TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
May 26, 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:837 0964 6547; Passcode: 277442

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	Special Recognitions – Nurses & Support Staff of the Year for 2022 ➢ Nurse of the Year (Day Shift): Laura Lamour ➢ Nurse of the Year (Night Shift): Dagmara Kolasa ➢ Above and Beyond: Karen Conyers ➢ Patient Support Staff of the Year: Rachael Herrera	10 min.	Chair
6	April 2022 Financial Statement Results	10 min.	CFO
7	New Business – a) Consideration of proposed Board Committee Charters and Committee List b) Consideration of Board Sponsorship for Foundation Gala	10 min. 5 min.	Chair Chair

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

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

	Agenda Item	Time Allotted	Requestor
8	Old Business – None		
9	Chief of Staff a) May 2022 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on May 23, 2022.	5 min.	COS
10	Consideration of Consent Calendar ***Requested items to be pulled <u>require a second</u>*** (1) Approval of Resolution 814, 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) Approval of Property & Casualty Insurance agreements with various carriers as reflected on the accompanying Executive Summary through McGriff Insurance Services, Inc. for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023 for a total annual/term cost of $2,126,696. (3) Approval of the renewal of the agreement with Dr. Dennis Ordas for the Out-Patient Behavioral Health Medical Directorship for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, at an hourly rate of $144.00, an annual cost of $90,856 and a total cost for the term of $179,712. (4) Approval of the renewal of an agreement with Dr. Frank Corona, for Medical Director leadership support of the Pulmonary Rehabilitation Service Line for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175.00 for an annual cost of $42,000 and a total cost for the term of $84,000. (5) Approval of the renewal of an agreement with Beckman Coulter for Laboratory Reagent rental for a term of 12 months, beginning August 1, 2022 and ending July 31, 2023, for an annual and term cost of $299,376. (6) Approval of the renewal of the Emergency Department Call Coverage Panel for Gastroenterology General and ERCP services to include Hellen Chiao, M.D., Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D., Michael Shim, M.D., and Matthew Viernes, M.D., for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, with an annual cost of $492,500 and a total term cost of $985,500. (7) Approval of the renewal of the Emergency Department Call Coverage Panel for Cardiology STEMI services to include Kenneth Carr, M.D.,Karim El-Sherief, M.D., Anitha Rajamanickam, David Spiegel, M.D. and Aaron Yung, M.D., for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, with an annual and total term cost of $365,000. (8) Approval of the renewal of the Emergency Department Call Coverage Panel for General Cardiology Services to include Hanh Bui, M.D.,		

	Agenda Item	Time Allotted	Requestor

Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, MD., Anitha Rajamanickam, M.D., Pargol Samani, M.D., David Spiegel, M.D. and Aaron Yung, M.D. for a term of 12 months, beginning July 1, 2022 and ending June 30, 2023, with an annual total term cost of $109,500.

(9) Approval of the renewal of the Emergency Department Call Coverage Panel for Interventional Radiology General and Stroke services to include Justin Gooding, M.D., Ankaj Khosla, M.D., Charles McGraw, M.D., Arian Nasiri, M.D., Michael Noud, M.D., Donald Ponec, M.D., Richard Saxon, M.D. and Cyrus Shabrang, M.D., for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, with an annual cost of $328,500 and a total term cost of $657,000.

(10) Approval of renewal of the Emergency Department Call Coverage Panel for Spine Surgery to include Neville Alleyne, M.D., Payam Moazzaz, MD., Tyrone Hardy, M.D, Mark Stern, M.D. and Kevin Yoo, M.D. for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, with an annual cost of $164,250, and a total term cost of $328,500.

(11) Approval of the First Addendum Lease Renew with 1958 Via Centre Dr., Vista, CA for an additional five (5) year term beginning July 1, 2022 and ending June 30, 2027 for a monthly expense of $16,473.44 and a total expense for the five (5) year term of $1,113,226.

(12) Administrative & Board Committees

A. Policies

1. Patient Care Services Policies & Procedures

a. Bronchoscopy Nursing Procedure
b. Census Zones, Managing of Policy
c. Code Caleb Standardized Procedure (DELETE)
d. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure
e. Incentive Spirometer (IS) Instruct and Monitoring
f. Pre-operative Education Medication Instructions to Surgical Patients Standardized Procedure
g. Provision of Education for Adolescents During Hospitalization
h. Wound, Ostomy, Continence Nurse (WOCN) Standardized Procedure

2. Administrative 200 District Operations 300 Patient Care

a. Plan to Manage and Estimate Project Costs 27
b. Smoke-free Environment 205

3. Unit Specific – Cardiac Cath Lab

a. AICD Check Procedure
b. Electrophysiology Study Procedure
c. Scheduling Cardiac Catheterization Cases Policy
d. Set Up for Sterile Table Procedure
e. Temp Pacemaker Electrode Removal Procedure
f. Venous Sheath Removal Procedure

4. Unit Specific – Cardiac Rehab

a. Definition of Cardiac Rehab Phases (DELETE)
b. Emergency Response Team
c. Maintenance and Repair of Exercise Equipment

	Agenda Item	Time Allotted	Requestor
	d. Patient Chart Requirements e. Safekeeping Patient Valuables (DELETE) f. Staffing Policy (DELETE) g. Transfer & Integration into Cardiac Rehabilitation Program (DELETE) **5. Unit Specific – Engineering** a. Prevention of Exposure to Blood Borne Diseases (DELETE) **6. Unit Specific – Food & Nutrition** a. Clinical Nutrition Dietitian Staffing b. Patient Meals Hours (DELETE) c. Personnel Qualifications for Management of Food and Nutrition (DELETE) **7. Unit Specific – Medical Staff** a. Credentialing Policy, Processing Medical Staff Reappointment 8710-548 b. Medical Record Documentation Requirements 8710-518 c. Standards for Seed Implants in the OR 8710-524 **8. Unit Specific – Outpatient Behavioral Health** a. Abbreviations b. Admission and Eligibility Criteria c. Admission Assessment d. Age Appropriate Care e. Clinical Assessment f. Contraband g. Daily Progress Notes h. Destructive or Potentially Violent Behavior i. Disaster Plan j. Discharge Planning & Discharge k. Family Involvement l. Laboratory Services m. Medical Emergencies n. Organizational Structure o. Physician Admission Order p. Physician Admission Order q. Referral and Admission Screening r. Role of the Therapist s. Scope of Services t. Smoke Free Environment u. Standards for Clinical and Professional Practice v. Substance Abuse w. Suicide Assessment x. Summary of Care List (DELETE) y. Treatment Planning **9. Unit Specific – Patient Care Management** a. Utilization Review Process **10. Unit Specific – Pharmacy** a. Automatic I.V. to Oral Conversion b. Drug Samples c. Employee Theft or Impairment Policy d. Labeling Standards e. Medication Recall Policy		

	Agenda Item	Time Allotted	Requestor
	f. Restricted Antimicrobials g. Risk Evaluation and Mitigation Strategies (REMS) Policy h. Technician Checking Technician Program **11. Unit Specific – Pulmonary Rehab** a. Disaster Plan **12. Unit Specific – Security** a. Closed Circuit Television System 512 b. Security Department Guidelines for Nuclear Medicine Policy 515 (DELETE) **13. Unit Specific – Surgical Services** a. Sanitation; Perioperative Policy **14. Unit Specific – Newborn Services** a. Scheduling Process for Procedures (13) Minutes – Approval of: a) April 28, 2022 – Special Meeting b) April 28, 2022 – Regular Meeting (14) Meetings and Conferences – None (14) Dues and Memberships - None (16) Reports (a) Dashboard – Included (b) Construction Report – None (c) Lease Report – (April, 2022) (d) Reimbursement Disclosure Report – (April, 2022) (e) Seminar/Conference Reports – None		Standard
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 min	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1.5 hour	
17	Adjournment		

TCHD BOARD OF DIRECTORS
2022 COMMITTEE ASSIGNMENTS

Pursuant to Article VI of the Bylaws, the Chairperson, with the concurrence of the Board of Directors, hereby constitutes the following Committees and appoints their members; provided that the Chair of any Committee shall be authorized to appoint members designated as non-voting to serve pro tem as voting Committee members as necessary to achieve a quorum at a meeting.

