Cooling towers, water display fountains, spas, pools, and other open water systems that can generate aerosols shall have a maintenance program that includes routine cleaning of the water reservoir and piping systems. The maintenance shall be conducted in accordance with the manufacturer's recommendations and appropriate cleaning instructions. When necessary, make up water should be provided from the normal water service system. Open-water systems that have been out of service for an extended period of time shall be thoroughly cleaned before being returned to service.
   b. Systems that generate or utilize aerosolized potable tap water (~~showers, drinking fountains,~~ ice machines~~, tap water faucets~~) shall be properly cleaned and maintained to control the contamination from potentially infectious biological agents if out of service for a period of time. Water storage tanks (hot water systems, reserve storage tanks) that are not continually utilized should be routinely cleaned and decontaminated.
   ~~c. During maintenance and cleaning procedures, the appropriate personnel protection equipment (PPE) shall be worn to prevent exposure to potentially infectious biological agents, such as Legionella, Mycobacterium, and Pseudomonas.~~
3. Treatment
   a. The water treatment program should include the routine application of the appropriate biocide treatment agents designed to eliminate and control biological agents and other contaminates that can accumulate from exposure to the open atmosphere~~. During the application of treatment and cleaning agents, the appropriate PPE shall be worn.~~
4. Documentation

a. Routine maintenance and treatment procedures of open water ~~and potable water~~ systems shall be recorded. Date of service, service and treatment activity~~, and personnel conducting the service~~ shall be recorded **and maintained by the Facilities Department**. ~~Maintenance and cleaning of open water and potable water systems that have been out of service for an extended period of time shall also be documented.~~

5. Preventative Maintenance
   a. ~~In frequencies determined by Director of Engineering or his/her designee A~~a qualified testing agency will be scheduled to perform testing and validation reports to determine the effectiveness of the Water Safety Management Plan **at a minimum of once a year**.
   b. Ice Machines and Cooling Towers are to be maintained per Manufacturer's Recommendations or Alternative Equipment Maintenance program.
   c. -Decorative fountains to be placed on a chemical treatment program or put out of service.
   d. Cooling Towers to be on a continuous chemical treatment program.
   e. Hot Water Tanks and Storage Tanks to be blowdown ~~in frequencies determined by Director of Engineering or his/her designee~~**at a minimum of once a year**.
   f. Disinfect Hot Water Storage Tanks and Cooling Towers ~~in frequencies determined by the Director of Engineering or his/her designee~~**at minimum once a year**.
   ~~g. Disinfect high risk Air Handling Unit Coils and Drain Pans in frequencies as needed determined by use and frequent inspections of the units. the Director of Engineering or his/her designee.~~
   ~~h.~~g. ~~In frequencies determined by Director of Engineering or his/her designee f~~Flush taps in vacant/low use areas **at a minimum of monthly**.
   ~~i.~~h. ~~In frequencies determined by Director of Engineering or his/her designees f~~Flush emergency eyewash and shower stations **at a minimum of bi-weekly**.

~~6. Staff Training~~
   ~~a. Staff members responsible for the water treatment program will be trained regarding proper cleaning and maintenance procedures, and the safe handling and proper application of water treatment and cleaning chemicals. All guidelines for handling hazardous materials and the recommendations for proper use of PPE will be presented.~~

Tri-City Medical Center
Oceanside, California

LABORATORY
~~GEN LAB QA~~LABORATORY GENERAL/QUALITY ASSURANCE

ISSUE DATE: 08/18 **SUBJECT: Individualized Quality Control Plan**

REVISION DATE(S):

Department Approval:	**~~06/18~~10/21**
Laboratory Director Approval:	**~~07/18~~10/21**
Department of Pathology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Professional Affairs Committee Approval:	**n/a**
Administration Approval:	**~~08/18~~02/22**
Board of Directors Approval:	**08/18**

A. **DEFINITION(S):**

1. Individualized Quality Control Plan (IQCP):— a**A** framework for customizing a quality control program for the test systems in each laboratory's unique environment.
2. Risk Assessment (RA)—: T**t**he process of identifying and evaluating the potential failures and errors that could occur during the pre-analytical (before testing), analytical (testing), and post-analytical (after testing) phases of testing.
3. Quality Control Plan (QCP): —d**D**escribes practices, procedures and resources needed by the laboratory to ensure the quality of a testing process. The QCP includes measures to assure the accuracy and reliability of test results, and that the quality of testing is adequate for patient care.
4. Quality Assessment (QA): T—**t**he implementation of policies and procedures to monitor and assess, and when indicated, correct problems identified related to test performance,
5. **California Department of Public Health (CDPH): A licensing and accreditation department for the State of California.**
~~5.~~**6.** College of American Pathologists (CAP): **A**—a member-based physician organization advocating best practices in pathology and laboratory medicine and provides accreditation of laboratories under deemed authority by CMS and CDPH.

B. **POLICY:**

1. **List of Individualized Quality Control Plans:** The laboratory has identified all tests using an IQCP on the **CAP's** List of Individualized Quality Control Plans form.~~ provided by the College of American Pathologists.~~ (COM.50200).
   a. Note: The use of the CAP form is required, even if standardized forms and templates are used by the laboratory. The laboratory is responsible for maintaining the accuracy of the data on the form and for providing a current copy to the inspector during an on-site CAP inspection.
2. **Risk Assessment:** The IQCP for a test, device, or instrument includes a risk assessment to evaluate potential sources of error. The risk assessment should include the following attributes. (COM.50300)
   a. Pre-analytic, analytic, and post-analytic phases of the testing process
   b. Intended medical uses of the test and impact if inaccurate results are reported (clinical risk)
   c. Components of the tests including reagents, environment, specimen, testing personnel, and test system
   d. Variations in the components based on use of the tests (e.g. use in different environments, by different personnel, or multiple identical devices)

e. Data from the laboratory's own environment, instrument/equipment performance, and testing personnel demonstrating acceptable performance over the maximum time interval between external quality control runs defined in the IQCP
f. Manufacturer's instructions and recommendations
g. The process used to identify the sources of potential failures and errors for a test system, and evaluate frequency and impact of those failures and sources of error.

3. **Quality Control Plan Approval:** The IQCP includes a written quality control plan approved by the laboratory director prior to implementation. (COM.50400)
   a. NOTE: The quality control plan may be part of a test procedure or be a separate written plan.
4. **Quality Control Plan Elements:** The IQCP must define all aspects monitored based on the potential errors identified during the risk assessment, including the following parameters as applicable. (COM.50500).
   a. The number, type (external and internal quality control systems), and frequency of quality control
   b. Criteria for acceptable performance
   c. Monitoring of the testing environment and reagents
   d. Specimen quality
   e. Instrument calibration, maintenance, and function checks
   f. Training and competency of testing personnel
   g. Provisions for multiple identical devices and variation for uses covered under one IQCP
5. The components of the quality control plan must meet regulatory and CAP accreditation requirements and be in compliance with the manufacturer instructions, at minimum. The quality control plan must control the quality of the test process and ensure accurate and reliable test results.
6. External control material samples must be analyzed with new lots and shipments of reagents or more frequently if indicated in the manufacturer's instructions.
7. **Ongoing Quality Assessment Monitoring:** Ongoing quality assessment monitoring is performed by the laboratory to ensure that the quality control plan is effective in mitigating the identified risks for the IQCP and includes the following records. (COM.50600)
   a. Review of quality control and instrument/equipment maintenance and function check data at least monthly
   b. Evaluation of errors relating to pre-analytic, analytic and post analytic phases of the testing process
   c. Review of complaints from clinicians and other healthcare providers regarding the quality of testing to confirm the clinical efficacy of testing
   d. Evaluation of corrective actions taken if problems are identified
   e. Re-evaluation of the quality control plan if changes to the reagents, environment, specimen, testing personnel, or test system elements of the risk assessment occur
   f. Re-approval of the quality control plan by the laboratory director or designee at least annually
   g. NOTE: If ongoing assessments identify failures in one or more components of the quality control plan, the laboratory must investigate the cause and consider if modifications are needed to the quality control plan to mitigate potential risk.

C. **PROCEDURE:**

1. Use the Eligibility Determination for Individualized Quality Control Plan (IQCP) Option to determine if the test, device, or instrument is eligible for an IQCP.
2. Complete a risk assessment in accordance with this policy.
3. Develop and document the quality control plan for the test, device, or instrument based upon the risk assessment and in accordance with this policy.
4. Review the IQCP with the laboratory director and obtain approval prior to implementation.
5. Complete ongoing quality assessment monitoring as part of regular quality assurance activities.
6. Document, at least annually, the effectiveness of the IQCP on the Annual Assessment of Individualized Quality Control Plan Form.

D. **FORM(S):**
1. Annual Assessment of Individualized Quality Control Plan Form
2. List of Individualized Quality Control Plans Form

E. **RELATED DOCUMENT(S):**
1. Eligibility Determination for Individualized Quality Control Plan (IQCP) Option

F. **REFERENCES:**
1. Department of Health and Human Services. (2014). Considerations When Deciding to Develop an IQCP [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIAbrochure12.pdf
2. Department of Health and Human Services. (2014). What is an IQCP? [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/CLIAbrochure13.pdf
3. Department of Health and Human Services. (2014). Developing an IQCP - A Step-by-Step Guide [Brochure]. CMS. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/IQCP-Workbook.pdf
4. College of American Pathologists. **(2019).** ~~*Laboratory*~~ *All Common Checklist*. Northfield, IL.~~,~~ ~~2017.~~

Tri-City Medical Center	Laboratory General Quality Assurance
PROCEDURE:	LABORATORY POLICY AND PROCEDURE DOCUMENT CONTROL~~PROCEDURE MANUALS AND TECHNICAL POLICIES, PROCEDURES AND DOCUMENT CONTROL~~
Purpose:	To provide a general overview of the secure document control system used by the Laboratory at Tri-City Medical Center.~~To provide the policy and procedure to comply with the College of American Pathologist accreditation requirements as specified in the Laboratory General Checklist. To describe the process by which all documents in use can be assured to be current, accurate and available.~~

A. **DEFINITIONS:** N/A

B. **POLICY:**

1. Document Control
   a. Tri-City Medical Center Laboratory has a document control system that manage policies, procedures, forms, and related documents that are subject to CAP accreditation. (GEN.20375).

C. **PROCEDURE:**

1. Review all laboratory policies and procedures on a biennial basis. (COM.10100).
   a. The review cycle is tracked via MCN, the hospital-wide document control system.
   b. Designated Content Experts are responsible for updating documents according to their review cycle, integrating updated material from all applicable accrediting bodies.
   c. MCN indefinitely retains all uploaded versions of documents. All versions of these documents are accessible upon request from the Laboratory Accreditation Support Specialist, including retired documents. (COM.10500).
   d. New and substantially revised procedures are reviewed by the Laboratory Director prior to implementation, then biennially after approval. (COM.10200).
2. Maintain required binders at each bench for quick access to policies and procedures.
   a. The Laboratory Accreditation Support Specialist is responsible for maintaining the binders, ensuring that the current version of each policy or procedure is available in the binder.
   b. All laboratory personnel have access to the digital versions of hospital policies, procedures, forms, job aids, manuals, etc., via the online document control system described above.
      i. See MCN Guide for the Laboratory for information on accessing and searching MCN.

~~EFFECTIVE DATE:~~	~~REVIEWED / DATE:~~	~~REVISED:~~	~~PREPARED BY:~~
~~8/22/00~~	~~8/24/06 cs, 8/18/07 cs, 8/13/08 cs~~	~~8/22/00; 9/14/04; 8/27/06;10/19/08~~	
	~~8/13/09 cs, 8/16/10 cs, 8/23/11cs~~	~~11/6/00;10/6/04;11/10/06; 2/12/08~~	~~APPROVED BY:~~
	~~8/27/12 cs, 8/28/13 cs, 8/28/14 cs~~	~~8/13/08; 9/28/10; 6/21/12; 12/4/12~~	
	~~8/23/16 cs,~~	~~8/29/17~~	

Effective Date	Department Review	Department Revision	Laboratory Medical Director	Medical Executive Committee	Administration	Board of Directors
08/90	08/06, 08/07, 08/08, 08/09, 08/10, 08/11, 08/12, 08/13, 08/14, 08/16, 08/18, 08/20	08/90, 09/94, 08/96, 10/98, 11/00, 10/04, 11/06, 02/08, 08/08, 09/10, 06/12, 12/12, 08/17, 0810/21	08/18, 10/21	~~Optional~~ n/a	02/22	

3. Maintain document control log:
   a. The Laboratory Accreditation Support Specialist maintains a secure document control log to track review dates of policies and procedures. The document control log is updated on an ongoing basis and provides an overview of all laboratory documents.
4. Assign documents to personnel via MCN competencies to ensure adequate knowledge of hospital policies and procedures:
   a. Competency assignments are requested through the Laboratory Accreditation Support Specialist.
   b. The Laboratory Accreditation Support Specialist sends out bimonthly notifications as needed to all personnel with pending competencies.
      i. See the MCN Competency Assignment Job Aid
   ~~a.~~c. Records of completed competencies maintained in MCN.
5. Develop new policies, procedures, forms, related documents, job aids, etc., according to approved templates and guidelines.
   a. Templates and guidelines are maintained by the Laboratory Accreditation Support Specialist in cooperation with the Education Department.
   b. Note: templates may not be altered. Do not add or remove header titles from templates.
   c. See the Laboratory Document Development and Maintenance Job Aid

D. FORMS: NA

E. RELATED DOCUMENTS
1. MCN Guide for the Laboratory
2. Laboratory Document Development and Maintenance Job Aid

F. EXTERNAL LINKS: N/A

G. REFERENCES: N/A

~~DOCUMENT CONTROL:~~

~~A document is any recorded item of a factual or informative nature, either paper or electronic. All policies, procedures, forms or materials associated to these policies and procedures are under document control. The Document Control Log is the tool used to identify and establish the review cycle for the documents in use by the lab. The documents are grouped according to manual, lab section and delegated reviewer and lists the date of reviews. The log is reviewed periodically by the leadership team and is on the Lab Shared Drive/Document Control List/Document Control Log/Annual Review by Last Review Date.~~

~~PROCEDURE MANUALS:~~

~~The PROCEDURE MANUAL is the statement of laboratory medical and administrative protocol regarding all test policies and procedures in the Laboratory. It is the reference used to ensure clinical lab scientists and other technical staff perform tests in a standardized manner to prevent errors in protocol or judgment that can jeopardize quality patient care. The manual must be complete and include all tests offered routinely by each section of the Laboratory. It must be easily available at the bench or in the general work area. The manual contains laboratory standards and uniform information concerning specific tests. This information includes policies, test protocol (sampling, reagents, step by step instructions, reporting of results) and a procedure for instrument function checks and preventive maintenance. It must also contain all supporting logs, tables and related forms. Strict adherence to policies and protocol as stated in the procedure manual is mandatory.~~

TECHNICAL PROCEDURES:

Before performing a test, the clinical lab scientist must read and thoroughly understand the procedure. If you do not understand the procedure, or have difficulty performing the test, contact the Technical Specialist or Lead CLS. Do not perform a test unless the procedure is verified and approved by the Laboratory Director. Patient values can only be reported from tests that have written and approved procedures.