Finance, Operations & Planning *(Monthly)*

1.	Committee Chair	Director Tracy Younger
2.	Board	Director Nina Chaya, M.D.
3.	Board	Director Adela Sanchez
4.	Board Alt.	Director Marvin Mizell
5.	Medical Staff	Chief of Staff
6.	Medical Staff	Chief of Staff Elect
7.	Medical Staff	Immediate Past Chief of Staff

Audit/Compliance & Ethics Committee *(Held quarterly as needed)*

1.	Committee Chair	Director Nina Chaya, M.D.
2.	Board	Director George Coulter
3.	Board	Director Marvin Mizell
4.	Board Alt.	Director Sanchez
5.	Medical Staff	Appointed by Medical Staff

Community Healthcare Alliance Committee *(Held quarterly as needed)*

1.	Committee Chair	Director Gigi Gleason.
2.	Board	Director Nina Chaya, M.D.
3.	Board	Director Adela Sanchez
4.	Board Alt.	Director George Coulter
5.	District Resident O'side.	TBD
6.	District Resident for Vista	TBD
7.	District Resident Carlsbad	TBD
8.	O'side Chamber Commerce	TBD
9.	Carlsbad Chamber Commerce	TBD
10.	Vista Chamber Commerce	TBD
11.	O'side Public Safety Officer	TBD
12.	Carlsbad Public Safety Officer	TBD
13.	Vista Public Safety Officer	TBD
14.	Chief of Staff or Designee	TBD

TRI-CITY HEALTHCARE DISTRICT

FINANCE AND OPERATIONS COMMITTEE

COMMITTEE CHARTER

The Finance and Operations Committee (the "Committee") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide governance oversight and to make recommendations to the District's Board of Directors (the "Board") by overseeing the functions of the District directly related to Finance and Operations. The Committee focuses on matters that are material to the District's operations. "Material" generally means financial impacts exceeding the Chief Executive Officer's approval limit as well as matters that, due to their nature, could expose the District to significant risks.

1. **Finance Oversight**: The Committee will oversee the Finance function of the District, including the following:

    a. Review monthly financial statements prepared by the Finance Department and presented by the Chief Financial Officer;

    b. Monitor the monthly financial statements for unusual trends and have the Chief Financial Officer provide a detailed explanation of the variances;

    c. Report to the Board regarding any issue involving the integrity or trustworthiness of the District's interim financial statements;

    d. Review any proposed changes to Finance-related policies and procedures, including Board Policy No. 19-017 (investments) and 19-013 (procurement).

2. **Operations Oversight:** The Committee shall:

    a. New contracts (not within the scope of another Board committee) as well as amendments and renewals of existing contracts that exceed the approval authority of the Chief Executive Officer as outlined in Administrative Policy and Procedure #232, Board Policy No. 19-013 and state law.

    b. Physician recruitments and other contracts with physicians.

II. Membership

The Committee shall consist of three Directors and three physicians (Chief of Staff, Chief of Staff Elect and Immediate Past Chief of Staff).

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

V. Reports

The Committee will report regularly to the Board regarding (i) all recommendations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the full Board for action.

VI. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved: Board of Directors: 9/20/2011
Approved: Board of Directors: 3/28/2013
Approved: Board of Directors: 5/29/2014
Approved: Board of Directors: 1/26/2017
Approved: Board of Directors:

TRI-CITY HEALTHCARE DISTRICT

AUDIT, COMPLIANCE & ETHICS COMMITTEE CHARTER

Tri-City Healthcare District's (the "District") Audit, Compliance & Ethics Committee (the "Committee") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

The Committee is to provide assistance, and make recommendations, to the District's Board of Directors ("Board") by overseeing, the external audit, the District's financial reporting obligations and the Ethics & Compliance Program. The Committee is responsible for making recommendations to the Board regarding the appointment, compensation, retention and oversight of the District's independent auditors; Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;

1. **Ethics & Compliance Program Oversight**. The Committee will oversee the District's Ethics & Compliance Program, including the following:

    a. Monitor the development and implementation of the District's Ethics & Compliance programs via periodic reports from the, District's Chief Compliance Officer.

    b. Review the Ethics & Compliance Program workplan, at least annually, as presented by the Chief Compliance Officer.

    c. Review and oversee revision of the District's Administrative Code of Conduct;

    d. Receive and revise draft policies from the Chief Compliance Officer.

    e. Make programmatic recommendations to the Chief Compliance Officer, senior management, and Board.

2. **External Audit and Financial Reporting Oversight.** The Committee shall:

    a. Review the accounting and financial reporting processes of the District and external audits of the District's annual financial statements;

    b. Report to the Board regarding any issue involving the integrity and trustworthiness of the District's annual financial statements;

    c. Review the independence, qualifications and performance of the District's external auditors;

d. Report to the Board regarding external auditor findings regarding the adequacy, efficacy, and adherence to policies and procedures related to accounting, internal accounting controls, ethical concerns, or auditing matters;

e. The Audit, Compliance & Ethics Committee Charter will be reviewed every three years.

II. Membership

The Committee shall consist of three (3) Directors of the District and one (1) physician appointed by the Medical Staff,

III. Meetings

The Committee may establish its own meeting schedule annually.

IV. Minutes

The Committee will maintain written minutes of its meetings, which will be filed with the minutes of the meetings of the Board.

V. Reports

The Committee will report regularly to the Board regarding (i) all determinations made or actions taken per its duties and responsibilities, as set forth above, and (ii) any recommendations of the Committee submitted to the Board for action.

VI. Conduct

Each Committee member shall comply with the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/.

Approved: Board of Directors: 9/29/11
Amended: Board of Directors: 4/26/12
Approved: Board of Directors: 3/28/13
Approved: Board of Directors: 5/30/13
Approved: Board of Directors: 5/29/14
Approved: Board of Directors: 8/25/16
Approved by Board of Directors: 1/25/18
Approved by Board of Directors:

TRI-CITY HEALTHCARE DISTRICT

COMMUNITY HEALTHCARE ALLIANCE COMMITTEE (CHAC) COMMITTEE CHARTER

The Community Healthcare Alliance Committee (the "CHAC") of the Tri-City Healthcare District ("District") has multiple purposes and is delegated certain key responsibilities as enumerated herein.

I. Purpose

CHAC is to provide governance oversight and to make recommendations to the District's Board of Directors ("Board") in two key areas:

1. CHAC will be a conduit for an exchange of knowledge between the District and the community to identify potential areas of cooperation as identified in the Triennial Community Health Needs Assessment (CHNA) conducted by the Hospital Association of San Diego and Imperial Counties (HASDIC);

2. The Committee will explore potential strategic alliances between the District and the community to address community health needs.

II. Guiding Principles

The CHAC operates under the following guiding principles:

1. Healthcare-related needs are defined broadly and are not limited to those addressed only by traditional healthcare facilities and providers;

2. The District should drive its outreach efforts based on the needs of those who reside within the boundaries of the District;

3. There are limited human and capital resources with which to meet the healthcare needs of the population of the District;

4. An annual plan and budget shall be established, within the District's Strategic Plan and budget, that prioritizes the needs to be addressed;

5. Targeted activities shall be measured (when possible);

6. The CHAC shall effectively interface with Administration and present their final recommendations to the TCHD Board of Directors;

7. The CHAC shall effectively interface with Administration and present their final recommendations to the TCHD Board of Directors;

III. Membership

CHAC shall have a maximum of 13 members representing the following community perspectives:

1. A minimum of one (1) and up to a maximum of three (3) Directors appointed by the Chairperson;

2. One (1) community member representing each of the cities of Carlsbad, Oceanside and Vista (three in all), appointed by the Chair of the Board of Directors, in coordination with the elected Board members on the CHAC Committee;

3. One representative appointed by the Chambers of Commerce of Carlsbad, Oceanside and Vista (three in all);

4. One public safety representative appointed by the City Managers of Carlsbad, Oceanside and Vista (three in all);

5. One representative of the Medical Staff appointed by the Medical Staff.

Appointing agencies are encouraged to promote representatives who have experience with diverse communities and perspectives.

Members representing key constituencies shall be selected by the organizations they represent and serve at the pleasure of the appointing authority, subject to the authority of the Chairperson in Section 1, Article V of the District's Bylaws. Such representatives shall be considered "community members" as described by Board Policy No. 19-031. Term limits and district residency requirements shall not apply to members representing key constituencies. In each instance, a letter of appointment from the appointing authority shall be transmitted to the District in order for the representative to be seated.

Community members shall be selected annually by the Board, with a maximum term of four (4) years as approved by the TCHD Board of Directors.

A quorum of CHAC shall consist of a majority of the members of the committee.

IV. Meetings

The Committee may establish its own meeting schedule annually.

V. Minutes

CHAC will maintain written minutes of its meetings. Draft minutes will be presented to the Board for consideration at its meetings. The Senior Executive Assistant or designee will provide assistance to the Committee in scheduling meetings, preparing agendas and keeping minutes.

VI. Reports

CHAC will report regularly to the Board regarding (i) all determinations made or actions taken pursuant to its duties and responsibilities, as set forth above, and (ii) any recommendations submitted to the Board for action.

VII. Conduct

Each Committee member is expected to read the District's Code of Conduct which can be found at http://www.tricitymed.org/about-us/code-of-conduct/ and shall comply with all provisions thereof while a member of this Committee.