Each test performed in the Laboratory must have a written technical procedure verified and approved by the Laboratory Director and by Section Pathologist, if designated by the Laboratory Director. The technical procedure must include explicit information and unequivocal instructions and may be developed by the Lab from the scientific literature or extracted from the manufacturer's product literature, OR a COMBINATION THEREOF. Procedures must meet the approval process prior to implementation.

1. FORMAT

Technical procedures will be written in a standard format established for this institution which are substantially in compliance with CLSI GP2-A5 *"Clinical Laboratory Technical Procedure Manuals" (March 2010)*. Refer to example pages 1 and 2 for proper format.

The use of inserts provided by a manufacturer is not acceptable in place of a procedure manual. However such inserts may be used as part of a procedure description if the insert is written in substantial compliance with CLSI GP2-A5 (2010) and describes the procedure as performed in the laboratory. Any deviation from the printed or electronic procedure must be detailed in the procedure manual.

A manufacturer's procedure manual for an instrument or reagent system that complies CLSI GP2-A5 (2010) may be acceptable as a component of the overall departmental procedures. Any modification to or deviation from the procedure manual must be clearly documented.

A. HEADING - List name of institution in bold face. Next to the name of the institution in bold face is
DISTRIBUTION. List the manual(s) in which the procedure is to be found. The procedure may be located in more than one manual, however all copies must be current.

B. BODY - List each category in caps, bold face and underlined, followed by a colon.

C. SIGNATURE PAGE - The signature page is at the bottom of the first page of the procedure. There are two alternative footers. See FOOTER FORMATS. Beginning at the upper left, place the EFFECTIVE DATE (date the procedure was put on line) followed by the following headings:

1) REVIEWED / DATE: The initials of the person authorized to review the procedure and the
date of the review.

2) REVISED: Maintain a list of the dates the procedure was revised.

3) PREPARED BY: The name of the author and the date prepared.

4) DESIGNEE APPROVED BY: The name of the pathologist for those sections in which a pathologist other than the Laboratory Director is designated to approve procedures. See Footer Format Examples; Format B at the end of this document. If there is no pathologist designee for the laboratory section, this signature box is not required. See Footer Format Examples; Format A at the end of this document

5) APPROVED BY: The name of the Laboratory Director. The Laboratory Director must approve all procedures dated July 11, 2011 and beyond. See Footer Format Examples; Format A at the end of this document.

D. PAGINATION - Using footer on the lower right corner of the page, state the title of the procedure using bold letters. Underneath the title indicate the sequential page number in the form of "PAGE X of Y" where Y is the total pages including the signature page.

2. CATEGORIES

Each technical procedure should address the following set of procedural categories. If an item is not applicable, enter the abbreviation N/A (not applicable) under the category heading or the category may be eliminated. Categories may be addressed in a separate policy or procedure. If so refer to that document. For more detailed explanation of each category, refer to CLSI GP2-A5 (2006) *"Clinical Laboratory Procedure Manuals"*. Other categories may be included such as definitions, tables of contents or special computer instructions.

A. **TITLE:** The title should be concise and descriptive. Use the name of the analyte as the first word. Specify type of specimen and method or instrumentation.

B. **INTRODUCTION/PRINCIPLE:** Includes summarized introduction, type of reactions involved, rationale or clinical significance of ordering the test.

C. **SPECIMEN:** Conditions for patient preparation such as fasting or special restrictive diets; Type of specimen required (serum, plasma, whole blood, timed urine, CSF, etc); Acceptable specimen collection containers (EDTA, heparin, sterile); Stability and storage requirements; special handling or transport instructions (collect on ice, transport to lab within 30 min., separate serum from blood within 1 hour of collection, etc.)

D. **REAGENTS/SUPPLIES:** Reagents, standards, controls, media used, special supplies including the usual supplier or manufacturer. Special precautions associated with chemical or bio-hazard written in bold type and indented. Direction for preparation noting any special equipment, degree of accuracy for measuring. Specify storage requirements including containers, temperature requirements, stability unopened and opened, labeling requirements including special precautions.

E. **INTRUMENTATION/CALIBRATION:** Instrument used; calibration procedure, and calibration frequency.

F. **CONTROLS:** Name of controls to be used; instructions for preparation and handling of controls; frequency of use; tolerance limits and how tolerance limits are to be established; corrective action to be taken if tolerance limits are exceeded; how quality control data are recorded and stored.
NOTE: Some of the above may be referred to as a separate policy or procedure.

G. **PROCEDURE:** Step-by-step detailed instructions using the imperative format. Keep the instruction free of extraneous statements or justifications. Include centrifugation instructions, speed or centrifugal force, length of time and temperature if critical. Specify actions to take in handling hazardous materials such as engineering controls, personal protective equipment, and safe work practices.

H. **CALCULATIONS:** Give stepwise instructions for performing the calculation including the formula and a precise example.

I. **EXPECTED VALUE/REFERENCE RANGE/CRITICAL VALUES:** Include the reference for the range, e.g. manufacturer's recommendation, literature, in-house developed, and the reporting units. Also, critical values requiring special handling, communication, confirmation, verification. This may be referred to as a separate policy or procedure. This section may be contained in a separate document. If so, refer to that document.

J. **TECHNICAL NOTES:** Include miscellaneous procedural note.

K. **LIMITATIONS:** State the linearity or reportable range. Include interfering substances.

L. **REPORTING RESULTS:** Pos or Neg; numerical or free test; reporting in Cerner, rounding off procedure and significant digits, acceptable units reporting units, and any special text codes or free text to include in the final report.

M. **REFERENCES:** When used as a source of information the following publications should be included: Literature References, Manufacturer Product Literature, Textbooks, Standards Publications, Written Personal Communications, and Research. Refer to CLSI GP2-A5 (2010) 5.1.16 for correct citation format

ATTACHMENTS/LINKS: List any forms, quality management records, charts, instrument logs, flow charts and other documents directly associated with the procedure.

Bi-ANNUAL REVIEW AND UPDATE OF PROCEDURES:

1. REVIEW CRITERIA AND PROCEDURE:

Each procedure in the manual must be reviewed by the Laboratory Directory or designee at least every two years. Additional review should take place whenever a change occurs in methodology or instrumentation. Bi-Annual review is documented on the actual procedure itself. (See Documentation of Review.) After a review, the decision must be made if the procedure can be used as written, needs to be revised or is obsolete. If obsolete, the procedure should be taken out of the manual, dated and placed in the quarantined archive file and held for three years, five years for Transfusion Medicine). Archived procedures must contain the initial date of use and the date discontinued or archived.

REVIEW CRITERIA:

Procedures must be reviewed for the following:

A. Conformance to required information and instructions. (See Technical Procedures).

B. Scientific validity and clinical relevance.

C. Conformance to current methodology, i.e., what is currently being done in the Lab.

~~D. Do changes made to the procedure require retyping?~~

~~1) Minor changes can be added to the original so long as they are signed and dated by an authorized person.~~

~~2) Major changes in any section required retyping.~~

~~2. DOCUMENTATION OF REVIEW:~~

~~Each procedure in the manual must be reviewed, initialed and dated by the Laboratory Director, or designee, at least bi-annually during the month the document was previously reviewed or whenever a significant change occurs. The reviewer's initials and date of review should be on the signature page of each procedure (see Footer Format Examples at the end of this document). If there are multiple copies of the manual, they must also carry all documentation.~~

~~3. If the procedure replaces an earlier one, make a note of the date of the revision on the review section.~~

~~4. CHANGE IN DIRECTORSHIP:~~

~~All procedures must be promptly reviewed and re-approved by the new laboratory director if there is a change in directorship.~~

~~DOCUMENT CONTROL: (GEN.20375)~~

~~1. The Document Control Log is the tool used to identify and establish the review cycle for the documents in use by the lab. The documents are grouped according to manual, lab section and designated reviewer and lists the date of reviews. The log is reviewed periodically by the Lab Leadership Team. The log is on the Lab Shared Drive/Document Control List/Document Control Log/Annual Review by Last Review Date.~~

~~2. All staff must read the policies and procedures relevant to their job activities. Documentation is to be kept on the individual's initial orientation form and any subsequent revisions that have significant changes.~~

~~3. New policies and procedures must be reviewed by the staff for whom the policy/procedure applies or who will be expected to perform the procedure. Documentation of the review will be kept on the "Policy / Procedure Review Documentation Form". Any competencies associated with new policies will be recorded and filed in the individual's Competency File for the relevant year.~~

~~4. The Laboratory Director must review and approve all new policies and procedures as well as substantial changes to existing documents, including the Collection Manual, prior to implementation. COM.10200.~~
~~a. Method of Director Approval:~~

- ~~Signature and date.~~
- ~~Electronic signature, access restricted.~~
- ~~At the individual procedure level in the signature box of each procedure.~~

~~b. Substantial changes:~~

- ~~Including, but not limited to, changes in the process that have direct clinical applications.~~

This is to be determined by the Laboratory Director.

5. Policies and procedures must be reviewed at least bi-annually within the month the document was previously reviewed or whenever a significant change occurs. The review must be performed by the laboratory director or designee as noted in DOCUMENTATION OF REVIEW above.

6. Discontinued policies and procedures are kept in a separate quarantined archive file and stored for three years, five years for Transfusion Medicine. All archived policies and procedures must contain the effective date and the date discontinued or archived.

7. All quality management procedures, forms and records as well as the location of all copies of procedures (including derivative documents such as bench copies or summary charts) are maintained under document control and are located in the respective department manuals as attachments or links. (GEN.20375)

REFERENCES:

Clinical and Laboratory Standards Institute. *Laboratory Documents: Development and Control; Approved Guideline 5th Ed.* Approved Guidelines GP2-A5. Vol 26 No. 12 March 2010.

College of American Pathologists. *Laboratory General Checklist.* 01_04_2012. W:\CAP 2012\Checklists 01-04-2012 word\GEN01042012.DOC

ATTACHMENTS:

FOOTER FORMAT EXAMPLES A and B:

Format A: To be used in lab sections that does not have a pathologist designee.

EFFECTIVE DATE:	REVIEWED / DATE:	REVISED:	PREPARED BY:
11/8/88	8/24/07cs, 8/13/08cs, 8/13/09cs	9/18/94; 1/12/03; 10/18/04, 8/24/06	
	8/16/10cs, 8/24/11cs	1/31/08; 7/16/08, 8/6/09, 5/18/12	APPROVED BY:

Format B: To be used in lab sections that does have a pathologist designee and Laboratory Director approval.

~~EFFECTIVE DATE:~~	~~REVIEWED: (Previous Dates, Rev By / Date)~~	~~REVIEWED/REVISED: (Signature / Date)~~	~~PREPARED By / Date:~~
~~8/22/90~~	~~8/24/06 cs, 8/18/07 cs,~~	~~8/22/90,9/14/94;8/27/96;10/19/98~~	
	~~8/13/08 cs, 8/13/09 cs,~~	~~11/6/00,10/6/04, 11/10/06, 2/12/08~~	~~DESIGNEE APPROVAL By / Date:~~
	~~8/16/10 cs, 8/23/11cs,~~	~~8/13/08, 9/28/10, 6/21/12,11/28/12~~	
	~~8/27/12 cs~~		~~DIRECTOR APPROVAL By / Date:~~

Tri-City Medical Center
Oceanside, California

LABORATORY
PATHOLOGY / PATHOLOGIST

ISSUE DATE: **SUBJECT:** **Pathology Staff Professional Competency Policy**

REVISION DATE~~(S)~~: 05/140, 05/16, 05/18

Department Approval ~~Date(s)~~:	**~~05/20~~10/21**
Laboratory Director Approval ~~Date(s):~~	**10/21**
~~Department of Pathology Approval Date(s):~~	
Medical Executive Committee Approval ~~Date(s)~~:	**01/22**
Administration Approval:	**02/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s):~~	

A. **DEFINITION(S):**
1. CAP: the College of American Pathologists. The accrediting body for the laboratory at Tri-City Medical Center.

B. **POLICY:**
1. Professional Competency (ANP.10010): The laboratory director ensures the professional competency of pathologists who provide interpretive services to the anatomic pathology laboratory.
2. The policy of the Anatomic Pathology Service of the Clinical Laboratory is to assure the interpretive professional competency of the physician staff of the Division of Pathology. These physician attributes are verified by the following activities listed immediately below. The results of these activities are reviewed annually by the Laboratory Director.
   a. Each pathologist is reappointed to the Medical Staff biennially, and as part of that process a required number of surgical pathology and cytopathology cases are peer-reviewed, authenticated, and submitted as part of the reapplication process. Successful reappointment of each physician to the Medical Staff constitutes de-facto evidence of successful compliance with this standard.
   b. In real-time, individual patient cases are circulated internally within the Division prospectively to multiple pathologist observers, in order to solicit their diagnostic opinions. These intradepartmental consultations are weighed, and incorporated into the final diagnosis, and are recorded by documenting the event in each affected final pathology report.
   c. All pathologist members of the Division participate in the four quarterly surveys per year, denoted A- D, of the College of American Pathologists (CAP) Surgical Pathology PIP (Performance Improvement Program) to earn their respective Continuing Medical Education (CME) credits in Anatomic Pathology. This assures that at least part of the CME credits of each practitioner are directly relevant to his or her daily pathology diagnostic responsibilities.

C. **PROCEDURE**: N/A

D. **FORM(S)**: N/A

E. **RELATED DOCUMENT(S)**: N/A

F. **EXTERNAL LINK(S):** N/A

G. **REFERENCES:**

1. College of American Pathologists. (2019). *Anatomic Pathology Checklist*. Northfield, IL.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 12/12

SUBJECT: CPOE Power Plan Revisions/Additions

REVISION DATE(S): 05/15

POLICY NUMBER: 8710-568

Medical Staff Department Approval:	~~02/19~~01/22
~~**Physician Information Technology Committee Approval:**~~	~~02/19~~
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	~~02/19~~01/22
Administration Approval:	~~03/19~~02/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. **PURPOSE:**
1. To provide a process for revising existing CPOE Power Plans or implementing new ones.

B. **DEFINITIONS:**
1. CPOE – Computerized Physician (or Provider) Order Entry
2. Power Plan – A grouping of orders that can be implemented together to facilitate the ordering process

C. **POLICY:**
1. All Power Plans must be created in the approved format and must be approved as prescribed in the procedure below.