Approved by Board of Directors: 11/6/14
Approved by Board of Directors: 1/31/19
Approved by Board of Directors:

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
May 18, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 5/27/2022 – 4/30/2024)

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 5/27/2022 through 4/30/2024:

- **AHDOOT, Morris MD/OB/GYN (TeamHealth)**
- **BALBUENA-ROOT, Melissa MD/Neurology (Real Time Neuromonitoring)**
- **DILLARD, Kira MD/Neurology (Real Time Neuromonitoring)**
- **FUSSNER, Steven MD/Neurology (Real Time Neuromonitoring)**
- **MCKEIRNAN, Anne MD/OB/GYN (Kaiser)**
- **PURCOTT, Kari MD/OB/GYN (Tri-City)**
- **SAUNDERS, Phillip DO/Oncology (The Oncology Institute)**
- **VITANTONIO, Daniel MD/Neurology (Real Time Neuromonitoring)**
- **WONG, Tina MD/Anesthesiology (ASMG)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
May 18, 2022

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 6/01/2022 – 5/31/2024)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 6/01/2022 through 5/31/2024, 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:

- **BEN-HAIM, Sharona, MD/Neurological Surgery/Active**
- **CHOUDRY, Bilal, MD/Neurology/Active**
- **CONTARDO, Marcus, MD/Pathology/Active**
- **FISCHER, Andrew, MD/Emergency Medicine/Active**
- **GARFF, Kevin, MD/Ophthalmology/Provisional**
- **JAFFER, Jihad, MD/Physical Medicine & Rehab/Active Affiliate**
- **KOBAYASHI, Gary, MD/Internal Medicine/Refer and Follow**
- **KROL, Thomas, MD/Gastroenterology/Active**
- **LANE, Richard, MD/Neurology/Provisional**
- **LAUFIK, Martin, MD/Radiology/Provisional**
- **LE, Yung, MD/Internal Medicine/Active**
- **LEE, Anna, MD/Pediatrics/Active**
- **LEE, Dandy, MD/Anesthesiology/Active**
- **LIAGHAT, Arash, MD/Anesthesiology/Active**
- **LINSON, Patrick, MD/Radiation Oncology/Active**
- **MAHIL, Amreesh, MD/Anesthesiology/Active**
- **MCCLAY, Edward, MD/Oncology/Active**

Attachment B

- **MITCHELL, Charles, MD/Radiology/Active**
- **OMURO, Arthur, DO/Neurology/Provisional**
- **PATEL, Cecil, MD/Radiology/Provisional**
- **PHILLIPS, Jason, MD/Urology/Active**
- **RASH, Dominique, MD/Radiation Oncology/Active**
- **RAYAN, Sunil, MD/Vascular Surgery/Active Affiliate**
- **TUNG, Howard, MD/Neurological Surgery/Active**
- **WANG, Chunyang, MD/Neurology/Active**

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

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

- **LOPEZ, Sandra, MD/Obstetrics & Gynecology/Active**

UPDATE TO PREVIOUS REAPPOINTMENT:

- **TAYANI, Ramin, MD/Ophthalmology/Refer and Follow**
  Recommend time-limited reappointment (02/01/2022 – 01/31/2024) to the Refer and Follow staff status with no clinical privileges.

  Note: Provider received a time-limited reappointment due to lack of required number of CME's, provider has submitted the required number of CME's to receive the full two-year reappointment.

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
May 18, 2022

Attachment B

RESIGNATIONS: (Effective date 5/31/2022 unless otherwise noted)

Automatic Resignation:

- BLASKIEWICZ, Donald, MD/Neurological Surgery

Voluntary:

- AZAM, Arsalan, MD/Emergency Medicine
- BURNEY, Melissa, PA-C/Allied Health Professional
- FITZGERALD, Adam, PA-C/Allied Health Professional
- GONZALES, Michelle, MD/Family Medicine
- JOHNSON, William, MD/Radiology
- HERGESHEIMER, Charles, MD/Internal Medicine
- KIRKLAND, Jared, MD/Teleradiology
- SUNDBLAD, Matthew, MD/Anesthesiology
- TEBON, Renee, PA-C/Allied Health Professional
- VAYSER, Dean, DPM/Wound Care

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
May 18, 2022

PROCTORING RECOMMENDATIONS

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

- **COHEN, David, MD**
  Release from Proctoring:

  Cardiology
  Watchman

- **KUTZ, Craig, MD**
  Release from Proctoring:

  Emergency
  General Patient Care.

- **WANG, Chunyang, MD**
  Release from Proctoring:

  Neurology
  Admit patients, Consultation, including via telemedicine (F), History & Physical, including via telemedicine (F).

RESOLUTION NO. 814

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 May 26, 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

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 26, 2022
MCGRIFF INSURANCE SERVICES, INC.

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

Vendor's Name: McGriff Insurance Services, Inc.

Area of Service: Property & Casualty Insurance

Term of Agreement: 12 months, Beginning, July 1, 2022 – Ending, June 30, 2023

Maximum Totals:

Annual Cost	Total Term Cost
$2,126,696	$2,126,696

Description of Services/Supplies:

- Umbrella Professional and General Liability Insurance (Chubb)
- Property Insurance (AIG)
- Management Liability Insurance (Markel, RSUI, AIG)
- Automobile Insurance (Non-Profits United)
- Pollution Insurance (Tokio Marine)
- Others: Volunteers, Employed Lawyers, Heli-Pad Liability, Cyber, Crime, GL/PL TPA Contract

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

Person responsible for oversight of agreement: Ray Rivas, CFO, Susan Bond, General Counsel

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with McGriff Insurance Services, Inc. for Property & Casualty Insurance agreements with various carriers as reflected on the attached Executive Summary for a term of 12months, beginning July 1, 2022 and ending June 30, 2023 for a total cost for the term of $2,126,696.

Executive Summary 2022 - 2023

We anticipated challenges heading into the renewal cycle based on a hard market for property, excess liability, management liability and cyber liability insurance. Adding to this market turmoil, an exploding Cyber Marketplace and increase in litigated claims in California. Unfortunately, increasing premium rates, reduced underwriting capacity, increased retentions and scaled back coverages are the new normal.

Coverage	Expiring Premium	Renewal Premium	Insurance Carrier	AM Best Rating
Umbrella - GL/PL	($20M) $501,000	($15M) $546,585	Federal (Chubb)	A+ (Superior) XV
		($5M) $129,063	TDC	
Claims TPA - Two Year Term	$60,000	$60,000	Western Litigation	
Premium Subtotal	**$561,000**	**$735,648**		
Directors & Officers Employment Practices Fiduciary Liability $5M Primary	$414,136	$457,772	Markel	A (Excellent) XV
Management Liability Excess $5m	$200,000	$210,000	RSUI	A+ (Superior) XIV
ML Side A Excess	$102,900	$102,100	National Union (AIG)	A (Excellent) XV
Cardiovascular Institute	$25,813	$25,813	Markel	A (Excellent) XV
Property	$375,927	$403,542	AIG	A (Excellent) XV
Pollution	$33,398	$36,174	Tokio Marine (Philly)	A+ (Superior) XV
Cyber	$57,704	$98,735	Coalition	
Automobile	$34,395	*Est.* $36,975	Non-Profits United	
Crime – 3 Year Term 2021 / 2024	$34,022	-	Fidelity & Deposit Companies (Zurich)	A+ (Superior) XV
Heli-Pad Liability	$8,526	$9,396	American Alternative	
Employed Lawyers	$9,999	$9,999	Federal (Chubb)	A++ (Superior) XV
Volunteer Accident	$859	$515	Axis	A (Excellent) XV
Total Premium	**$1,858,679**	**$2,126,696**		

Premiums include taxes and fees

McGriff

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT Co-Medical Director – Outpatient Behavioral Health Services

Type of Agreement	X	Co-Medical Directors		Panel		Other: Increased Hours
Status of Agreement		New Agreement		Renewal – New Rates	X	Renewal – Same Rates

Physician's Name: Dennis Ordas, M.D.

Area of Service: Outpatient Behavioral Health-Morning and Afternoon Program

Term of Agreement: 24 months, Beginning, July, 1, 2022 – Ending, June 30, 2024

Maximum Totals: Within Hourly Fair Market Value. This agreement has the exact terms as his 2020-2022 contract

	Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	24 month (Term) Cost
Medical Director Duties	$144	32	384	$4,608	$55,296	**$110,592**
Case Care Management Duties	$144	16	192	$2,304	$27,648	**$55,296**
Vacation Coverage	$144	As needed	48 max	$576	$6,912	**$13,824**
Total:		**52**	**624**	**$7,488**	**$89,856**	**$179,712**

Co-Medical Director Responsibilities:

- Provide medical supervision and direction to the unit, including the morning, afternoon and evening programs
- Supervise and promote the quality of care and evaluate delivery systems.
- Oversee the development of evidence-based clinical services and provide psychiatric expertise.
- Facilitate weekly problem solving and treatment team meetings with clinical staff.
- Review all treatment plans at least monthly to determine appropriateness of problems and treatment goals.
- Evaluate and review policies and procedures and make suggestions for changes as appropriate.
- Provide education to other physicians ahttps://kasa-solutions.com/proposed-legislation-allows-lmft-lmhc-bill-medicare/nd departments regarding intensive outpatient level of care

Case Care Management and other Duties:

- Take on utilization management duties and respond to insurance authorization calls for IOP and communicate clinical determination of medical necessity
- Evaluate patients at least once per month for medical necessity and discharge readiness
- Evaluate whether patients are medically stable and meet inclusion/exclusion criteria for IOP on admission and monthly thereafter.
- Prepare reports and records as requested by hospital and regulatory bodies
- Provide professional guidance to staff Monday through Friday and evaluate risk/protective factors and recommend whether a patient needs inpatient treatment or can be managed with safety planning. Respond to calls Mondays through Fridays, 8 am-5 pm.

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

Person responsible for oversight of agreement: Sarah Jayyousi-Operations Manager, Outpatient Behavioral Health / Candice Parras, Chief Patient Care Services

Motion:
I move that the TCHD Board of Directors authorize the agreement with Dr. Dennis Ordas for the Behavioral Outpatient co-medical directorship for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, for an hourly rate of $144, an annual cost of $89,856, and a total cost for the term of $179,712.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for Pulmonary Rehab

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

Physician's Name: Frank E. Corona, M.D. dba Tri-City Pulmonary Medical Group, a Professional Corporation

Area of Service: Pulmonary Services Department

Term of Agreement: 24 months, Beginning, July 1st, 2022 – Ending, June 30th, 2024

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	XX month (Term) Cost
$175.00	20	240	$3,500	$42,000	$84,000

Position Responsibilities:

- Medical director leadership support of the Pulmonary Rehabilitation service line.
- Medical leadership oversight of the respiratory care department (Pulmonary Services) and the respiratory care practitioners.
- Review and make recommendations regarding clinical applications of respiratory care. Assistance in developing policies, procedures, clinical protocols, forms, reports and records by TCMC in connection with the department.
- Assist with the provision and design of educational services to the respiratory care staff members.

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

Person responsible for oversight of agreement: (Responsible Party: Eva England, Cardiovascular Service Line Director)

Motion:

I move that the TCHD Board of Directors authorize Dr. Frank Corona as the Coverage Physician for a term of 24 months beginning July 1st, 2022 and ending June 30th, 2024, not to exceed an average of 20 hours per month or 240 hours annually, at an hourly rate of $175.00 for an annual cost of $42,000 and a total cost for the term of $84,000.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 26, 2022
BECKMAN COULTER PROPOSAL

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

Vendor's Name: Beckman Coulter

Area of Service: Laboratory

Term of Agreement: 12 months, Beginning, August 1, 2022 – Ending, July 31, 2023

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$24,948	$299,376	$299,376

Description of Services/Supplies:

- Reagent Rental Consumables used in the laboratory Department
- Chemistry Test Reagents I.E, (CMP) Comprehensive Metabolic Panel, troponin test, drug screening, tumor markers.
- 1.2 million tests performed last year

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

Person responsible for oversight of agreement: Eva England, Senior Director

Motion:
I move that the TCHD Board of Directors authorize the renewal of an agreement with Beckman Coulter for Laboratory Reagent rental for a term of 12 months, beginning August 1, 2022 and ending, July 31, 2023, for an annual and term cost of $299,376.

TCHD Board of Directors
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – GASTROENTEROLOGY-GENERAL & ERCP

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

Vendor's Name: Hellen Chiao, M.D., Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D., Michael Shim, M.D., Matthew Viernes, M.D.

Area of Service: Emergency Department On-Call: Gastroenterology- General and ERCP

Term of Agreement: 24 months, Beginning, July 1, 2022 - Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase in General coverage rate from $775 to $850/24 hour. ERCP unchanged.

Rate/Day	Term	Annual Cost
GI- $850	FY2023 FY 2024	$310,250 $310,250
ERCP- $500	FY2023 FY2024	$182,500 $182,500
	Total Term Cost	**$985,500**

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for Gastroenterology General and ERCP services to include Hellen Chiao, M.D., Christopher Devereaux, M.D., Thomas Krol, M.D., Javaid Shad, M.D., Michael Shim, M.D., and Matthew Viernes, M.D., for a term of 24 months, beginning July 1, 2022 and ending, June 30, 2024, with an annual cost of $492,500, and a total term cost of $985,500.

TCHD Board of Directors
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, STEMI

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

Vendor's Name: Kenneth Carr, M.D., Karim El-Sherief, M.D., Anitha Rajamanickam, M.D, David Spiegel, M.D., Aaron Yung, M.D.

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

Term of Agreement: 12 months, Beginning, July 1, 2022 - Ending, June 30, 2023

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

Rate/Day	Term	Annual Cost
$1000	FY2023	$365,000
	Total Term Cost	**$365,000**

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for Cardiology STEMI services to include Kenneth Carr, M.D., Karim El-Sherief, M.D., Anitha Rajamanickam, M.D., David Spiegel, M.D., and Aaron Yung, M.D., for a term of 12 months, beginning July 1, 2022 and ending, June 30, 2023, with an annual and total term cost of $365,000.

TCHD Board of Directors
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – CARDIOLOGY, GENERAL

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

Vendor's Name: Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, M.D., Anitha Rajamanickam, M.D., Pargol Samani, M.D., David Spiegel, M.D.

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

Term of Agreement: 12 months, Beginning, July 1, 2022 - Ending, June 30, 2023

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

Rate/Day	Term	Annual Cost
$300	FY2023	$109,500
	Total Term Cost	**$109,500**

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for General Cardiology services to include Kenneth Carr, M.D., Karim El-Sherief, M.D., Ashish Kabra, M.D., Mohammad Pashmforoush, M.D., Anitha Rajamanickam, M.D., Pargol Samani, M.D., and David Spiegel, M.D., for a term of 12 months, beginning July 1, 2022 and ending, June 30, 2023, with an annual and total term cost of $109,500.

TCHD Board of Directors
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – INTERVENTIONAL RADIOLOGY

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

Vendor's Name: Justin Gooding, M.D., Ankaj Khosla, M.D., Charles McGraw, M.D., Arian Nasiri, M.D., Michael Noud, M.D., Don Ponec, M.D., Richard Saxson, M.D., Cyrus Shabrang, M.D.

Area of Service: Emergency Department On-Call: Interventional Radiology(General and Stroke)

Term of Agreement: 24 months, Beginning, July 1, 2022 - Ending, June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Increase in coverage rate from $750 to $900/24 hour.

Rate/Day	Term	Annual Cost
$900	FY2023 FY 2024	$328,500 $328,500
	Total Term Cost	**$657,000**

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for Interventional Radiology General and Stroke services to include Justin Gooding, M.D., Ankaj Khosla, M.D., Charles McGraw, M.D., Arian Nasiri, M.D., Michael Noud, M.D., Don Ponec, M.D., Richard Saxson, M.D., and Cyrus Shabrang, M.D., for a term of 24 months, beginning July 1, 2022 and ending, June 30, 2024, with an annual cost of $328,500, and a total term cost of $657,000.

TCHD Board of Directors
DATE OF MEETING: May 26, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – SPINE SURGERY

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

Vendor's Name: Neville Alleyne, M.D., David Amory, M.D., Payam Moazzaz, M.D., Tyrone Hardy, M.D., Mark Stern, M.D., Kevin Yoo, M.D.

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

Term of Agreement: 24 months, Beginning, July 1, 2022 - Ending, June 30, 2024

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

Rate/Day	Term	Annual Cost
$450	FY2023 FY2024	$164,250 $164,250
	Total Term Cost	**$328,500**

Description of Services/Supplies:

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

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

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

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Emergency Department Call Coverage Panel for Spine surgery to include Neville Alleyne, M.D., David Amory, M.D., Payam Moazzaz, M.D., Tyrone Hardy, M.D., Mark Stern, M.D., and Kevin Yoo, M.D., for a term of 24 months, beginning July 1, 2022 and ending, June 30, 2024, with an annual cost of $164,250 and total term cost of $328,500.

TCHD BOARD OF DIRECTORS
DATE OF MEETING: May 26, 2022
First Lease Addendum Proposal – 1958 Via Centre Dr., Vista - OSNC

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

Practice Name: Orthopaedic Specialist of North County – Vista location (TCMC 1206b practice)

Premises: 1958 Via Centre Drive, Vista, CA 92081 (4,995 sq. ft.)