D. **PROCEDURE:**
1. Physicians may customize existing Power Plans that have been moved to their personal folder.
2. Requests for revisions (by physician, pharmacy, or nursing) to an existing Power Plan or a new Power Plan shall be submitted Division/Department meeting for approval. Requests must be in writing and must provide the exact language to be included in the Power Plan. Once approved by department/division a Request for Assistance (RFA) will be placed by Physician Engagement Specialist. A Physician Champion will be assigned.
3. Revisions will be built in the Cert domain for validation by all disciplines that are affected and will be signed off by Physician Champion representative(s) prior to building the changes in the production domain.
4. Final Revisions will be reviewed and approved by Physician Information Technology Committee (PITC)
5. The new/revised Power Plan/orders will be implemented and appropriate staff educated as needed.
6. PITC will list all new or revised Power Plans/orders in minutes and sent to Medical Executive Committee as an informational item on their agenda.
7. All medical power plans must be reviewed and approved every three years.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 03/07

SUBJECT: Surgical Assistance

REVISION DATE(S): 11/11, 07/12, 04/17

POLICY NUMBER: 8710 – 545

Medical Staff Department Approval:	~~07/18~~01/21
Operating Room Committee Approval:	~~07/18~~04/21
Division of GVS Approval:	~~09/18~~ n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/19~~01/22
Administration Approval:	~~03/19~~02/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. **PURPOSE:**

1. To identify Amount and Level of Assistance required in Surgical Cases.

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
GENERAL					
Abdominal Perineal/ Low Anterior Resection	X			X	
Robotic Procedures (Major, as determined by the surgeon)	X			X	
~~Hepatic Procedures~~/Whipple/Major Liver Resection	X			X	
THORACIC					
Robotic Thoracic Procedures (Major, as determined by the surgeon)	X			X	
UROLOGIC					
Open Prostatectomy Procedures	X			X	
Open Renal Procedures	X			X	
Cystectomies	X		X	~~X~~	
OB/GYN					
Hysterectomy Procedures	X			X	

SURGICAL CASES	AMOUNT OF ASSISTANCE		LEVEL OF ASSISTANCE		
	1ST	2ND	MD	MD/PA/RNFA	OTHER
Cesarean Sections	X			X CNM	X Emergency
CV					
Open Heart Procedures	X	X	X	X*	

2. Amount and level of assistance for all other procedures are at the discretion of the operating surgeon.
3. For emergent surgical cases, the amount and level of assistance for procedure may be waived at the discretion of the surgeon.
4. **Cystectomy procedures:**
   ~~3.~~ **a. Requires two (2) physicians; Can be two urologists or one urologist and one general surgeon**
~~4.~~**5.** Open heart procedures:
   a. 1st Assistant must be another cardiac/thoracic surgeon or surgeon
   b. 2nd Assistant may be MD or PA/RNFA

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: 8/06

SUBJECT: Criteria for Case Referrals to Morbidity and Mortality (M&M) Meetings

REVISION DATE(S): 4/09, 8/12, 09/15, 03/18, ~~09/15~~10/21

NICU~~Women and Newborn Services~~ Department Approval:	**~~03/18~~10/~~20~~10/21**
Perinatal Collaborative Practice Approval:	**~~05/18~~0118/21**
Division of Neonatology Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/18~~01/22**
Administration Approval:	**~~12/18~~02/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/18**

A. **PURPOSE:**
1. To facilitate discussion for educational purposes and to improve the outcomes of newborns.

B. **POLICY:**
1. It is the policy of Tri-City Medical Center to have a minimum of quarterly Morbidity and Mortality (M&M) review meetings.

C. **PROCEDURE:**
1. The Neonatologist~~/Allied Health Professional (AHP)~~ in collaboration with the Obstetrician identifies neonates that meet the criteria for the M&M meeting.
2. These criteria include, but are not limited to:
   a. Death;
   b. Transfer out;
   c. Birth that requires extensive resuscitation;
   d. Major birth trauma (i.e., neonatal respiratory depression);
   e. IVH 3 & 4;
   f. ROP requiring laser surgery;
   g. Complications from procedure resulting in the prolongation of hospital stay or disability;
   h. Major congenital abnormalities; or
   i. Apgar scores of less than 5 at 1 minute and 5 minutes of age
3. The team consists of all disciplines involved in the decision making and care for mom and baby, i.e., genetics; lab; Clinical Nurse Specialist; Social Worker; performance improvement representative; Neonatologist; Obstetrician; NICU and OB nurses; Ultrasound technician; and/or Pathologist.
4. The M&M is held quarterly. **Findings and any educational opportunities for the multi-disciplinary team will be reviewed in perinatal collaborative.**
5. Team members are invited to participate in person, or through email and/or telephone calls.

D. **SUPPORTIVE DATA:**
1. Collaborative aims of M&M are to improve the health of pregnant women, infants and children by collecting high quality information on perinatal outcomes and research utilization, which then allow for performance improvement and bench marking processes in perinatal care and neonatal intensive care units.

E. **REFERENCE(S):**

1. CCS Manual of Procedures, Chapter 3.25, CCS Standards for Neonatal Intensive Care Units; Chapter 3.25-29. 1999

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES
NEONATAL INTENSIVE CARE UNIT (NICU)

ISSUE DATE: NEW **SUBJECT: Donor Breast Milk Use**

REVISION DATE:

NICU Department Approval:	**12/20**
Perinatal Collaborative Practice Approval:	**1108/21**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/22**
Administration Approval:	**02/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide guidelines for the safe use of donor breast milk (DBM)

B. **POLICY:**
1. Infants are eligible for DBM if they meet the following criteria:
   - **a. NICU admission and one of the following:**
   - ~~a.~~**b.** Prematurity <34 weeks
     - i. Once the infant reaches 34 weeks, physician to transition infant to appropriate formula if maternal milk not available. Use of DBM may be extended based on exceptional nutritional requirements at the discretion of the physician.
       - ~~i.~~1) **Infant will be transitioned from donor milk to formula over a 48 hour period, alternating donor milk and formula every other feed.**
   - ~~b.~~**c.** Infants <1500 grams
   - ~~c.~~**d.** Infants with a history of bowel injury such as necrotizing entercolitis (NEC)
   - ~~d.~~**e.** At the discretion of the Attending Physician
2. Infants > 34 weeks may receive DBM for 3 days but not to exceed 5 days based on certain criteria.
   - a. DBM should be considered when the mother intends to exclusively breastfeed (BF), is pumping regularly but has insufficient supply, or breastfeeding is medically contraindicated.
   - b. If the mother is available, attempt to get expressed breast milk (EBM) by breastfeeding, hand expression or pump; mother needs to continue expression to stimulate milk production and supply breast milk.
   - c. Infant Medical Indication for Supplementation with DBM:
     - i. "Bridge milk" for infant of mother whose milk supply does not meet infant's nutritional needs:
       - 1) Late preterm/small for gestational age
       - 2) Excessive weight loss not improving with exclusive breastfeeding/EBM
       - 3) Hyperbilirubinemia judged to be secondary to poor intake
       - 4) Hypoglycemia unresponsive to breastfeeding
       - 5) Maternal/Infant separation (i.e. mom in PACU or long C/S and can't pump/express milk)
   - d. Duration of DBM/Transition to Formula:
     - i. Evaluate at 72 hours
       - 1) If mother's milk supply increasing and getting close to infant's nutritional needs (getting > ½ EBM), continue DBM and re-evaluate at 96 hours
       - 2) If mother's milk supply low and not increasing, transition to formula

3) If BF contraindicated, transition to formula

ii. Re-Evaluate at 96 hours
1) If mother's milk supply increasing and will have full supply in next 24 hours (infant only getting small volume of DBM), continue DBM
2) If mother's supply still insufficient and not nearing infant's nutritional needs, transition to formula

iii. Transition to formula for all babies at 120 hours

3. Informed consent is required for the infant to receive DBM.
4. Feeding order is required for administration of DBM.
5. Only donor milk obtained from a Human Milk Banking Association of North America (HMBANA) bank or a bank with a California Tissue Bank License will be used. This ensures that donors are screened and appropriate safety precautions such as pasteurization and testing of donated milk are followed.
6. Donor milk will be stored in a designated refrigerator/freezer with thermometers for temperature monitoring:

Breast Milk Temperature Guidelines	
Method	**Temperature**
Refrigeration	Less than or equal to 4° C (39° F)
Freezer	Less than or equal to -20° C (-4° F)

a. **Temperatures will be monitored by the internal Awarepoint system. Engineering will set system to alert based on the temperatures above. Unit representative will be notified if temperatures deviate from designated range. Engineering will be contacted for out-of-range temperatures. External temperature reading will be spot checked against internal system reading once a month (or more frequently if temperatures are not correlating).**

C. **PROCEDURE:**

1. DBM Management
   a. Staff will use the electronic breast milk management system - Bridge Medical (Bridge) to track all DBM received from the Milk Bank from receipt to fortification and feeding as well as discarding milk that has reached expiration.
   b. DBM will be shipped and stored frozen. When the milk arrives, the person receiving the shipment will inspect the bottles for thawing and leakage or broken bottles. Any bottle found to be thawing or leaking will be discarded.
   c. Each bottle of donor milk will be logged into Bridge upon receipt.
      i. Log in to Bridge. Select Milk Management. Select either Receive Donor Bottles or Batch Receive Donor Bottles (for more than one bottle).
      ii. If Bridge is not operational, DBM will be received on a Donor Milk Log with lot number and expiration date and received into the Bridge system once possible.
   d. Donor milk will be stored frozen until it is needed.
2. Thawing DBM
   a. To thaw breast milk, use a hospital approved milk warmer following the manufacturer's instructions.
   b. If milk warmer is not available, milk may be thawed in the refrigerator. Do not thaw milk on the counter, in boiling water or microwave.
   c. Once thawed, swirl the container of milk to mix the cream back in, and distribute the temperature evenly. Do not stir or shake the milk.
   d. Measure volume of breast milk required for feeding into appropriate feeding container. Promptly refrigerate unused portion of thawed breast milk.
   e. DBM must be labeled with patient identifiers and expiration date ~~24~~ **48** hours after thawing.

i. Login to Bridge. Scan patient's wristband. Select "Prepare Bottles". Scan Donor Milk Label. Enter thaw date/time. Complete additional information as appropriate (Divide & Add fortifiers). Print new Label(s).

3. Warming DBM
   a. Use hospital approved milk warmer to warm breast milk just prior to administration. Warmed breast milk is good for two hours, and then must be discarded.
   b. Do not use microwave oven for warming breast milk.
   c. Prior to administration, the breast milk will be scanned in the system to verify correct patient and milk. In the event the system is unavailable, an independent two RN check will be utilized and documented in the EMR.
   d. Following the infant feeding, discard the remaining milk within 1 hour of the start of the feeding.
4. Administration of human milk feedings
   a. DBM must be verified prior to feeding by administering the milk in the Bridge System.
      i. If Bridge is not operational, DBM will be signed out on a Donor Milk Log by lot number and volume with the patient's name, medical record number, and date of birth noted. Two RNs must perform an independent double check to verify breast milk and document accordingly in the electronic medical record.
5. Recall Policy
   a. If milk bank recalls donor milk check for any available bottles with recalled lot numbers.
   b. Sequester milk in biohazard bag.
   c. Return to milk bank or dispose at their direction.
   d. Dispose of recalled bottles from Bridge tracking system.

D. **RELATED DOCUMENTS**

1. Breast Milk Management in the NICU Policy & Procedure

E. **REFERENCE(S):**

1. AAP COMMITTEE ON NUTRITION, SECTION ON BREASTFEEDING and COMMITTEE ON FETUS AND NEWBORN (2017). Donor human milk for the high-risk infant: Preparation, safety, and usage options in the United States. *Pediatrics, 139*(1): e20163440. doi: 10.1542/peds.2016-3440
2. Beauman, S. & Bowles, S. (Eds.) (2019). *Policies, procedures, and competencies for neonatal nursing care* (6th edition). National Association of Neonatal Nurses.
3. Human Milk Banking Association of North America (2019). Best practices for expressing, storing and handling of human milk in hospitals, homes and childcare settings (4th ed.). Raleigh, NC HMBANA.
4. Pediatric Nutrition Dietetic Practice Group, Steele, C. & Collins, E. (2019). *Infant and pediatric feeding: Guidelines for preparation of human milk and formula in health care facilities (3rd ed.).* Chicago, IL: Academy of Nutrition and Dietetics.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 01/18 **SUBJECT: Drug Supply Chain Security Act**

REVISION DATE~~(S)~~:

Pharmacy Department Approval:	**~~11/17~~11/21**
Pharmacy and Therapeutics Committee Approval:	**~~11/17~~11/21**
Medical Executive Committee Approval:	**~~11/17~~01/22**
Administration Approval:	**02/22**
Professional Affairs Committee Approval:	**~~01/18~~ n/a**
Board of Directors Approval:	**01/18**

A. **BACKGROUND:**

1. The Drug Quality and Security Act (DQSA) was signed into law in November 2013. Title II of the act, The Drug Supply Chain Security Act (DSCSA) established new definitions and requirements related to product tracing and outlines steps to building an electronic system that 10 years after enactment will identify and trace prescription drugs distribution in the United States. Many milestones will be implemented until DSCSA completion in 2023. Initial milestones are implemented for enforcement in 2015. This policy reflects the first phase.
2. The DSCSA replaces pedigree requirements of the Prescription Drug Marketing Act (PDMA) and preempts state requirements unless state requirements are more stringent.
3. The DSCSA requirements apply to transactions or changes in ownership of finished dosage forms performed by authorized trading partners including dispensers (pharmacies).

B. **PURPOSE:**

1. To establish procedures in compliance with federal regulations defined in Title II of the Drug Quality and Security Act (DQSA), Drug Supply Chain Security that protect consumers by improving detection and removal of potentially dangerous, adulterated and/or counterfeit products from the pharmaceutical distribution supply chain.

C. **DEFINITIONS:**

1. Trading partner - A manufacturer, repackager, wholesale distributor, dispenser or third-party logistics provider.
2. Dispenser - A retail pharmacy, hospital pharmacy, a group of chain pharmacies under common ownership and control that do not act as a wholesale distributor.
3. Third-party logistics provider - An entity that provides or coordinates warehousing or other logistics services of a product in interstate commerce on behalf of a manufacturer, wholesale distributor, or dispenser of a product, but does not take ownership of the product, nor have responsibility to direct the sale or disposition of the product.
4. Product - A prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing (such as capsules, tablets, and lyophilized products before reconstitution); does not include blood or blood components intended for transfusion, radioactive drugs or radioactive biological products, imaging drugs, intravenous products, medical gas, homeopathic drugs, or a drugs compounded in compliance with section 503A or 503B.
5. Transaction - The transfer of product between persons in which a change of ownership occurs. Exemptions: The term transaction does not include the distribution of; sample medications, blood and blood component products, IV fluids, dialysis solutions, medical gases, etc. See Exceptions to the DSCSA Tracing Requirements.