Term of Agreement: 5 year, Beginning, July 1, 2022 – Ending, June 30, 2027

Within Fair Market Value: Yes (FMV was determined by Lease Comparables)

Rental Rate:	**Monthly Expense**
Rental Rate of $2.90 per square foot, per month, with a 3% increase each year. (4,995 sq. ft.)	$14,476.44
Common Area Maintenance Fees – $0.60 SF	$2,997.00
Total 5 Yr. Term Expense Amount:	**$1,113,226**

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

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development

Motion:

I move that the TCHD Board of Directors authorize the First Addendum Lease Renewal with 1958 Via Centre Dr., Vista, CA for an additional five (5) year term beginning July 1, 2022, ending June 30, 2027. This proposal remains within the current fair market value rental rate of $2.90 per square foot, plus monthly CAM fees of $0.60 for a monthly expense of $17,473.44, for a total expense for the five (5) year term of $1,113,226.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
May 19th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Bronchoscopy Nursing Procedure	3 year review, practice change	
2. Census Zones, Managing of Policy	3 year review, practice change	
3. Code Caleb Standardized Procedure	DELETE	
4. HIV Identification Screening Prevention of Perinatal Transmission Standardized Procedure	2 year review, practice change	
5. Identification of Newborns Procedure	3 year review, practice change	
6. Incentive Spirometer (IS) Instruct and Monitoring	3 year review	
7. Pre-Operative Education Medication Instructions to Surgical Patients Standardized Procedure	2 year review, practice change	
8. Provision of Education for Adolescents During Hospitalization	3 year review	
9. Wound, Ostomy, Continence Nurse (WOCN) Standardized Procedure	2 year review, practice change	
Administrative 200 District Operations 300 Patient Care		
1. Plan to Manage and Estimate Project Costs 27	3 year review, practice change	
2. Smoke-Free Environment 205	3 year review	
Cardiac Cath Lab		
1. AICD Check Procedure	3 year review, practice change	
2. Electrophysiology Study Procedure	3 year review, practice change	
3. Scheduling Cardiac Catheterization Cases Policy	- NEW	
4. Set Up for Sterile Table Procedure	3 year review, practice change	
5. Temp Pacemaker Electrode Removal Procedure	3 year review, practice change	
6. Venous Sheath Removal Procedure	3 year review, practice change	
Cardiac Rehab		
1. Definition of Cardiac Rehab Phases	DELETE	
2. Emergency Response Team	3 year review	
3. Maintenance and Repair of Exercise Equipment	3 year review, practice change	
4. Patient Chart Requirements	3 year review	
5. Safekeeping Patient Valuables	DELETE	
6. Staffing Policy	DELETE	
7. Transfer & Integration Into Cardiac Rehabilitation Program	DELETE	

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
May 19th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Engineering		
1. Prevention of Exposure to Blood Borne Diseases	DELETE	
Food & Nutrition		
1. Clinical Nutrition Dietitian Staffing	3 year review, practice change	
2. Patient Meals Hours	DELETE	
3. Personnel Qualifications for Management of Food and Nutrition	DELETE	
Medical Staff		
1. Credentialing Policy, Processing Medical Staff Reappointment 8710-548	3 year review	
2. Medical Record Documentation Requirements 8710-518	practice change	
3. Standards for Seed Implants in the OR 8710-524	3 year review, practice change	
Outpatient Behavioral Health		
1. Abbreviations	3 year review	
2. Admission and Eligibility Criteria	3 year review, practice change	
3. Admission Assessment	3 year review, practice change	
4. Age Appropriate Care	3 year review	
5. Clinical Assessment	3 year review, practice change	
6. Contraband	3 year review	
7. Daily Progress Notes	3 year review, practice change	
8. Destructive or Potentially Violent Behavior	3 year review, practice change	
9. Disaster Plan	3 year review, practice change	
10. Discharge Planning & Discharge	3 year review, practice change	
11. Family Involvement	3 year review	
12. Laboratory Services	3 year review, practice change	
13. Medical Emergencies	3 year review	
14. Organizational Structure	3 year review	
15. Physician Admission Order	3 year review	
16. Referral and Admission Screening	3 year review	
17. Role of the Therapist	3 year review	
18. Scope of Services	3 year review,	

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
May 19th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
	practice change	
19. Smoke Free Environment	3 year review	
20. Standards for Clinical and Professional Practice	3 year review	
21. Substance Abuse	3 year review	
22. Suicide Assessment	3 year review	
23. Summary of Care List	DELETE	
24. Treatment Planning	3 year review	
Patient Care Management		
1. Utilization Review Process	3 year review, practice change	
Pharmacy		
1. Automatic I.V. to Oral Conversion	3 year review, practice change	
2. Drug Samples	3 year review	
3. Employee Theft or Impairment Policy	3 year review	
4. Labeling Standards	3 year review	
5. Medication Recall Policy	3 year review	
6. Restricted Antimicrobials	3 year review, practice change	
7. Risk Evaluation and Mitigation Strategies (REMS) Policy	3 year review	
8. Technician Checking Technician Program	3 year review	
Pulmonary Rehab		
1. Disaster Plan	3 year review	
Security		
1. Closed Circuit Television System 512	3 year review, practice change	
2. Security Department Guidelines for Nuclear Medicine Policy 515	DELETE	
Surgical Services		
1. Sanitation; Perioperative Policy	practice change	
Women & Newborn Services		
1. Scheduling Process for Procedures	3 year review, practice change	

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**BRONCHOSCOPY NURSING**
Purpose:	To identify the roles and responsibilities of the primary, procedural, and recovery Registered Nurse (RN) when caring for patients requiring a bronchoscopy.
Supportive Data:	Bronchoscopy is a diagnostic or therapeutic procedure used to examine the tracheobronchial tree through a lighted tube, aspirate of bronchial secretions, remove foreign bodies, and obtain biopsy specimens. Bronchoscopy may be an emergent or elective procedure.
Equipment:	Personal Protective Equipment Cardiac Monitor Transport Monitor (if applicable) End-tidal Carbon Dioxide Monitor with Tubing Oxygen Devices with Tubing Vital Sign Machine with Pulse Oximeter Infusion Pump Crash Cart with Defibrillator or Automated External Defibrillator (AED) Suction Device and Suction Tubing Yankauer

A. **DEFINITIONS:**

1. Diagnostic Bronchoscopy: Performed to diagnose and assess pulmonary status through visualization and obtaining specimens via biopsies, brushings or washings.
   a. Diagnostic bronchoscopies must be performed in a negative airflow room (143, 243, 387, 443, 487, or the Bronchoscopy Suite) exceptions include:
      i. Patient is intubated and on a ventilator
      ii. Patient is in a private room with a High-efficiency particulate arrestance (HEPA) filtration system.
2. Therapeutic Bronchoscopy: Performed to remove retained secretions. Must be performed in a private room or Bronchoscopy Suite.
   a. A negative airflow room is not required, but must be performed in a private room.
3. Primary Nurse: Registered Nurse (RN) assigned primary care of a patient and responsible for preparing the patient for bronchoscopy as outlined in the Patient Care Services: Universal Protocol Procedure.
4. Procedural RN: RN qualified to implement PCS: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure.
5. Assisting Personnel: Staff assisting a physician during bronchoscopy procedure. Examples include:
   a. Inpatient: Respiratory Care Practitioner (RCP)
   b. Outpatient: Endoscopy/Surgical staff
6. Recovery RN: RN responsible for recovering patient post procedure.
7. Procedural Assessment: Pre-procedure, intra-procedure, immediate-post procedure assessment requirements performed by procedural and recovery RNs.

B. **POLICY:**

1. The primary RN is responsible for notifying their unit ~~Assistant Nurse~~ Manager ~~(ANM)/relief~~ **or** echarge **RN** of the pending scheduled bronchoscopy as soon as possible.