6. Transaction History (TH) - A statement in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.
7. Transaction Information (TI) – TI includes:
    a. Proprietary or established name or names of the product
    b. Strength and dosage form
    c. National Drug Code number
    d. Container size and the number of containers
    e. Lot number
    f. Date of the transaction
    g. Date of the shipment, if more than 24 hours after the date of the transaction
    h. Business name and address of the person from whom ownership is being transferred
    i. Business name and address of the person to whom ownership is being transferred
8. Transaction Statement(TS) - A statement or attestation, in paper or electronic form, that the entity transferring ownership:
    a. Is authorized as required under the Drug Supply Chain Security Act
    b. Received the product from a person that is authorized
    c. Received transaction information and a transaction statement from the prior owner of the product
    d. Did not knowingly ship a suspect or illegitimate product
9. Suspect product - A product for which there is reason to believe that such product is:
    a. Potentially counterfeit, diverted, or stolen
    b. Potentially intentionally adulterated
    c. Potentially the subject of a fraudulent transaction; or
    d. Appears otherwise unfit for distribution such that the product would result in serious
        i. adverse health consequences or death to humans

D. **POLICY:**

1. It is the policy of Tri-City Hospital District (TCHD) to maintain awareness about suspicious activity or potential threats to the drug supply chain, and to devote attention and effort to detect suspect product.
2. Obtain pharmaceuticals only from authorized trading partners as defined by the Food Drug and Cosmetic Act
3. Trace, quarantine, investigate, retain samples, clear, notify others and dispose of suspect or illegitimate products
4. Accept ownership of product only if the prior owner provides the transaction history (TH), transaction information (TI), and transaction statement (TS)
5. Provide subsequent owners with the TH/TI/TS unless the transaction is exempt or the sale is from dispenser to dispenser to fill a specific patient need
6. Retain records of TH/TI/TS for no less than 6 years after the transaction
7. Respond to request for TH/TI/TS due to a recall or investigation of suspect or illegitimate product from the Secretary of Health and Human Services or other appropriate Federal or State official within 2 business days
8. Return a product to the trading partner where the product was obtained without providing tracing information
9. Have a written agreement with a third-party provider (i.e. authorized wholesaler, distributor or other third-party service provider) to maintain the required TH/TI/TS on behalf of the facility.

E. **PROCEDURE:**

1. Confirm authorized trading partners
    a. Pharmaceuticals are only obtained from authorized trading partners
    b. Trading partners (manufacturers, repackagers, wholesale distributors, dispensers, and third-party logistics providers) are confirmed to be authorized as defined by the Food Drug and Cosmetic Act
    c. Manufacturer's and repackagers are confirmed as authorized trading partners using the

FDA's drug establishment registration database.

d. Wholesale distributors, third-party logistic providers and dispensers, are validated with the state authority to confirm licensure

2. Identification or suspect product
   a. Characteristics that might increase the likelihood that a product is a suspect or illegitimate product are listed in Characteristics of Suspect or Illegitimate.
   b. Strategies employed to identify suspect product include, but are not limited to:
      i. Avoid unsolicited offers and offers for product for sale at a very low price or one that is "too good to be true."
      ii. Examine the package and the transport container (case or tote) for signs that it has been compromised (e.g., opened, broken seal, damaged, repaired, or altered).
         1) Identify any unexplained changes since it was last received
         2) Identify if product inserts are missing or do not correspond to the product
         3) Verify shipping addresses, postmarks, or other materials to validate that
            a) the product did not come from an unexpected foreign entity or source
      iii. Examine the label on the package, or the label on the individual retail unit, for;
         1) Missing information, such as the lot number or other lot identification, NDC, or strength of the drug
         2) Altered product information, such as smudged print or print that is very difficult to read
         3) Misspelled words
         4) Bubbling in the surface of a label
         5) Lack of an Rx symbol
         6) Foreign language with little or no English provided
         7) Foreign language that is used to describe the lot number
         8) A product name that differs from the name of the FDA-approved drug
         9) A product name that is the product name for a foreign version of the drug
         10) Lot numbers and expiration dates on product that do not match the lot numbers and expiration dates of its outer container

3. Quarantine:
   a. Identified suspect products are quarantined to prevent distribution or transfer until they are cleared for distribution or dispensing; or are determined to be illegitimate
   b. Suspect products are quarantined in a physically separate area that is clearly identified

4. Notifications:
   a. Upon determination that a product is suspect or illegitimate, immediate trading partners and the FDA are notified within 24 hours of the determination
   b. FDA notification:
      i. FDA Form 3911 accessed at the FDA website.
   c. Termination of notification in consultation with the FDA:
      i. To terminate notification in consultation with the FDA when the notification is believed to be no longer necessary access the FDA website.

5. Investigation:
   a. Upon identification of a suspect product, an investigation is promptly conducted in coordination with trading partners (wholesale distributor, manufacturer) to determine if the product is illegitimate.
   b. Validate transaction history and transaction information and otherwise investigate to determine if the product is illegitimate
   c. If investigation determines that the product is not illegitimate and the product is cleared, the FDA is notified and the product may be distributed or dispensed
   d. If investigation determines that the product is an illegitimate product
      i. The product is removed from the pharmaceutical distribution supply chain, which may include disposal or return of the product for disposal

ii. A sample of the product is retained for further physical examination or laboratory analysis of the product by the manufacturer or other appropriate Federal or State official upon request

e. Records of the investigation are retained for at least 6 years after the conclusion of the investigation.

6. Obtaining, retaining and retrieving transaction records TH/TI/TS
   a. Transaction records (TH/TI/TS) are obtained from authorized trading partners for all applicable products.
   b. The records are maintained and retained in a readily retrievable manner for at least 6 years from date of the transaction
   c. Wholesaler/ Distributor records are provided electronically and are retrievable at any time.
   d. Direct Purchase from the Manufacturer – all packing slips are verified to contain the required transaction records. Packing slips are scanned into electronic database and maintained bu buyer.
   e. Borrow/Loan vs. Drug Transfer/Sale – all non, patient-specific transactions will require documentation of T3.
7. Record retention requirements
   a. Transaction records (TH/TI/TS), suspect product investigations and notifications must be retained for 6 years

F. **EXTERNAL LINK(S):**
1. FDA's Drug Establishment Registration Database: https://www.accessdata.fda.gov/scripts/cder/drls/default.cfm
2. FDA Form 3911: http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm
3. FDA Terminate Notification: http://www.accessdata.fda.gov/scripts/cder/email/drugnotification.cfm

G. **RELATED DOCUMENT(S):**
1. Exceptions to the DSCSA Tracing Requirements
2. Characteristics of Suspect Products

H. **REFERENCE(S):**
1. Title II of the Drug Quality and Security Act-Drug Supply Chain Security (DSCSA) http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/ucm376829.htm Accessed April 2015
2. Draft Guidance: Drug Supply Chain Security Act Implementation: Identification of Suspect Product and Notification Accessed April 2015
3. Draft Guidance: DSCSA Standards for the Interoperable Exchange of Information for Tracing of Human, Finished Prescription Drugs: How to exchange product tracing information Accessed April 2015
4. FDA Drug Supply Chain Security Act Implementation Plan: http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/ucm382022.htm

Tri-City Medical Center
Oceanside, California

PHARMACY MANUAL

ISSUE DATE: 4/12 **SUBJECT: General and Concentrated Electrolytes Policy**

REVISION DATE: 06/12, 10/15

Department Approval ~~Date(s)~~:	**~~07/15~~11/21**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**~~07/15~~11/21**
Medical Executive Committee Approval ~~Date(s)~~:	**~~09/15~~01/22**
Administration Approval:	**02/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~10/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**10/15**

A. **PURPOSE:**

1. To provide an organization–wide drug safety policy to prevent medication errors associated with concentrated electrolytes as recommended by the Institute for Safe Medication Practices (ISMP) and The Joint Commission (TJC). These guidelines and procedures are to be followed by all personnel involved in the intravenous administration of concentrated electrolytes.
2. This policy addresses the non-emergent prescribing, administration, dispensing, and storage of intravenous electrolytes for maintenance and replacement supplementation. In addition, this policy will address prescribing of hypotonic and hypertonic solutions.

B. **POLICY**:

1. There shall be safety measures in place to minimize the potential for medication errors regarding the ordering, preparation, labeling, distribution, administration, storage, and monitoring of all intravenous electrolytes.
   a. Concentrated electrolyte solutions include, but are not limited to: potassium chloride, potassium phosphate, potassium acetate, 3% sodium chloride, 23.4% sodium chloride, sodium acetate, and sodium phosphate.
   b. This policy shall also encompass the safe use of all other intravenous electrolytes including, but are not limited to: calcium chloride, calcium gluconate, magnesium sulfate, sodium bicarbonate, and sterile water for injection.
2. Tri-City Medical Center maintains supplies of concentrated electrolytes in the Pharmacy Department. Concentrated electrolytes will not be stocked in patient care areas.
   a. 3% hypertonic saline shall not be stored in automated dispensing machines (ADM) and shall be dispensed patient specific from the pharmacy one bag at a time.
   b. 23.4% hypertonic saline shall not be stored in an ADM and shall be dispensed patient specific from the pharmacy. To prevent accidental infusion, pharmacy shall dispense one VIAL at a time and shall never dilute further and/or dispense in a bag to prevent accidental infusion.
      i. Can only be ordered by a neurologist or neurosurgeon
   c. Large volume (1000mL or larger) sterile water for injection shall not be stored in patient care areas and will not be dispensed without additives to avoid hemolysis.
   d. Exceptions:
      i. Potassium chloride vials may be stored in perfusion carts only.
      ii. Pre-mixed mini-bags for electrolyte replacement pursuant to approved protocol are available in automated dispensing machines (ADM). Different strengths shall be separated to avoid look-a-like errors.
      iii. Magnesium sulfate vials, calcium chloride and/or calcium gluconate vials/syringes are stored in emergency medication trays and automated dispensing machines for emergency use only.

3. The number of drug concentrations available at Tri-City Medical Center are standardized whenever possible and limited to the minimum required to meet patient care needs.
4. All orders for concentrated electrolyte solutions must be entered electronically into Cerner.
   a. Exceptions: verbal/telephone orders followed by a written order will be accepted during an emergency.
5. When infusion of concentrated electrolytes are required for patient use, only commercially prepared products (whenever possible), with patient-specific labeling, shall be dispensed.
6. Solution orders that require admixture (i.e. there is not a pre-mixed solution ready for administration available) will be prepared by Pharmacy and delivered to the patient care area of use on a per patient basis.
7. Route of electrolyte administration is dependent on the specific electrolyte, concentration, and urgency. (Appendix II: Dosing and Administration Guidelines).
8. All intravenous electrolytes shall be administered with an electronic infusion device (i.e. Alaris Smart Pump) and will not be given via IV Push.
   a. Exception: Calcium chloride may be administered via slow IV push in central line during code blue only; calcium gluconate may be administered via slow IV push in a large vein over 5 to 10 minutes; magnesium sulfate may be administered via slow IV push not to exceed 150mg/min (may administer over 1 to 2 minutes in patients with persistent pulseless VT or VF with known hypomagnesemia) and must be diluted to a concentration ≤ 20%.
9. Hypertonic solutions MUST be administered via central line with an electronic infusion device. If a central line is not available then, the largest patent vein should be utilized until a central line is placed.

C. **PROCEDURE:**

1. Prescribing
   a. Pharmacy shall require prescriber's orders for maintenance electrolytes to specify the name of the electrolyte, name of diluent, concentration, and infusion rate (e.g. D5 ½ NS with 20 mEq KCl/liter at 20 mL per hour).
   b. Pharmacy shall require prescriber's orders for bolus electrolytes to specify the name of the electrolyte, dose (in mEq, mmoL, or mg), concentration of electrolyte, administration rate (dose/hour or mL/hour), and route of administration.
   c. For children less than or equal to 13 years of age, the prescriber's order shall include patient's weight in kg, dose of electrolyte on a per kg basis, and volume of electrolyte to be administered.
   d. Dosing of electrolyte in obese patients (i.e. actual weight > 130% IBW or BMI > 30 kg/m2) should be based on an adjusted body weight when weight based dosing is required (Consult pharmacist for weight adjustment calculations).
   e. Electrolyte replacement in patients that are asymptomatic should be treated with oral supplement whenever possible if there is a functional gastrointestinal tract. EXCEPT IN THE CASE OF MAGNESIUM. (Appendix IV: Selected Available Oral Electrolyte Replacement Products.
   f. Pharmacy shall provide the prescriber with a selection of standardized electrolyte solutions to order from. Tri City Medical Center-Intravenous Electrolyte Administration Guide (Appendix I: Selection of standardized solutions available at TCMC).
   g. In the event that one of the standardized solutions cannot satisfy the patient's needs, a pharmacist will contact the prescriber to assure that the requested solution is clinically indicated. Only then will the solution be compounded.
   h. In the event of an order for a hypotonic or hypertonic solution, the order will be discussed with prescriber to assure the solution is clinically indicated. It will be dispensed on a patient specific basis following dosing guidelines.
      i. Serum osmolarity range 240-340 mOsm/L.
         1) Hypotonic solution-lower osmolarity than serum.
         2) Hypertonic solution-higher osmolarity than serum.
      ii. Sterile water for injection or 0.225% sodium chloride will not be dispensed without additives in order to avoid hemolysis.