~~Department~~ Patient Care Services Content ExpertRevie w	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Committee~~	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
09/12, 05/17, **05/21**	10/12, 07/17, **02/22**	10/12, 07/17, **03/22**	06/18, **03/22**	n/a	01/12, 06/18, **04/22**	**05/22**	02/13, 07/18, **n/a**	02/13, 07/18

2. The Acute Care Services (ACS) and Progressive Care Unit (PCU) ~~ANM/relief~~ ~~c~~charge **RN** is responsible for contacting the Telemetry ~~ANM/relief~~ ~~c~~charge **RN**as soon as possible, when informed by the primary RN or bronchoscopy orders are obtained.
   a. The Telemetry ~~ANM/relief c~~charge **RN** will assign the role of procedural RN to **a** ~~the~~ Telemetry ~~PRN RN or~~ **RN** designee.
   b. When Telemetry RNs are not available to assist with inpatient bronchoscopies, the Intensive Care Unit (ICU) ~~ANM/relief~~ **Manager or** ~~c~~charge **RN** will be notified.
   c. Telemetry staff RNs will notify the Telemetry ~~PRN~~ RN ~~or~~ designee when orders are received for a bronchoscopy. The Telemetry ~~PRN~~ RN ~~or~~ designee will notify the Telemetry ~~ANM/relief c~~charge **RN**.
3. The Telemetry ~~ANM/relief c~~charge **RN** will notify the Post Anesthesia Care Unit (PACU) charge RN to make arrangements for ACS and PCU patients to be recovered in the PACU by a PACU RN.
   a. Telemetry patients will be returned to their assigned room to be recovered by the Telemetry procedural RN.
   b. Outpatient bronchoscopies are recovered in PACU by PACU staff.
4. The inpatient procedural RN will:
   a. Contact the PACU RN prior to the start of the procedure to provide an estimation of the completion time of the bronchoscopy.
   b. Contact the PACU RN at the end of the procedure, prior to transport to provide hand-off for ACS and PCU patients.
5. All inpatient ACS and PCU patients will be recovered in PACU by PACU staff.
   a. When PACU cannot assist with the recovery of ACS or PCU patients, the Telemetry procedural RN will recover the patient in their assigned inpatient room.
6. The Telemetry Procedural RN may not recover patients at any time in the Bronchoscopy Suite.

C. **SCHEDULING:**
1. Inpatient:
   a. The ordering physician will contact the Lead RCP to schedule the bronchoscopy procedure.
   b. The primary RN will:
      i. Ensure the order for bronchoscopy is entered in the Electronic Health Record (EHR).
      ii. Contact the ~~ANM/relief~~ charge **RN** as soon as possible, to allow sufficient time for the Telemetry ~~ANM/relief~~ charge **RN** to initiate post-procedure recovery arrangements for ACS and PCU patients.
2. Outpatient:
   a. The ordering physician will schedule the procedure with Surgery scheduling.
   b. The physician will coordinate outpatient fluoro-bronchs with Radiology and Endoscopy or Surgery.
   c. Bronchoscopies requiring C arm/Fluoroscopy are coordinated between the Imaging Departments.

D. **PRIMARY RN RESPONSIBILITIES:**
1. Pre-Procedure:
   a. The primary RN is responsible for completing the Pre-Procedure verification process per the Patient Care Services: Universal Protocol Procedure.
   b. Primary Nurse shall:
      i. Ensure patient has a patent intravenous (IV) access and the ordered IV solution is infusion via an infusiong pump.
      ii. Ensure an end-tidal carbon dioxide (ETCO2) module and oxygen tank is available for transport
      iii. Telemetry units: if bronchoscopy will be performed in a patient room, ensure the following equipment is also available:

a) Electronic vital sign machine
b) Suction equipment
c) Crash cart readily available
d) Bedside cardiac monitor

c. Ensure pre-procedure medications are ordered and listed on the Medication Administration Record (MAR).
d. Administer pre-procedure medications as ordered prior to the arrival of the procedural RN.
   i. On-call medications will be administered by the procedural RN.
e. Complete the Pre-~~P~~procedure Checklist.
f. Provide hand-off communication to the procedural RN.
g. Prepare the patient for transport, if the bronchoscopy is to be performed in the Bronchoscopy Suite.
   i. Coordinate with the procedural RN to arrange transport of the patient.
   ii. Transport patient via bed with oxygen, if applicable.
h. Document the ~~Off-Unit Transfer~~ **Nursing Handoff/Transport Communication** in Cerner.

2. Post-procedure primary RN responsibilities:
   a. Receive hand-off report from the PACU or Telemetry procedural RN.
   b. Assess the patient per orders. A focus assessment may include, but is not limited to the following:
      i. Level of consciousness
      ii. Breath sounds
      iii. Vital signs (blood pressure, heart rate, respiratory rate, oxygen saturation continue) to monitoring as ordered
         1) Telemetry patients – monitor cardiac rate and rhythm
   c. Maintain Nothing by Mouth (NPO) status until patient is fully awake and advanced diet is ordered.
   d. Implement falls prevention per Patient Care Services: Fall Risk Procedure and Unit Specific Fall Precautions Procedure.
   e. Monitor patient for increased mucus production, shortness of breath, difficulty swallowing, decreases or increases in heart rate (HR) and arrhythmias on cardiac monitoring units.
      i. Anticipate minimal bleeding if brushings or biopsies were obtained.
   f. Document the patient's arrival to the unit, assessment findings, and vital signs in the medical record.
   g. Notify the procedure physician if the patient complains of shortness of breath, an increase in bloody mucus, and/or new onset arrhythmias.

E. **PROCEDURAL RN RESPONSIBILITIES**

1. Perform immediate pre-procedure, intra-procedure, and post-procedure task and assessments as outlined in Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures.
2. Document immediate pre-procedure, intra procedure, and post-procedure task and assessments in the medical record.
3. Inpatient recovery and transport process:
   a. Contact a ~~LTT~~ **Patient Mobility Technician (PMT)** to assist with transporting the patient.
   b. Provide hand-off report to PACU for ACS and PCU patients.
      i. If a bed is not available in PACU, transport the patient to their assigned inpatient room.
      ii. Recovery monitoring of the patient will be provided by the procedural RN, until a bed is available in PACU or until patient returns to their pre-sedation Aldrete level.

c. Telemetry patients will be transported to their assigned inpatient room and recovered by the procedural RN.
   i. Provide hand-off communication to the primary RN when patient maintains their pre-sedation RASS level.

4. Post-procedure monitoring requirements:
   a. Monitor patient's outcomes per the Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures and as follows:
      i. Increase in bloody secretions
      ii. Hypoxia
      iii. New onset cardiac arrhythmias
      iv. Bronchospasm
      v. Hypotension
      vi. Signs of respiratory distress
      vii. Vomiting or complaint of nausea
      viii. Difficulty maintaining pre-sedation level of consciousness
   b. Maintain NPO status as ordered.
   c. Obtain chest x-ray per order.

5. Outpatients:
   a. Discharge patient as outlined in the Patient Care Services: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedures: Post Procedure Care, Documentation, and Discharge

F. **RELATED DOCUMENT(S):**
1. Patient Care Services Procedure: Fall Risk Procedure and Score Tool
2. Patient Care Services Procedure: Sedation/Analgesia Used During Therapeutic or Diagnostic
3. Patient Care Services Procedure: Universal Protocol

G. **REFERENCE(S):**
1. Urden, L.D., Stacy, K.M., & Lough, M.E. (20174). Critical care nursing: Diagnosis and management. (~~7~~8th ed). Elsevier. St. Louis: MO

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 4/06 **SUBJECT:** Census Zones, Managing of

REVISION DATE(S): 6/06, 8/08, 4/11, 01/15, 08/18

Patient Care Services Content Expert~~Department Approval~~:	**~~05/18~~02/22**
Clinical Policies & Procedures Committee Approval:	**~~06/18~~03/22**
Nursing Executive Committee Approval:	**~~07/18~~05/22**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~08/18~~05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/18**

A. **PURPOSE:**

1. To provide a management plan for Tri-City Medical Center that shall ensure appropriate and consistent inpatient access which ensures patients have access to appropriate and consistent care during periods of high census.

B. **POLICY:**

1. The management of patient volume is essential in order to minimize delay and/or diversion of patients into Tri-City Medical Center.
2. In order to initiate the appropriate census management activities, the census zone status shall be **reviewed daily be the Administrative Supervisor (AS) and communicated as needed for timely patient throughput and problem solving based on census.** ~~communicated to nursing each day at the daily bed meetings~~.
   a. Daily bed meetings occur 7 days a week at a designated time each shift.
3. ~~The Administrative Supervisor (AS) shall document census zone status on the **Administrative Supervisor report.** Staffing, Patient Flow worksheet and daily census.~~
4. Daily bed census information is communicated to **nursing leadership** ~~shift supervisors~~ or designees supporting patient care in the **shift** ~~daily~~ census report that is sent out via email.
5. All bed requests will be entered into **the electronic patient placement program (for example** Aionex)~~,~~ to facilitate tracking and patient placement.
6. The number of available beds/staff determines the census management zone level.