2. Administration
   a. Potassium Administration Guidelines:
      i. Potassium shall not be administered IV push. It shall be administered via a slow infusion, diluted with a suitable volume of solution.
      ii. Potassium shall never be added to an infusing IV, as doing so results in the pooling of potassium and a resultant bolus concentration of the drug being administered.
      iii. Patients with concomitant hypomagnesemia should have the magnesium deficit corrected prior to potassium supplementation to prevent refractory hypokalemia.
      iv. Administration of Potassium in Non-Critical Care setting:
         1) Potassium Intermittent Infusions "Piggybacks"
            a) Maximum infusion rate via peripheral line is 10 mEq/hour. Maximum infusion rate via central line is 20 mEq/hour and must be on continuous ECG monitoring.
         2) Potassium large volume continuous infusions (1000mL or more)
            a) Maximum concentration of potassium is 40 mEq/liter of solution with a maximum infusion rate of 10 mEq/hour (20 mEq/hour if the patient is on continuous ECG monitoring).
         3) Doses up to 200mEq in 24 hours generally should not be exceeded.
      v. Administration of Potassium in Critical Care setting
         1) Maximum concentration and infusion rates are recommended as listed above.
         2) Exceptions: Depending upon the estimated potassium deficiency and the urgency of the situation [for example: severe hypokalemia (potassium below 2.5 mEq/L), cardiac arrhythmias, diabetic ketoacidosis] rare patients require a concentration, dosage and/or rate of administration which temporarily exceeds those guidelines stated above.
            a) Maximum concentration of potassium is 80 mEq/liter in a critical care setting on continuous ECG monitoring.
            b) Maximum rate of potassium infusion is established at 40mEq per hour, which requires continuous ECG monitoring in critical care settings. Doses up to 200mEq in 24 hours generally should not be exceeded.
      vi. Potassium level must be checked after administration of 60mEq potassium prior to administration of additional potassium.
   b. Potassium Phosphate and Sodium Phosphate Administration Guidelines:
      i. Intravenous phosphate is potentially dangerous, since it can precipitate with calcium and produce a variety of adverse effects including hypocalcemia, renal failure, and potentially fatal arrhythmias.
         1) Phosphate solutions shall not be infused via the same IV catheter as calcium containing solutions.
      ii. Potassium phosphate or sodium phosphate shall not be administered IV push and shall be administered via a slow infusion, diluted with a suitable volume of solution.
      iii. In situations of hypophosphatemia requiring parenteral administration of intravenous phosphate, it may be necessary to administer concentrated solutions of potassium phosphate or sodium phosphate.
         1) The salt chosen depends on the patient's serum sodium and potassium levels.
            a) Potassium phosphate should not be used if serum potassium GREATER than 4.5 mEq/L. Sodium phosphate should not be used if serum sodium is GREATER than 145 mEq/L.
            b) If both potassium and phosphate replacement required, subtract the mEq of potassium given as potassium phosphate from total amount of potassium required (7 mmol of Potassium phosphate = 10 mEq of potassium).

2) Maximum phosphate concentration for peripheral line administration = 7 mmol/100mL (10 mEq of potassium/100mL, if using potassium phosphate).
3) Maximum phosphate concentration for central line administration = 15 mmol/100mL (20 mEq of potassium/100mL, if using potassium phosphate).
4) Maximum infusion rate of phosphate 7 mmol/hr (10 mEq/hr potassium, if using potassium phosphate) via peripheral line or central line without cardiac monitoring.
5) Maximum infusion rate of phosphate up to 14 mmol/hr (20 mEq/hr potassium, if using potassium phosphate) via central line with cardiac monitoring in the Critical Care Setting.
6) Potassium level must be checked after administration of 60mEq potassium (27 mmol phosphate) prior to administration of additional potassium.

c. Sodium Chloride 3% Administration Guidelines:
i. Sodium chloride 3% is available in 500mL bag (3g NaCl/100mL = 15g NaCl/500mL = 513 mEq NaCl/1000mL = 1027 mOsm/1000 mL)
ii. Use of Hypertonic Saline (Sodium Chloride 3%) is primarily reserved for patients for:
1) Treatment of increased intracranial pressure
2) Treatment of cerebral edema
3) Clinical signs of cerebral herniation
4) Treatment of acute and chronic euvolemic symptomatic hyponatremia
iii. Central line preferred due to high osmolarity. For emergent situations, peripheral (large bore vein with good blood flow) may be utilized.
iv. Usual Dosing:
1) Bolus: 100-250mL over 15-20 minutes
2) Infusion: 5-150 mL/hr (start at 5-30 mL/hr)
a) Rate of correction should generally not exceed 10-12 mEq/L in first 24 hours and 18 mEq/L in first 48 hours to prevent osmotic demyelination syndrome
v. Bolus doses of hypertonic saline may only be prescribed by Neurology, Neurosurgery, Critical Care or Pulmonary physicians and shall be reserved for administration in critical care settings.
1) Exception: Any location in emergent situation with continuous monitoring pending transfer to critical care area.
vi. Administration of hypertonic saline continuous infusions shall be reserved for critical care areas and telemetry. Administration is not permitted on acute care, L&D, and post-partum floors.
1) Exception: Any location in emergent situation with continuous monitoring pending transfer to critical care or telemetry unit.
vii. All orders require renewal by MD after every 500mL administered.
viii. The provider will determine the overall sodium replacement goal, initial sodium goal for the first four (4) hours of the intervention, and rate of correction.
1) The plasma sodium [Na+] should be raised at a rate of 1 to 2 mEq/L per hour in patients with severe symptoms (seizures, coma, evidence of brainstem dysfunction).
2) The plasma sodium [Na+] should be raised by no more than 10-12 mEq/L in 24 hours and no more than 18 mEq/L in 48 hours.
3) The pharmacist shall have the ability to hold any hypertonic saline infusion whereby the sodium [Na+] has increased by GREATER than 12 mEq/L in a 24 hour period OR GREATER than 18 mEq/L in a 48 hour period per pharmacy protocol.
a) Exceptions: hypertonic saline infusions for cerebral edema, herniation or any brain condition.
4) The pharmacist must contact the prescriber immediately upon holding of the hypertonic saline infusion and for further orders.
ix. The pharmacist shall verify the indication for all hypertonic saline infusions.

x. The pharmacist will verify the calculations regarding the dose and rate of the infusion ordered by the provider via the following process:
   1) Determine the overall sodium replacement goal and the initial sodium replacement goal as documented by the Provider.
   2) Determine the actual serum sodium level of the patient.
   3) Calculate the total body sodium deficit by:
      a) [0.6 for males or 0.5 for females] x Weight** (in kg) x (Desired Na - Patient's Na)
         i) Note: For weight > 30% of ideal body weight (IBW), use adjusted weight. Adjusted weight = 0.5 x (ABW-IBW) + IBW up to maximum of 100 kg.
   4) Verify the replacement rate for the first 24 hours.
      a) [0.6 for males or 0.5 for females] x Desired increase in Serum Na x _____kg = mEq sodium to be replaced.
         i) Note: Not to exceed an increase of 10-12 mEq/L in a 24 hour period or 18 mEq/L in 48 hours.
      b) 3% sodium chloride contains 513 mEq/L sodium and 513 mEq/L chloride.
      c) Volume of 3% sodium chloride to be infused = ____ mEq sodium to be replaced/(513) x 1000 = _____ mL/24 hours.
      d) Rate (mL/hour) = total number of mL per 24 hours.
   5) See Appendix V for Quick Estimation for Asymptomatic Hyponatremia
   6) See Appendix VI for Quick Estimation for Chronic Hyponatremia

xi. The order should be assessed periodically by the prescriber for continued therapy (every 12 hours is recommended).

xii. Recheck electrolytes (serum sodium, chloride, potassium, bicarbonate, serum osmolarity) and clinical status every 2 to 4 hours, with a minimum of every 4 hours.

xiii. Precautions:
   1) Severe neurologic complications may result from rapid changes in serum sodium concentration and serum osmolality.
   2) Patients with a history of cirrhosis or alcoholism may be at increased risk for osmotic demyelination syndrome with rapid sodium correction.
   3) Rapid withdrawal of hypertonic saline infusion may result in rebound cerebral edema.
   4) Plasma volume expansion may worsen pre-existing heart failure or cause pulmonary edema
   5) Administration of hypertonic saline via peripheral line may result in phlebitis and skin necrosis.

D. **RELATED DOCUMENTS:**
1. Maintenance Solutions Containing Potassium
2. Guidelines for Dosing & Administration of Electrolyte Replacement
3. Osmolarity of Selected IV Fluids
4. Selected Available Oral Electrolyte Replacement Products
5. Quick Estimation for Asymptomatic Hyponatremia
6. Quick Estimation for Symptomatic Hyponatremia

MAINTENANCE SOLUTIONS CONTAINING POTASSIUM

Solution	KCl content (mEq/L)	Volume	Solution	KCl content (mEq/L)	Volume
1/2NS	20	1000 mL	D5 1/2 NS	10	1000 mL
NS	20	1000 mL	D5 1/2 NS	20	1000 mL
NS	40	1000 mL	D5 1/2 NS	30	1000 mL
D5W	20	1000 mL	D5 1/2 NS	40	1000 mL
D5 NS	20	1000 mL			

Multi-electrolyte MAINTENANCE SOLUTIONS

Solution	Content	Volume
Lactated Ringer's Injection	K 4 mEq/L, Na 130 mEq/L, Ca 3 mEq/L, Cl 109 mEq/L, Lactate 28 mEq/L	1000 mL
Dextrose 5% in Lactated Ringer's Injection with 20 KCl	Dextrose 5%, K 24 mEq/L, Na 130 mEq/L, Ca 2.7 mEq/L, Cl 129 mEq/L, Lactate 28 mEq/L	1000 mL
Dextrose 5% in Lactated Ringer's with 40 KCl Injection	Dextrose 5%, K 44 mEq/L, Na 130 mEq/L, Ca 2.7 mEq/L, Cl 149 mEq/L, Lactate 28 mEq/L	1000 mL

Solutions Available for BOLUS ADMINISTRATION*

Solution (all provided in D5W or NS)	Electrolyte Content	Volume	Route of Administration
Calcium chloride 10 mg/mL	1 gram	100 mL	Central only
Calcium gluconate 10 mg/mL	1 gram	100 mL	Peripheral or Central
Magnesium sulfate 10 mg/mL	1 gram	100 mL	Peripheral or Central
Magnesium sulfate 40 mg/mL	4 gram	100 mL	Central only
Potassium acetate 0.1 mEq/mL	10 mEq potassium	100 mL	Peripheral or Central
Potassium acetate 0.2 mEq/mL	20 mEq potassium	100 mL	Central only
Potassium chloride 0.1 mEq/mL	10 mEq potassium	100 mL	Peripheral or Central
Potassium chloride 0.2 mEq/mL	10 mEq potassium	50 mL	Central only
Potassium phosphate 0.1 mEq/mL	7.5 mmol phosphate=11 mEq potassium	100 mL	Peripheral or Central
Potassium phosphate 0.1 mEq/mL	15 mmol phosphate = 22 mEq potassium	250 mL	Peripheral or Central
Potassium phosphate 0.2 mEq/mL	30 mmol phosphate = 44 mEq potassium	500 mL	Peripheral or Central
Sodium phosphate 0.1 mEq/mL	7.5 mmol phosphate=10 mEq of sodium	100 mL	Peripheral or Central
Sodium phosphate 0.1 mEq/mL	15 mmol phosphate = 20 mEq of sodium	250 mL	Peripheral or Central
Sodium phosphate 0.2 mEq/mL	30 mmol phosphate = 40 mEq of sodium	500 mL	Peripheral or Central

Guidelines for Dosing & Administration of Electrolyte Replacement
****This is meant to serve as a reference please see TCMC electrolyte replacement protocol ****

Potassium Acetate and Potassium Chloride Bolus Dosing and Administration (IV)				
Serum Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**	**Hourly Maximum**
3.0 - 3.5 mEq/L	10 mEq	0.2 - 0.3 mEq/kg/dose	Over 1 - 2 hours	10 mEq
2.5 - 3.0 mEq/L	20 – 40 mEq	0.5 mEq/kg/dose*	Over 1 - 2 hours	20 mEq*
<2.5 mEq/L	40 - 80 mEq	1 mEq/kg/dose*	Over 2- 4 hours	20 mEq*

- Patients with renal insufficiency should receive less than or equal to 50 % of the dose.
- Check a magnesium level especially in patients with hypokalemia and hypocalcemia.
  - Magnesium deficiency should be corrected to facilitate the correction of hypokalemia.

Potassium Phosphate and Sodium Phosphate Bolus Dosing and Administration (IV)			
Serum Phosphate Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**
Mild, 2.3-2.7 mg/dL	7.5 mmoL	0.08 mmol/kg/dose	Over 2 hours
Moderate, 1.5-2.2 mg/dL	15 mmoL	0.16-0.24 mmol/kg/dose	Over 4-6 hours
Severe, <1.5 mg/dL	30 mmoL	0.36 mmol/kg/dose	Over 6 hours

- Equivalencies : 3mmol/mL phosphate = 285 mg/mL
  4.4 mEq/mL potassium = 170 mg/ mL
- Risk of calcium-phosphate precipitation when infused in the same IV catheter as solutions containing Calcium!

Magnesium Sulfate Bolus Dosing and Administration (IV)				
Serum Magnesium Level	**Adult Dose**	**Pediatric Dose**	**Infusion Rate**	**Hourly Maximum**
Mild/ Moderate: 1 - 1.5 mg/dL	1-4 gram	25-50 mg/kg/dose	Over 2-4 hours	1 gram
Severe: < 1 mg/dL	4-8 gram	50 mg/kg/dose	Over 4-8 hours	1 gram

- Equivalencies: 1gram Magnesium Sulfate= 8.2 mEq magnesium
- Adult total dose should not exceed 12 gram over 12 hours

Calcium Dosing and Administration (IV)		
Dosing	**Adult Dose**	**Pediatric Dose**
Intermittent	Mild: 1-2 gram over 30 -60 minutes Severe: 1 gram of Calcium chloride or 3 gram of calcium gluconate over 10 minutes;	Calcium chloride:10-20 mg/kg/dose Calcium gluconate: 50-100 mg/kg/dose Administration: over 30 - 60 minutes
Continuous Infusion (Severe hypocalcemia)	500 mg - 1 gram/hour	Calcium chloride: 5-10 mg/kg/hr Calcium gluconate:10 -20 mg/kg/hr

- Equivalencies: 1 gm calcium chloride = 13.6 mEq (elemental calcium)
  1 gm calcium gluconate = 4.56 mEq (elemental calcium)

- Corrected calcium for low albumin:[(4 - alb) x 0.8] + calcium level
- Risk of calcium-phosphate precipitation when infused in the same IV catheter in solutions containing phosphate!
- Potential risk for cardiac arrhythmias associated with rapid calcium infusion.
- Blood products preserved with citrate may cause hypocalcemia: Administer 1.35 mEq of calcium for each 100 mL of blood transfused
- Not for IM or SubQ administration (severe necrosis and sloughing may occur).
- Avoid rapid administration (do not exceed 100mg/min except in emergency situations)
- For intermittent IV infusion, infuse diluted solution over 1 hour or no greater than 45-90 mg/kg/hour (0.6-1.2 mEq/kg/hr); administration via central or deep preferred; do not use scalp small hand or foot veins for IV administration.
- Monitor ECG if calcium is infused faster than 2.5 mEq/minute; stop the infusion if the patient complains of pain or discomfort.
- Warm solution to body temperature prior to administration.