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

~~1.~~**7.** Available Bed:
   a. Staffed
   b. Empty and clean
   c. Empty and dirty
   d. Occupied – pending discharges
   e. Occupied – pending transfers

~~2.~~**8.** Green Census Zone:
   a. Availability of beds is adequate
   b. Staffing is adequate
   c. Emergency Department (ED) has available beds
   d. Many discharges/transfers anticipated
   e. Inpatient beds available to accommodate surgery schedule

~~3.~~**9.** Yellow Census Zone:

a. Availability of beds is limited
b. Staffing limited, premium, and/or incentive pay has been offered to staff and agencies
c. ED is full, no admissions holding
d. Limited discharges/transfers anticipated
e. Inpatient beds are limited to accommodate surgery schedule

~~4.~~**10.** Red Census Zone:
a. No availability of beds
b. Premium and/or incentive pay has been offered to staff and agencies with insufficient response
c. House-wide resources are limited
d. ED is full and/or on diversion and patients are being held for admission
e. Census is at capacity in all inpatient care areas (excluding OB Couplets)
f. Inpatient beds not available to accommodate surgery schedule
g. Postanesthesia Care Unit (PACU), Emergency Department (ED), Cath Lab, and Outpatient PACU may have patients delayed for inpatient bed placement

~~5.~~**11.** Leadership Team:
a. The leadership team consists of the Chief Nurse Executive (CNE), ~~AS, Assistant Nurse Manager (ANM),~~ **~~Clinical~~ Nurse Directors and Managers and Supervisors, Administrative Supervisor,** Case Manager/Discharge Planner, **Ancillary Managers/Directors for Laboratory and Radiology,** ~~all Managers, Directors,~~ Medical Staff Office, Environmental Services (EVS) Delegate, and Educators. **Other departments will be included based on patient need. Based on the current "zone", not all members of the leadership team will be included in meetings to discuss patient flow.**

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

1. During the "Green Census Zone":
   a. The **Charge Nurse** ~~ANM~~/designee for each inpatient care unit shall ensure appropriate assignments of patients to staff.
   ~~a.~~**b.** **Patients waiting for admission will be assigned a staffed ready bed in Aionex**
   ~~b.~~**c.** Potential discharges shall be identified **and the RN should~~may~~ collaborate as needed with the physician, case manager and/or family for timely discharge.**
   ~~c.~~**d.** Patient Flow shall be evaluated by the leadership team **on a continual basis.**
2. During the "Yellow Census Zone":
   ~~d.~~**a.** **The AS may call an emergency bed meeting to discuss patient flow and action plan to improve patient throughput**
   ~~e.~~**b.** The leadership team shall assess staffing; confirm resources for overflow capacity, beds, surgery schedule, and ED census to prepare for possible "Red Census Zone."
   ~~f.~~**c.** Clinical Directors/Managers shall assist **the Charge Nurses** ~~ANMs~~ and staff with patient placement and acuity by contacting physicians to downgrade or discharge patients as appropriate.
   ~~g.~~**d.** Hospitalists shall be contacted to assist with physician communication regarding discharges.
   ~~h.~~**e.** Vacant patient areas shall be prepared for use. This includes contacting Patient Accounting to advise that patients may be admitted to the following overflow areas:
      i. PACU/**ICU Overflow -** ~~Outpatient PACU~~ – Primarily ICU, Telemetry
      ~~ii.~~ ~~1 North~~/**Acute** ~~Rehab~~**Rehabilitation Unit (ARU) – any** Med/Surg **admission to the ARU would** ~~,~~need California Department of Public Health (CDPH) approval ~~for Rehab.~~
      ~~iii.~~ ~~3 Pavilion and 3 East~~
      iv. Station D
   ~~i.~~**f.** Same nursing department standards shall be followed in the areas accepting overflow patients.

~~2.~~**3.** During the "Red Census Zone":
a. If immediate crisis occurs, ensure Yellow Zone procedures ~~is~~ **are** initiated.

b. The AS shall:
   i. Initiate overflow plan(s) and mobilize staffing resources.
   ii. Prioritize patient bed assignment and admissions as beds become available.
   iii. Notify Nursing Leadership.
   ~~iv. Notify the Clinical Operation Leader.~~
   v. Notify Hospitalists
c. The EVS **Manager/**Supervisor shall page for a STAT bed clean for all available beds.
d. The ~~L~~leadership of Surgical Services, Radiology, ~~N~~nurses, and Medical Staff office shall evaluate elective procedures on Radiology and surgical schedules for potential delays/reschedules and communication strategies to physicians.
e. Case Managers/Discharge Planners shall:
   i. Assess for potential discharges.
   ii. Contact Medical Directors to triage patients out of areas.
f. ~~The Leadership of~~ Supply Chain Management and Sterile Processing shall evaluate the need to rent extra monitors and/or equipment and provide extra supplies to units.
g. Biomedical Engineering and Sterile Processing Departments shall provide additional supplies and equipment as needed from internal and external sources to include contracted vendors.
h. The Director of Food & Nutrition shall evaluate the need for additional food requests.
i. The Director of Pharmacy shall evaluate the need for increased pharmacy services.

~~3.~~**4.** The **Nurse Manager**~~Charge Nurse ANM~~/designee shall make rounds on the units to assess the Census Status and communicate pending discharges to the AS.

~~4.~~**5.** During the "Red Census Zone," status updates shall be given every **2** 4 hours to Nursing Leadership.

~~5.~~**6.** Nurse Managers/designee and the AS shall meet to assess overall staffing and census zone status.

~~6.~~**7.** Medical recommendations for "Red Census Zone" are as follows:
a. Admitting patients is dependent upon discharges. Physicians shall be asked to re-evaluate for discharges and transfers to accommodate admissions.
b. Patients leaving within one (1) hour and awaiting rides shall be moved to a staff area that is vacant.
c. Case Managers/Discharge Planners/Social Workers shall facilitate skilled nursing facility discharges as a top priority.
d. Elective cases may need to be cancelled in accordance with C Suite approval.

~~7.~~**8.** **Patient flow will be reassessed every 2 hours to determine zone color and status.**
a. **Leadership will be notified by the AS when the zone changes from Red to Yellow or Green.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

DELETE – follow Patient Care Services Policy: Code Caleb Response Plan

STANDARDIZED PROCEDURE: CODE CALEB

A. **POLICY:**

1. Function:
   a. Management of cardiopulmonary arrest in the infant up to 30 days old following Neonatal Resuscitation Program (NRP) guidelines **when the Neonatologists are involved with the Code.** when event occurs on the Labor and Delivery (L&D) Unit, Mother-Baby Unit and Neonatal Intensive Care Unit (NICU). NRP and/ or Pediatric Advanced Life Support (PALS) guidelines shall be utilized when event occurs in the Emergency Department (ED) and any other location on the hospital campus based on responder training. A Code Caleb shall be called for any infant up to 30 days old in need of resuscitation and stabilization within the institution, surrounding grounds and unexpectedly upon arrival **to the hospital**in the ED.
2. Circumstances:
   a. Setting: Tri-City Medical Center
   b. Supervision: None required. The standardized procedure shall be implemented and the attending physician **and Neonatologist** shall be notified immediately. Upon arrival, the physician assumes responsibility in directing the resuscitation.
   c. Patient contraindications: None
3. Data Base:
   a. The initial steps of infant resuscitation shall be provided within a few seconds and include: Providing warmth, positioning the infant on a back, side or sniffing position and drying **(if wet)** and stimulating the infant. Resuscitation efforts shall be implemented when:
      b. Objective: Infant is apneic, gasping, ineffectively breathing, the heart rate (HR) is less than 100, and/or infant is unresponsive to stimulation
   c. Diagnosis: Life threatening emergency
   d. Plan: Initiate a Code Caleb by dialing 66 on the telephone, implement the Standardized Procedure as appropriate, and notify the attending physician/neonatologist
   e. Assessment: Infant will be reassessed **per NRP or PALS guidelines**after each intervention.
   f. Record Keeping: Events are to be recorded on the Neonatal Resuscitation Record, and in the patient's electronic medical record.

B. **PROCEDURE (INFANTS UP TO 30 DAYS OLD UTILIZING NRP GUIDELINES):**
   The Neonatologists will initiate NRP Guidelines when assisting with a Code Caleb.

1. Respiratory Distress/Arrest:
   a. If infant is unresponsive to tactile stimulation (drying, back rub, foot flick, bulb syringe suction) provide positive pressure ventilation (PPV) per NRP guidelines at a rate of 40-60 breaths per minute (slightly less than once a second).
   b. Apply a pulse oximeter to infant's right hand/wrist.
      i. During resuscitation efforts immediately after birth, the infant's oxygen saturation level shall direct the titration of the oxygen percent required to achieve infant target oxygen saturation ranges listed in the "Targeted Pre-ductal **SpO_2** Spo2

Department Review Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nurse Executive Council Committee	Perinatal Collab-orative Practice	Department of Emergency Medicine	Pharmacy and & Therapeutics Committee	Dept. of Pediatrics	Inter-disciplinary Committee	Medical Executive Committee	Admin	Professional Affairs Committee	Board of Directors
11/07, 11/09, 09/12, 09/14, 02/19	12/07, 11/09, 09/14, 11/16, 03/19, 03/20	01/08, 12/09,10/1, 01/17, 03/19, 04/20	12/15, 04/17, 05/20	06/20	02/08, 12/09, 09/14, 11/16, 05/19, 07/20	05/16, 05/17, n/a	02/08, 12/09, 07/17, 01/21	02/08, 02/10, 10/17, 04/22	05/22	11/17, n/a	02/08, 02/10, 12/17

after Birth" Table.
1) Term gestations: NRP suggests beginning at 21% oxygen level and adjust concentration based on clinical condition.
2) Preterm infant consideration: start initial PPV with oxygen blended at 30%.
3) **SpO_2**Spo2 range should be between 85% and 95% by 10 minutes of life
ii. For resuscitation not immediately following birth, may begin PPV oxygen concentration at 100% and reduce rate to achieve oxygen saturation ranges greater than 90%
c. If the HR is less than 100 bpm, take ventilation corrective steps: adjust mask, reposition head, suction mouth and nose, open mouth, increase ventilation pressure and/or use an alternate airway.
d. If there is no improvement with PPV, consider endotracheal intubation.
e. If the heart rate increases to greater than 100 and/or there are spontaneous respirations, begin post resuscitation care.