Sodium Bicarbonate

- Metabolic acidosis: sodium bicarbonate dosage should be based on blood gases and pH measurements.
- HCO_3 dose (mEq) = 0.5 X weight (kg) X (24 – serum HCO_3 (mEq/L)) or use following equations:

  Pediatrics HCO_3 dose (mEq) = 0.3 X weight (kg) X base deficit (mEq/L)

  Adults HCO_3 dose (mEq) = 0.2 X weight (kg) X base deficit (mEq/L)

  KEYPOINT: Neonates & infants use 0.5 mEq/mL solution.
- Maximum rate of administration should not exceed 1 mEq/kg/hr. Rapid or excessive administration of sodium bicarbonate may produce tetany or cerebral edema/hemorrhage especially in infants.
- Recommendations for the addition of sodium bicarbonate to IV fluids:

IV stock solution	Volume	Maximum Sodium Bicarbonate Addition	Resultant Na + concentration
0.45 % NaCl	500 mL	37.5 mEq (0.75 vial)	152 mEq/L
0.45 % NaCl	1000 mL	75 mEq (1.5 vials)	152 mEq/L
D5 W	500 mL	75 mEq (1.5 vials)	150 mEq/L
D5W	1000 mL	150 mEq (3 vials)	150 mEq/L
D5 0.45% NaCl	500 mL	37.5 mEq (0.75 vials)	152 mEq/L
D5 0.45 % NaCl	1000 mL	75 mEq (1.5 vials)	152 mEq/L
D10W	500 mL	75 mEq (1.5 vials)	150 mEq/L
D10W	1000 mL	150 mEq (3 vials)	150 mEq/L

Each vial/amp of sodium bicarb contains 50 meq of sodium

- Addition of sodium bicarbonate to IV fluids should not result in a hypertonic solution.
- Sodium bicarbonate should not be added to 0.9 % sodium chloride containing solutions.
- Exceptions: Preparation and dispensing of hypertonic sodium bicarbonate solutions require discussion with prescriber and approval by Clinical Manager. Also see Sodium Chloride 3% Administration Guidelines above.

Osmolarity of Selected IV Fluids

Solution	mOsm/liter
½ Normal Saline (0.45% NaCl)	154
Normal Saline (0.9% NaCl)	308

Dextrose 5% in Water	**252**
Dextrose 10 % in Water	**505**
Dextrose 5% and 0.2% NaCl	**321**
Dextrose 5% and 0.45% NaCl	**406**
Dextrose 5% and 0.9 % NaCl	**560**
Dextrose 5% and 0.2% NaCl with 20 mEq KCl	**361**
Dextrose 5% and 0.45% NaCl With 20 mEq KCl	**447**
Lactated Ringers	**273**
Dextrose 5% and Lactated Ringers	**525**

- Consult with pharmacist and/or standard references for osmolarity of other solutions.
- Sterile water for injection or 0.225% sodium chloride will not be dispensed without additives to avoid hemolysis

Selected Available Oral Electrolyte Replacement Products

Phosphate Replacement PO[•] Products				
Formulation	**mg PO_4**	**mmol PO_4**	**mEq Na^+**	**mEq K^+**
K-Phos Neutral	250	8	13.1	1.1

Potassium Replacement Products (PO)		Comments
Formulation	**Strengths**	
Potassium chloride (Extended release capsule)	10 mEq ER (Micro-K)	• Oral route preferred over IV • Do not crush extended release products • Need to correct hypomagnesemia in order to correct potassium levels • Excess chloride salts may cause metabolic acidosis • Excess acetate salts may cause metabolic alkalosis
Potassium chloride (Liquid)	20mEq/15mL 40mEq/30 mL	
Potassium chloride (Effervescent table)	25 mEq effervescent	

Calcium Replacement PO Products				
Formulation	**Strength**	**Route**	**Elemental Calcium (mEq/dL)**	**Elemental Calcium (%)**
Calcium acetate (Tablet)	667 mg (169 mg Elemental)	I.V. or Oral[B]	12.7	25
Calcium carbonate (Tablet/Suspension)	650 mg 1250 mg/5mL	Oral[B]	20	40

Quick Estimation for Asymptomatic Hyponatremia

IBW kg	40 kg	50 kg	60 kg	70 kg	≥ 80 kg
Estimated Rate of 3% to correct Serum Na 8mEq/L/24h (mL/hr)	13 mL/hr	16 mL/hr	20 mL/hr	23 mL/hr	26 mL/hr

Quick Estimation for Symptomatic Hyponatremia

IBW kg	40 kg	50 kg	60 kg	70 kg	≥ 80 kg
Initial rate of 3% NaCl to increase Na by approx 3-5 mEq/L	80mL/hr x 2hrs STAT Na level at 2 hours	100 mL/hr x 2hrs STAT Na level at 2 hours	120mL/hr x 2hrs STAT Na level at 2 hours	140mL/hr x 2hrs STAT Na level at 2 hours	160mL/hr x 2hrs STAT Na level at 2 hours
If seizures do not resolve continue 3% NaCl	80mL/hr	100mL/hr	120mL/hr	140mL/hr	160mL/hr
Maintenance rate (patient not seizing) for the 1st 24 hours	↓ Infusion to 7mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 9mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 11mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 13mL/hr x 22 hrs Serial Na levels Q4h	↓ Infusion to 15mL/hr x 22hrs Serial Na levels Q4h
3% NaCl may be continued until serum Na >120.					

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 04/73 **SUBJECT:** Licensure and Professional Standards

REVISION DATE~~(S)~~: 06/05, 07/06, 07/09, 01/12, 07/15, 03/18

Department Approval:	~~12/17~~11/21
Pharmacy & Therapeutics Committee Approval:	~~01/18~~11/21
Medical Executive Committee Approval:	~~02/18~~01/22
Administration Approval:	02/22
Professional Affairs Committee Approval:	~~03/18~~ n/a
Board of Directors Approval:	03/18

A. **POLICY**:

1. The Pharmacy Department will operate within all applicable state and federal laws, regulations and licensure requirements. In matters of professional judgment or practice standards, recommendations from the American Society of Health-System Pharmacists (ASHP) and The Joint Commission will be given first consideration and priority.
2. State of California: (Example)
   a. Pharmacy Department services will be provided according to the regulations of the Department of Health Services as stated in Title 22 for licensed acute care hospitals. These requirements will be integrated into policies and procedures where necessary.
      i. Pharmaceutical Services Definition (section 70261)
      ii. Pharmaceutical Services General Requirements (section 70263)
      iii. Pharmaceutical Services Staff (section 70265)
      iv. Pharmaceutical Services Equipment and Supplies (section 70267)
      v. Pharmaceutical Services Space (section 70269)
   b. All laws, regulations and licensure requirements of the California State Board of Pharmacy will be met and followed.
      i. The hospital's Pharmacy Department will have at all times a valid and current pharmacy permit issued by the board which will be posted in public view.
      ii. All Pharmacists, Pharmacist Interns and Pharmacy Technicians must maintain valid and current licensure with the board according to law and hospital policy.
      iii. All Pharmacists, Intern Pharmacists, and Pharmacy Technicians shall renew licensure per Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430.
      iv. A current copy of State Pharmacy Law with Rules and Regulations is available on the California Board of Pharmacy website.
3. Federal:
   a. The hospital will comply with all laws, regulations and requirements of the Drug Enforcement Administration (DEA).
      i. The hospital will maintain current and valid registration with DEA. The registration certificate will be posted in public view in the Pharmacy.
      ii. All required records will be maintained by the Pharmacy Department, including order forms (DEA-222), disposal (DEA-41), loss (DEA-106) and the biannual inventory.
      iii. In accordance with DEA regulations, all schedules II, III, IV and V (CII, CIII, CIV & V) drugs will be stored separately in a locked cabinet in the main Pharmacy,

automated drug dispensing machines on the patient care units or double-lock storage cabinets in ancillary areas. Access is restricted to licensed personnel.

b. The Pharmacy Department will comply with the Conditions of Participation for Medicare of the Centers of Medicare and Medicaid Services.

4. Practice Standards:
   a. Dispensing: A Pharmacist will review each medication prior to dispensing. Exceptions to this can be found in the Pharmacy Policy: Technician Checking Technician Program.
   b. Staffing Guidelines: The ratio of Pharmacy Technicians to Pharmacists will not exceed two to one (2:1), except that this ratio shall not apply to personnel performing clerical functions pursuant to California Code of Regulations and the ratio of Intern Pharmacists to Pharmacists will not exceed two to one (2:1) at any time.

B. **RELATED DOCUMENT(S):**
1. Administrative Policy: Monitoring Licenses, Professional Registrations, and Certificates 430
2. Pharmacy Policy: Technician Checking Technician Program

C. **EXTERNAL LINK(S):**
1. California State Board of Pharmacy http://www.pharmacy.ca.gov/
2. Pharmacy Law Book with Rules and Regulations (2017). *California State Board of Pharmacy* http://www.pharmacy.ca.gov/laws_regs/lawbook.pdf

D. **REFERENCE(S):**
1. Pharmaceutical Services Definition, Title 22 California Code of Regulations Division 5 § 70261.
2. Pharmaceutical Services Equipment and Supplies, Title 22 California Code of Regulations Division 5 § 70267.
3. Pharmaceutical Services General Requirements, Title 22 California Code of Regulations Division 5 § 70263.
4. Pharmaceutical Services Space, Title 22 California Code of Regulations Division 5 § 70269.
5. Pharmaceutical Services Staff, Title 22 California Code of Regulations Division 5 § 70265.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 11/11 **SUBJECT: Pharmaceutical Representatives**

REVISION DATE: 03/12, 07/17

Department Approval:	**~~04/17~~11/21**
Pharmacy and Therapeutics Committee Approval:	**~~05/17~~11/21**
Medical Executive Committee Approval:	**~~06/17~~01/22**
Administration Approval:	**02/22**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**
1. Interactions between medical centers and industry are vital to public health, but they must be conducted in a way that is principled and upholds the public trust.
2. The purpose of this policy is to address the specific interactions between Tri City Healthcare District (TCHD) personnel and the pharmaceutical vendor industry.

B. **SCOPE:**
1. Applicable to all medical, nursing, pharmacy, and other healthcare professionals at TCHD.
2. All pharmaceutical representatives (including but not limited to sales representatives and medical science liaisons).

C. **DEFINITION(S):**
1. Gift: Any favor, discount, hospitality, loan, forbearance, gratuity, or other item having economic value.
   a. Excludes food or meals provided as part of an educational presentation/meeting and items of educational value (such as text books) that are $100 or less in value.
2. Pharmaceutical representative: An employee or consultant representing the interests of one or more pharmaceutical manufacturers by providing educational material and/or promoting the sale of drug products.

D. **POLICY:**
1. The Pharmacy Clinical Manager or his/her designee is the primary point of contact for all pharmaceutical representatives conducting business within TCHD.
2. Signed Statement:
   a. Each pharmaceutical vendor must sign a statement acknowledging his/her familiarity with this policy.
   b. A copy of this policy will be presented for acknowledgement to all pharmaceutical vendors via RepTrax.
3. Scheduling Appointments:
   a. Pharmaceutical vendors are not permitted on the TCHD campus without an appointment approved by the Pharmacy Clinical Manager.
   b. Appointments will be limited to business hours (Monday – Friday 0800-1700) unless specific authorization is given by the Pharmacy Clinical Manager on a case by case basis.
4. Permitted Activities:
   a. With prior approval, pharmaceutical sales representatives are allowed in the facility for the following activities at the request of the Pharmacy Clinical Manager or designee:

i. To provide educational programs and scheduled in-services. See section Educational Programs below.
ii. To exhibit informational / promotional displays in assigned areas. See section Drug Displays below.

5. Physician Contact by Sales Representatives:
   a. Contact with physicians on hospital property requires the prior approval of the Pharmacy Clinical Manager.
   b. Contact with physicians is limited to those services having offices on the hospital premises (e.g., radiology staff, cardiology services staff).
   c. Contact with physicians at their office regarding Pharmacy and Therapeutics Committee activities is not permitted.
6. Restricted Formulary:
   a. Pharmaceutical sales representatives must promote products according to approved FDA guidelines and facility approved guidelines.
   b. Medications not on the formulary may not be promoted unless so authorized and with the permission of the Pharmacy Clinical Manager.
7. Prohibited Activities:
   a. Presenting false, undocumented, misleading statements or claims to any physician or other healthcare professional associated with the hospital, whether or not made while on hospital or campus grounds, that serve to misrepresent a drug's usage in therapy.
   b. Distributing gifts.
   c. Providing information or distributing promotional material regarding non-formulary, newly-approved, restricted or non-contracted drugs within the facility, without first obtaining approval in writing from the Pharmacy Clinical Manager. This includes providing and distributing information to Pharmacy & Therapeutics (P&T) and Medical Executive Committee (MEC) members.
   d. Exhibiting drug displays is strictly prohibited, unless requested by the Pharmacy Clinical Manager and approved by administration prior to display.
   e. Distributing pharmaceutical samples at the hospital (and acceptance by hospital staff) is strictly prohibited except as specifically outlined in the Pharmacy Services Policy: "Drug Samples".
   f. Obtaining or completing any part of the hospital's Formulary Request Form.
   g. Soliciting the names of the Pharmacy and Therapeutics Committee members or other related committee with regard to the formulary management process.
8. Site Access and Hospital Security:
   a. Upon entering the facility, pharmaceutical sales representatives will check in at the RepTrax kiosk located in the Main Lobby.
   b. The representative is required to wear an identification badge provided by the RepTrax kiosk.
   c. Representative must be escorted to the area to be visited and accompanied, at all times while in the facility, by a hospital employed or contracted personnel a physician, or a physician's representative. Representatives not escorted will be asked to leave the premises.
   d. Representatives are not allowed in any patient care areas without express permission by the Pharmacy Clinical Manager.
   e. Representatives discovered not wearing a badge, or working outside approved locations, will be asked to leave the premises. In such cases, hospital security and the Department of Pharmacy will be notified.
   f. Representatives may not access any patient specific information.
9. Drug Displays:
   a. Drug displays are promotional in nature and are discouraged. The Pharmacy Clinical Manager evaluates and advises the facility about whether displays support the mission of the facility and the care of patients. If it is determined that displays are needed, they

are limited to products on the facility formulary unless the promotion of a non-formulary product has been approved.

b. Displays, when approved, are held in an area away from patient and visitor traffic and may not restrict the passage of medical or other staff through an area.

10. Educational Programs:
    a. The topic and content of all educational programs sponsored or presented by pharmaceutical representatives must be approved by the Pharmacy Clinical Manager.
    b. This approval is required prior to scheduling the program of any materials to staff or physicians within the facility.
    c. If the educational program is approved, representatives will visit only the approved designated area as scheduled.
    d. Any pharmaceutical representative found to have distributed educational materials/information or held programs within the facility that have not been authorized by the Pharmacy Clinical Manager will be in violation of this policy and will be subject to restricted access to the facility.
11. Penalties for Pharmaceutical Representatives for Policy Deviations:
    a. Activities deemed inappropriate by the Pharmacy Department or any other department of the hospital, will result in a recommendation to the P&T Committee, MEC, and subsequently to hospital administration to bar the representative involved from visiting the facility. This ban will be in effect until lifted by written permission from an administrative officer of the hospital.
12. Gifts:
    a. All gifts from pharmaceutical representatives, regardless of value are strictly prohibited.
    b. Vendors may offer a hospital incentive (i.e. discounted pricing, supplies/equipment, maintenance support) pursuant to contract agreement if a buyer agrees to purchase the vendor's company goods or services. Personal incentives (e.g., merchandise, tickets to special events, vacation trips, etc.) are considered gifts and cannot be accepted under any circumstances.
    c. Employees may not accept gifts, gratuities, or compensation in exchange for listening to a sales talk by an industry representative, for prescribing or changing a patient's prescription, or for attending a CME or non-CME activity (unless the individual is a speaker or is otherwise actively participating or presenting at the event).
13. Participation in Industry Sponsored Programs, Speaker's Bureaus, and Consulting:
    a. Employees may accept only fair market compensation for specific, legitimate services provided by them to industry. The terms of the arrangements, services provided, and compensation must be set forth in writing and signed by both parties.
    b. Employees may not accept compensation for listening to a sales presentation (e.g. detailing) by an industry representative.
    c. Employees who are simply attending a CME or other instructional activity, and are not speaking or otherwise actively participating or presenting at the meeting, may not accept compensation from companies either for attending or defraying costs related to attending the meeting.
    d. Employees must disclose any honorarium or payment received for all industry sources when requesting medication be added to the formulary or before presenting at Pharmacy and Therapeutics Committee meetings.
14. Industry Sponsored Scholarships and Other Educational Funds for Trainees:
    a. TCHD staff and trainees may not accept scholarships or other special funding directly from a vendor.
    b. Vendors may make donations to the Education Department fund through the Foundation; the department will use its own criteria to select trainees to receive support for participation in educational events.
    c. Under no circumstance can a trainee be paid by a commercial sponsor to attend an educational event where the trainee is not speaking.

d. For CME/non-CME-certified activities, reimbursement for travel, lodging, honoraria, or personal expense may not come directly from industry.
e. Exception to this rule applies only if the attendee is speaking at the event.
f. The policy is not intended to preclude industry support for staff to travel to evaluate major clinical equipment for prospective acquisition by TCHD.

15. Purchasing:
    a. Staff involved in institutional decisions concerning the purchase of or approval of medications or equipment, or the negotiation of other contractual relationships with industry must not have any financial interest (e.g., equity ownership, compensated positions on advisory boards, a paid consultancy or other forms of compensation) in the vendor that might benefit from the institutional decision.
    b. This provision is not intended to preclude indirect ownership, through mutual funds or other investment vehicles, of equities in publicly traded companies.
    c. Staff must disclose their actual and potential conflicts of interest related to any institutional deliberations and generally may not participate in deliberations in which he or she has an actual or potential conflict of interest.

E. RELATED DOCUMENT(S):

1. Administrative Policy: 203 Business Visitor Visitation Requirements

F. REFERENCE(S):

1. Pharmaceutical Research and Manufacturers of America (PhRMA). Washington D.C., January 2009. *Code on Interactions with Healthcare Professionals.*
2. CMS Conditions of Participation §482.13(c)(1)
3. Health Insurance Portability and Accountability Act (HIPAA) of 1996

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/11

SUBJECT: Transdermal Fentanyl Patch Prescribing and Use

REVISION DATE: 08/15, 09/17

POLICY NUMBER: 8390-6020

Departmental Approval:	~~07/17~~11/21
Pharmacy & Therapeutics Committee Approval:	~~07/17~~11/21
Medical Executive Committee Approval:	~~08/17~~01/22
Administration Approval:	02/22
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **PURPOSE**:
1. To provide a guideline summarizing safe use practices to reduce the preventable harm to patients in the hospital setting.

B. **POLICY**:
1. Due to the Food and Drug Administration (FDA) black box warning, this policy and procedure restricts prescribing to opioid-tolerant patients for the management of persistent, moderate to severe chronic pain that requires continuous, around the clock opioid administration for an extended period of time AND cannot be managed by other means such as nonsteroidal anti-inflammatory drugs, opioid combination products, or immediate-release opioids. Fentanyl patch use in non-opioid tolerant patients has resulted in fatal respiratory depression.
2. Fentanyl patches are not to be used to treat sudden, occasional or mild pain, or pain after surgery.
3. Fentanyl patches should not be prescribed for opioid naïve patients receiving comfort care measures or end of life management Patients must meet the Tri-City Healthcare District (TCHD) for use of Fentanyl Transdermal System (see appendix II) and follow dosing guidelines in order to receive fentanyl patches.

C. **PROCEDURE**:
1. Prescribing:
   a. Upon receiving an order for fentanyl patches the pharmacist shall evaluate the following:
      i. Determine if patient is continuing therapy for chronic pain.
      ii. Determine if the patient is opioid tolerant, defined as:
         1) Taking oral morphine 60 mg/day or oral hydromorphone 8 mg/day or oral oxycodone 30 mg/day OR another opioid at a dose comparable to a fentanyl patch per the Fentalnyl (Duragesic) Dose Conversion Guidelines for 7 days or longer.
      iii. Determine if the patient has any absolute contraindications for use:
         1) Patients who are not opioid tolerant as defined above.
         2) Management of postoperative pain.
         3) Management of mild pain or intermittent pain.
         4) Management of acute pain or if opioid analgesia is only needed for a short period of time (less than 7 days).
      iv. Determine if the patient has any relative contraindications for use:

1) Concomitant use with ketoconazole, erythromycin, nefazodone, diltiazem or grapefruit juice requires careful monitoring and may require adjustment in fentanyl dosage.
2) Transdermal fentanyl may not be appropriate for patients with fever, diaphoresis, cachexia, morbid obesity, and ascites, all of which may have a significant impact on the absorption, blood levels, and clinical effects of the drug.

b. Pharmacist will then verify the following and if necessary, change dose of fentanyl patch based on Fentanyl Dose Conversion Guideline:
   i. Fentanyl patch is prescribed at the lowest dose needed for pain relief.
   ii. First-time doses (new starts) should not exceed 25mcg/hr unless recommended by pain specialist or approved by Clinical Manager. Fentanyl patch 12 mcg/hr should be considered for elderly or frail patients.
   iii. Consider concomitant opiates and other medications known to have additive CNS or respiratory depression effects in evaluating the appropriateness of the dose.
      1) Discontinue or taper all other around-the-clock or extended release opioids when initiating therapy with fentanyl transdermal patch.
   iv. In selecting an initial dose, attention should be given to the following:
      1) Daily dose, potency, and characteristics of the opiate the patient has been taking previously.
      2) Reliability of dose conversion guidelines to predict the potency of the fentanyl dose needed.
      3) Patient's medical status.
      4) To account for incomplete cross-tolerance, a 25% dose reduction is needed when switching among opiates in patients whose pain is well controlled. No reduction is necessary in patients with poorly controlled chronic pain. For patients who have acute pain but whose chronic pain is otherwise controlled, a 25% dose reduction is still needed.
   v. Frequencies of q48h are generally not recommended.
      1) Frequencies of Q48h may be appropriate for a small number of adult patients and may be evaluated on a case-by-case basis. Such frequencies will not be allowed for new starts unless approved by the Clinical Manager.
   vi. During dose titration, increasing dosages shall not be made prior to 72 hours after initiation of therapy, and not prior to 6 days after dose changes.
      1) Titrate dose based on the daily dose of supplemental opioids required by the patient on the second or third day of the initial application.
      2) Dose should be increased in 25 mcg increments. Larger increments may be considered for some patients on high doses if prescribed and followed by pain specialist.
      3) Dose increases are not appropriate for patients who have acute pain but whose chronic pain is otherwise controlled. Such pain should be managed by appropriate use of breakthrough analgesia.
   vii. When discontinuing transdermal fentanyl and not converting to another opioid, use a gradual downward titration, such as decreasing the dose by 50% every 6 days to reduce risk of withdrawal symptoms.
      1) For disposal of fentanyl patches see Patient Care Services Controlled Substances Management Policy.

c. The pharmacist reviewing the order will document the following:
   i. Verification of inclusion criteria.
   ii. Initial dose and date/time of initiation.
   iii. Validation of inpatient and outpatient drug dosing history (including last refill information).

iv. Any potential drug interactions.
v. Discussions with prescriber, if any.

2. Dispensing and Labeling:
   a. Fentanyl patches will been set up as a patient specific medication.
   b. Do not cut patch warning will be placed in MAR notes.
   c. Tall man lettering will be used fentanyl.
3. Monitoring:
   a. Patient monitoring for opioid related side effects will be performed by nursing staff as per the Pain Management Patient Care Services Policy.

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

1. Fentanyl (Duragesic) Dose Conversion Guidelines
2. Tri-City Medical Center Criteria for Use of Fentanyl Transdermal System
3. Patient Care Services: Controlled Substances Management Policy

E. **REFERENCE(S)**:

1. ISMP Medication Safety Alert! Community/Ambulatory Care Edition. Volume 13, Issue 3. March 2014
2. Acute Care ISMP Medication Safety Alert! Ongoing, Preventable Fatal Events with Fentanyl Transdermal Patches are Alarming! June 28, 2007.
3. CHA Medication Safety Committee High Alert Medication Guideline- Fentanyl Transdermal Patch. April 2011.
4. Grissinger, Matthew. Inappropriate Prescribing of Fentanyl Patches is Still Causing
5. Alarming Safety Problems. Pharmacy and Therapeutics. 2010; 35(12): 653-654.
6. Lexicomp, Inc. (Lexi-DrugsTM). Lexicomp. July 5, 2017.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 11/93

SUBJECT: Unlabeled Uses of FDA-Approved Medications

REVISION DATE: 12/93, 06/96, 05/97, 09/99, 08/00, 09/01, 02/03, 06/05, 07/06, 07/09, 01/12, 07/15, 01/18

Department Approval:	~~10/17~~11/21
Pharmacy & Therapeutics Committee Approval:	~~11/17~~11/21
Medical Executive Committee Approval:	~~11/17~~01/22
Administration Approval:	02/22
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **DEFINITION(S):**

1. For purposes of this policy "unlabeled use" includes the use of a drug product in (1) doses, (2) patient populations, (3) indications, (4) routes of administration that are not reflected in Federal Drug Admiration (FDA) approved product labeling.

B. **POLICY:**

1. Pharmacy shall consider the off-label use of FDA approved drugs as prescribed by a physician/Allied Health Professional (AHP) to treat chronic, disabling, or acute, life-threatening illnesses medically necessary when:
   a. The drug has been approved by the FDA for at least one (1) indication and
   b. The drug is listed in a standard drug reference compendium for the off-label indication, such as:
      i. The United States Pharmacopoeia Drug Information (USPDI)
      ii. American Hospital Formulary Drug Information (AFHS-DI)
      iii. National Comprehensive Cancer Network (NCCN)
      iv. Thompson Micromedex DrugDex
      v. Lexicomp
      vi. Clinical Pharmacology

      or,
   c. The off-label use is supported substantially by accepted peer-reviewed medical literature
2. Off-label use of a drug shall not be considered if the FDA has determined said use to be absolutely contraindicated.
3. If the unlabeled use is not identified in the aforementioned compendia, the physician/AHP must present a proposal for said unlabeled use, along with documentation of safety and efficacy, to the Pharmacy and Therapeutics Committee at Tri-City Healthcare District (TCHD) for approval.
4. If the physician/AHP insists upon immediate use of a medication for unlabeled use not identified in the aforementioned compendia, the pharmacist will contact the physician/AHP for information regarding off label use and seek approval from the Clinical Manager. If information supporting off label use is verified by pharmacy, the electronic medication order will be verified by the pharmacist for immediate administration of the drug by nursing personnel.
5. If there is disagreement between the pharmacist and the prescribing physician/AHP, the Chairman of the Pharmacy and Therapeutics or his/her designee must be contacted for approval.
6. If the Pharmacy and Therapeutics Chairman is unavailable, the chain of command is as follows:

a. Division Chief
b. Department Chairman or Vice-Chairman
c. Chief of Staff

7. Once a decision is made regarding the "unlabeled use" of a medication by the Chairman of the Pharmacy and Therapeutics Committee, or Division Chief, or Department Chairman, or Department Vice-Chairman, or Chief of Staff, the decision is final.
8. The decision will be communicated to the Pharmacy Department, and documentation in the chart will be noted by the pharmacist regarding the final decision.

Tri-City Medical Center	Distribution: Imaging Services/Cardiology 7633-135
PROCEDURE: Safe Patient Transportation	
Purpose: To ensure the safety of the patient and staff during transportation and transfers to procedure tables	
Supportive Data: Nursing Implications: Equipment	**DELETE – follow Patient Care Services Policy: Transfer of Patients Intra Facility**

~~A. Procedure:~~

~~Transport staff shall notify the patient's RN or designated care giver when arriving on the unit of the pending transport. The transport staff shall use the "ticket to ride" document and ask the RN for any clarifications needed to ensure a safe patient transport.~~

~~Transport staff shall knock and politely introduce themselves to the patient and/or family members when entering the patient's room. The transport staff shall correctly identify the patient using two patient identifiers including written exam documentation which contains the patient's demographics information and the test to be performed. Transport staff shall inform the patient and/or family of the test to be performed and answer any questions that may arise.~~

~~Maintain dignity of patient at all times by keeping the patient covered with blankets and/or sheets. Ask the patient if they have any questions or need more information. Ask the patient if they agree with the request to take them to a procedure area. Prior to leaving the unit or procedure area ask the patient if they are cold and need additional blankets during the transport.~~

~~The patient shall never be left unattended during the transportation process. Abandonment of the patient increases the risk of patient injury. Remaining with the patient at all times will lessen patient anxiety and reduce risk of a patient fall. During the transportation process, remain observant of the patient for signs of physical or emotional distress.~~

~~Always elevate the side rails and apply safety straps during transport and during pre and post procedure periods.~~

~~Ensure head, arms and legs are protected, adequately padded, and patient is comfortable as possible. Always verbalize to patient to keep hands and arms inside the safety rails. Explain all actions to alert patient, i.e. placing safety strap, elevating side rails and keeping fingers out of the way, raising head of bed at patient's request if no spine precautions exist.~~

~~Confirm IV lines, indwelling catheters, monitoring system lines and drains, and any other lines are secure and not pinched or stretched in any way. Ensure catheter bag remains below the level of the patients bladder at all times.~~

~~The patient should be transported feet first; rapid movements, particularly when going around a corner should be avoided. Rapid movements, especially if the patient has received medications, can cause the patient to become disoriented, dizzy, nauseated, and induce vomiting.~~

~~Never leave the patient unattended when arriving at the procedure department. Transport staff shall provide hand off communication directly to the staff in the procedure area using the "Ticket To Ride" documentation.~~

Department Review	Department Revision	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Board of Directors
n/a	10/18, 02/20	n/a	n/a	n/a	02/22	

Transfer to Procedure Table

If the patient is alert, explain the transfer procedure prior to implementation to ensure patient understanding of the process, reduce patient anxiety and promote safety. Ask the patient if they understand the transfer process before initiating the transfer. Maintain the patient's privacy and dignity during the transfer by keeping the patient covered. This will aid in decreasing the patient's anxiety and ensure personal and moral rights.

Ensure skin integrity by cushioning exposed areas during the transfer.

A minimum of two staff members must be present when transferring a patient from a bed, stretcher, gurney, cardiac chair etc. to a procedure table and back. When a patient is in a wheelchair and is mobile one employee is acceptable only if the situation is considered safe by the technologists and the patient is not over 180lbs.

Verbally communicate to the patient which staff member will assist in the transfer including the employee's names. Explain the transfer mechanism and devices to be used during the transfer to the procedure table. Ask the patient if they are in pain or if the patient has any sensitive or painful areas to manage during the transfer to the procedure table. Instruct the patient to inform the staff if they are in pain during the transfer. Inform the patient of the different surface texture and hardness of the transfer boards and procedure tables.

During the actual transfer, all staff and the patient need to work in unison to ensure a smooth transfer. Do not use sudden motion techniques and always use transfer assist devices to protect the employee's physical well being. Keep the patient informed during the entire transfer process.

Once the transfer has been completed ask the patient if they have any questions, are uncomfortable, in pain or need additional padding for sensitive areas. Maintain the patient's dignity by keeping them covered and ask if they are cold and need additional blankets.

B. FORMS:

C. APPROVAL PROCESS

a. Division of Imaging
b. Medical Executive Committee
c. Professional Affairs Committee
d. Board of Directors

Tri-City Medical Center	~~Distribution: Imaging Services 7633-136~~ Radiology
PROCEDURE:	**REFERRAL NOT COMPLETE, MISSED (NO SHOW) & CANCELLED APPOINTMENTS 7633-136**
Purpose:	To ensure physician notification when a Imaging Services referral is not done due to the following criteria: 1. A referred patient fails to schedule the appointment when TCMC is requested to directly contact the patient. 2. A patient misses (no shows) a scheduling appointment. 3. A patient cancels an appointment and does not reschedule
~~Supportive Data:~~	
~~Equipment:~~	
~~Issue Date:~~	

A. **PROCEDURE DIRECT PATIENT CONTACT REQUESTED REFERRALS:**

1. When Imaging Services patient referrals cannot be scheduled due to the inability to contact the patient or when contact is made but the patient chooses not to schedule the appointment the referring physician office shall be notified.
   a. For failed scheduled appointments the scheduling department will fax the original physician referral form with a written note on the form indicating the reasons for the appointment failure.
   b. The scheduling staff shall save the fax confirmation form and the failed referral form to the fax server folder titled "failed referral appointments".
2. Missed Scheduled Appointments (No Shows):
   a. When a patient fails to show for their scheduled appointment the day shift front desk staff is responsible for reconciling all no-show appointments.
      i. No show appointments from the prior day shall be processed prior to end of shift.
      ii. Weekend no show appointments shall be processed on the following Monday.
      iii. Contact the referring physician's offices with notification of the no-show appointment.
      iv. Document in Cerner the person and time contacted using the Appointment Inquiry Icon in the scheduling application.
3. Patient cancels their appointment in person or by telephone with no reschedule.
   a. When a patient cancels their appointment and dose not reschedule the appointment.
      i. Contact the referring physician's offices with notification of the patient directed canceled appointment.
      ii. Document in Cerner the person and time contacted.
      iii. Cancel the appointment scheduled in Cerner.

~~B. **FORMS:**~~

~~C. **APPROVAL PROCESS**~~

1. ~~Division of Imaging~~
2. ~~Medical Executive Committee~~
3. ~~Professional Affairs Committee~~
4. ~~Board of Directors~~

Radiology Department	Department of Radiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Board of Directors
11/18, 02/20	n/a	n/a	n/a	02/22	

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS

January 27, 2022 – 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 3:40 p.m. on January 27, 2022.

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 Adela Sanchez
Director Tracy M. Younger

Absent was Director Gigi Gleason

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 3:40 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Coulter to approve the agenda as presented. Director Chaya seconded the motion. The motion passed unanimously (5-0-0-1) with Director Gleason absent.

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 January 27, 2022 Regular Board of Directors Meeting Agenda.

The following individuals requested to speak under Public Comments:

- Cathy Cronce, RN
- Edmundo Garcia, CNA Labor Representative

5. December, 2021 Financial Statements – Ray Rivas, Chief Financial Officer

Mr. Rivas, Chief Financial Officer reported on the fiscal year to date financials as follows (Dollars in Thousands):

- Net Operating Revenue – $170,319
- Operating Expense - $180,858
- EBITDA - $1,160
- EROE ($5,311)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 151
- Adjusted Patient Days – 55,097
- Surgery Cases – 3,327
- ED Visits – 25,130

Mr. Rivas also reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $27,869
- Operating Expense - $30,855
- EBITDA – ($277)
- EROE – ($1,358)

Mr. Rivas reported on the current month Key Indicators as follows:

- Average Daily Census – 157
- Adjusted Patient Days – 9,285
- Surgery Cases – 527
- ED Visits – 4,115

6. New Business

a) Board Member Vacancy

Chairperson Chavez referred to Board Counsel's memorandum regarding the Board Member Vacancy in Zone 5. In essence, the Board will post the vacancy on January 31st and interested candidates must apply by 5:00 p.m. on February 17th. The Notice of Vacancy will be posted on the District's webpage, as well as in the local newspapers and libraries The Board will hold a Special Meeting in open session on February 25, 2022 to interview the applicants and select a candidate.

Chairperson Chavez cautioned Board members against meeting candidates individually as doing so could violate the Brown Act. Chairperson Chavez

explained the interview process and encouraged Board members to send Mr. Scott questions they would like to ask the individual candidates.

It was moved by Director Coulter to approve the filing of vacancy for Zone 5. Director Sanchez seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason**

7. Old Business – None

8. Chief of Staff

a) Consideration of the January 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 24, 2022.

Dr. Henry Showah, Chief of Staff Elect presented the Medical Staff and Allied Health Credentials in Dr. Johnson's absence. The Medical Staff credentials included 10 Initial Appointments, three of which were Kaiser physicians, 18 Reappointments, four Relinquishment of Privileges and 15 Proctoring Recommendations. Allied Health Professional credentials included two Initial Appointments, one Reappointment, three Resignations and two Proctoring Recommendations.

It was moved by Director Chaya to approve the January 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on January 24, 2022. Director Younger seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason**

9. Consideration of Consent Calendar

It was moved by Director Coulter to approve the Consent Calendar as presented. Director Chaya seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Sanchez and Younger**
NOES:	**Directors:**	**None**

ABSTAIN: Directors: None
ABSENT: Directors: Gleason

10. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar.

11. Comments by Members of the Public

Chairperson Chavez recognized Edmundo Garcia, CNA Labor Rep. Mr. Garcia stated he is giving his time to Chris Hart.

Chris Hart, RN commented on the proposed wage grid presented by Management as well as staff morale. She stated the bargaining team has called for a strike vote which will be take place on February 1st.

Chairperson Chavez also recognized Cathy Cronce, RN. who called on the Board and leadership to prioritize safe patient care. She also commented on the number of Travelers which were brought in to support the nurses and high census. Lastly, Ms. Cronce commented on the strike vote scheduled for February 1st.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported work force is a primary concern across our state and nation. Patient and employee safety is Tri-City Medical Center's number one concern and remains our priority. He noted four area hospitals went on internal disaster recently and we are happy to report that Tri-City did not, however it has definitely been challenging. Mr. Dietlin stated we are doing everything we can to staff as many beds as we can and have taken multiple steps to do that.

Mr. Dietlin reported this past Saturday Tri-City had 75 COVID positive inpatients compared to 100 a year ago. The county saw the high point on Saturday with 1,400 positive COVIDs which was double that of the Delta variant of 700 and at its height last January was 1,800. Mr. Dietlin commented that no area is immune to the impact of this disease including our physicians and staff. Between December 27th and January 26th 250 employees were out due to positive COVID results which compounded the workforce challenges.

Mr. Dietlin reported the County went on a moratorium on ED bypasses for two weeks but fortunately the hospital has been able to manage that traffic. He acknowledged Dr. Ma and Candice Parras for managing the entire process.

Mr. Dietlin thanked the entire Tri-City team for taking care of our community and their heroic efforts.

13. Board Communications

Director Chaya commented on the pandemic and the difficult situation the hospital is in trying to compete with Travelers. She emphasized the importance of working together rather than against each other and being honest and forthright about what we can and cannot do. Director Chaya stated she hopes we can come together for the good of the hospital.

Director Sanchez commented on the agreement approved today for a laborist group which will enable Tri-City to continue its Women & Newborn services as it is very important to keep those services in the community.

Director Sanchez stated the Board truly does appreciate the frontline workers and supports them all. She expressed her appreciation to the nurses who are working so hard.

Director Coulter echoed fellow Board member comments. He commented that the district must remain financially viable and hopes that the hospital and union can work together towards resolution.

Director Younger stated she appreciates the speakers who took the time to speak today and acknowledged their passion. She stated the Board too would like the matter resolved and come to an agreement.

Director Younger stated she feels confident with the OB plan that will provide laborist coverage.

Lastly, Director Younger reported February is Heart Month and gave a "shout out" to Cardiac Rehab.

14. Report from Chairperson

Chairperson Chavez apologized for the technical issues at the beginning of today's meeting.

Chairperson Chavez also reported that the Board held a Special Meeting earlier this afternoon and authorized Mr. Dietlin to take appropriate action for mediation with CNA. He stated that everyone supports our nurses.

Lastly, Chairperson Chavez adjourned today's meeting in memory of former Director RoseMarie Reno who served on the Tri-City Healthcare District Board of Directors from 1984 to 2021. Today we honor Mrs. Reno's memory and many contributions.

15. Move to adjourn

It was moved by Director Younger and seconded by Director Coulter to adjourn the meeting. The motion passed (5-0-0-1) with Director Gleason absent.

16. There being no further business Chairperson Chavez adjourned the meeting at 4:30 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

January 27, 2022 – 2:00 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 2:00 p.m. on January 27, 2022.

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 Adela Sanchez
Director Tracy Younger

Absent was Director Gigi Gleason

Also present via teleconference were:

Steve Dietlin, Chief Executive Officer
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 2:00 p.m. via teleconference with attendance as listed above.

2. Approval of agenda

   It was moved by Director Younger to approve the agenda as presented. Director Coulter seconded the motion. The motion passed (5-0-0-1) by a roll call vote with Director Gleason absent.

4. Oral Announcement of Items to be discussed during Closed Session

   Chairperson Chavez made an oral announcement of the items listed on the January 27, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, two matters of Potential Litigation, Conference with Labor Negotiators and Reports Involving Trade Secrets with a disclosure date of March 1, 2022.

5. Motion to go into Closed Session

   It was moved by Director Coulter and seconded by Director Younger to go into Closed Session at 2:07 p.m. The motion passed (5-0-0-1) by a roll call vote with Director Gleason absent.

6. At 3:30 p.m. the Board returned to Open Session with attendance as previously noted.

7. Report from Chairperson on any action taken in Closed Session.

The Board in closed session conferred with legal counsel related to two Existing Litigation matters and discussed: 1) The Medical Acquisition Company vs. Tri-City Healthcare District and 2) The Tri-City Healthcare District vs. the Medical Acquisition Company and took no action.

The Board conferred with legal counsel regarding two potential litigation matters and took no action.

The Board also conferred with its Labor Negotiator and directed the Negotiator to take appropriate action concerning pursuing mediation,

Lastly, the Board heard a Report Involving a Trade Secret matter and took no action.

8. Open Session

Consideration to approve laborist coverage for Women's and Newborn Services, including agreements between TCHD and DHP of CA.

Mr. Steve Dietlin, CEO explained the proposed agreement with DHP of CA will provide laborist coverage beginning March 1, 2022 and will enable Tri-City to continue its Women & Newborn services 24/7 coverage.

It was moved by Director Sanchez to approve laborist coverage for Women's and Newborn Services, including agreements between TCHD and DHP of CA. Dr. Chaya seconded the motion.

The vote on the motion via a roll call vote was as follows:

AYES:	**Directors:**	**Chavez, Chaya, Coulter, Sanchez and Younger**
NOES:	**Directors:**	**None**
ABSTAIN:	**Directors:**	**None**
ABSENT:	**Directors:**	**Gleason**

8. Adjournment

It was moved by Director Younger and seconded by Director Coulter to adjourn the meeting at 3:36 p.m. The motion passed (5-0-0-1) by a roll call vote with Director Gleason absent.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
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	65.6	67.0	73.8						66.6	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	51.8	

TCMC Days in Accounts Payable (A/P)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD Avg	Goal Range
FY22	102.6	96.5	99.7	93.7	95.8	94.8	92.0						96.4	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	99.6	

TCHD EROE $ in Thousands (Excess Revenue over Expenses)

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	C/M YTD	C/M YTD Budget
FY22	($900)	($1,011)	($733)	$132	($1,441)	($1,358)	($1,172)						($6,482)	($5,698)
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)	$210	($554)	$4,682	$4,774	($2,782)	

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%	-5.23%	-4.87%	-3.99%						-3.25%	-2.96%
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%	-1.50%	

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	($359)	($277)	($105)						$1,055	$2,546
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935	$1,383	$422	$5,782	$5,855	$5,696	

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%	-1.30%	-1.00%	-0.36%						0.53%	1.32%
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%	3.07%	

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	5.09	5.60	4.78						5.24	5.29
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	5.48	

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	$52.4	$54.6	$51.2						
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 January 31, 2022

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)	34,354.61	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)	11,495.40	09/01/21	08/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suit A Oceanside, CA 92058	7094
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,547.22	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)	39,237.00	10/01/12	10/01/22	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg.5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	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	01/31/22	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**211,514.45**				

(a) Total Rent includes Base Rent plus property taxes, association fees, insurance, CAM expenses, etc.

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending January 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	AACN RECERTIFICATION	10722EDU	150.00	83346	RUETTEN, KYUNGHEE KIM
8740	ASRT MEMBERSHIP	11422 EDU	125.00	83671	LEKOSKI MITCHELL
8740	ONS ONCC	122221EDU	103.00	84034	DANILO D APOSTOL
8740	PREGNACY AND POST PARTUM	10722EDU	200.00	84036	REID BOUCHARD

**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.