2. Bradycardia (HR less than 60):
a. If the HR is less than 60, after a minimum of 30 seconds of PPV, initiate chest compressions at a ratio of 3:1 (compressions: ventilation).
b. Increase oxygen concentration to100% if not already done
c. Assist Neonatologist with endotracheal (ET) intubation and /or umbilical venous catheter (UVC) line placement.
d. If the heart rate remains below 60, consider epinephrine administration:
i. Intravenous (IV)/ Intraosseous (IO) dosing: 0.1 mL/kg (0.1 mg/mL Concentration)
ii. Administer every 3-5 minutes via rapid intravenous push (IVP).Endotracheal (ET) dosing: 0.5mL/kg (0.1 mg/mL Concentration)
1) Administer every 3-5 minutes

3. Prematurity (Gestational age less than 35 6/7 weeks):
a. Protect from heat loss: Radiant warmer, heated towels, portable warming mattress, hat
i. If less than 32 weeks consider polyethylene plastic wrap
b. May begin PPV at 30% oxygen concentration, initially if required
c. May benefit from continuous positive airway pressure (CPAP)

4. Hypovolemia (Risk factors, pale, poor perfusion, oxygen saturation ratings less than 90%):
a. Start intravenous (IV) line
b. Assist Neonatologist with UVC line placement
c. Administer IV fluid bolus 10 mL/kg normal saline bolus slow IVP over 5 minutes- 10 minutes.

5. Hypoglycemia:
a. Obtain bedside capillary or arterial glucose. If blood glucose level is less than 45 mg/dL and infant symptomatic, start IV line and/or assist the Neonatologist with UVC line placement.
b. Administer D10 bolus: 2 mL/kg slow IVP.

C. **PROCEDURE (INFANTS UP TO 30 DAYS OLD UTILIZING PALS GUIDELINES):**
The Emergency Department staff will initiate PALS Guidelines when they respond to a Code of an infant up to 30 days old.

1. Respiratory Distress/Arrest:
a. Provide warmth.
b. Establish patent airway.
c. Position supine with head in neutral or slightly extended position.
d. Suction PRN for secretions
e. Oxygen administration and positive pressure ventilations (PPV), if needed.
f. Assist with intubation as appropriate.
g. Obtain STAT Arterial Blood Gas (ABG) and chest x-ray as needed.

2. Heart rate less than 60 beats per minute (bpm) (Bradycardia):
   a. Initiate compressions.
   b. Begin bag/mask ventilation with 100% oxygen.
   c. Establish venous access with Normal Saline (NS) flush.
      i. Establish (IV) access with NS at TKO rate (to be used for resuscitation medications or fluids as necessary). Consider (IO); umbilical vein pending arrival of neonatologist. .
      ii. If hypovolemia suspected (blood loss history, poor perfusion, pale, weak pulse) administer IV fluids of NS at 10 mL/kg slow Intravenous push (IVP) over 5-10 minutes.
   d. Medications for Bradycardia:
      i. Epinephrine
         1) Indicated when heart rate remains less than 60 bpm despite 30 seconds PPV and another 30 seconds of coordinated compressions and ventilations.
         2) Recommended route is IV/IO. Consider endotracheal (ET) route while IV access is being obtained.
            3) IV/IO dosing: 0.1 mL/kg (**0.1**0.1 mg/mL Concentration). Administer every 3 – 5 minutes during arrest, max IV/IO individual dose 1 mg.
            4) Rate of administration is rapid IVP.
            a) Endotracheal dosing: 0.5mL/kg (0.1 mg/mL Concentration). Administer every 3 – 5 minutes during arrest until IV/IO access achieved, then begin first IV/IO dose.
3. Symptomatic Hypoglycemia:
   a. Obtain bedside capillary or arterial glucose. If glucose < 45 mg/dL then treat with D10 W bolus IV/IO 2 mL/kg slow IVP.

D. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

1. Current **unencumbered** California RN license.
2. Education:
   a. Successful completion of NRP course for staff in L&D, Mother Baby Unit & NICU (with a current course completion card)
   b. Successful completion of PALS course for staff in the ED (with a current course completion card).
3. Experience: Initial job requirement
4. Initial Evaluation: RN must be observed demonstrating successful skills in management of a neonatal resuscitative event using NRP and/or PALS guidelines as appropriate.
5. Ongoing evaluation annually.

E. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

1. Method: This standardized procedure was developed through collaboration with nursing, medicine, and administration.
2. Review every two years.

F. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

All Registered Nurses (RNs) who have successfully completed requirements as outlined above are authorized to direct and perform Code Caleb. Standardized Procedure.

RELATED DOCUMENT(S):

1. **Pre-ductal SpO_2 Target**

G. REFERENCE(S):

1. Neonatal Resuscitation Program Textbook, Seventh Edition. (2016). American Academy of Pediatrics and American Heart Association

~~2. Pediatric Advanced Life Support Textbook, (2011). American Heart Association and American Academy of Pediatrics~~ **de Caen AR, Berg MD, Chameides L, et al. Part 12: Pediatric Advanced Life Support: 2015 American Heart Association Guidelines Update for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation 2015; 132:S526.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: HUMAN IMMUNODEFICIENCY VIRUS (HIV) SCREENING, IDENTIFICATION/TREATMENT FOR THE PREVENTION OF PERINATAL TRANSMISSION

I. **POLICY:**

A. Function:

1. To provide guidelines for the RN to identify and provide treatment for obstetric HIV infected patients admitted to Tri-City Medical Center.
2. To identify pregnant patients with positive HIV results and reduce the risk of maternal to child transmission to the newborn.
   a. Allows intrapartum treatment for pregnant patient and fetus.
   b. Allows ongoing treatment for the pregnant patient and exposed newborn during the postpartum period.
3. To identify community resources for pregnant patients who are HIV positive
   a. University of California San Diego (UCSD) Mother and Adolescent HIV Program Hotline: (619)-543-8089.
   b. National Prenatal HIV Consultation and Referral Service: (888-448-8765)
4. To comply with Health codes as outlined in State and Federal laws – January 2008
   a. The state of California requires that all pregnant women are offered HIV screening throughout the pregnancy and at the time of hospital admission

B. Circumstances for Screening

1. Setting: Tri-City Medical Center
2. Supervision: None
3. Exclusions: Emergency Department (ED)

II. **PROCEDURE FOR INPATIENT AREAS, OTHER THAN WOMEN AND NEWBORN SERVICES (WNS), WHO ARE TREATING PREGNANT PATIENTS:**

A. During the patient history, data collection, the RN shall complete an HIV risk screening to determine if the patient should be offered HIV testing

1. Each pregnant patient shall receive information about the importance of having an HIV test and documentation of providing this information is noted in the medical record.
2. If patient declines, the refusal shall be documented in the medical record.
3. If patient agrees to HIV testing, **place an order for HIV testing.**
   ~~a. Documentation of the pregnant patient's "acceptance of HIV testing" will automatically generate an order in the electronic medical record for the rapid HIV test lab draw.~~
   ~~b.~~a. Expect results from the chemistry lab (ext 7909) within two hours once test is drawn.

B. The admitting physician will review the results and discuss the findings and antiretroviral prophylaxis with the patient in a confidential manner as indicated.

1. The admitting physician shall refer the patient with positive results to her obstetrician and/or the maternal child adolescent HIV program as soon as possible to review therapy, method of delivery, infant care, and follow-up.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership Executive Council	Infection Control Committee	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/18	8/12, 1/15, 04/18	8/12, 02/15, 04/18, **10/21**	03/15, 05/18, **11/21**	9/12, 04/15, n/a	11/12, 05/15, 07/18, **01/22**	11/12, 06/15, 08/18, **04/22**	09/18, **05/22**	07/15, n/a	12/12, 07/15, 09/18

III. PROCEDURE FOR LABOR AND DELIVERY (WNS) ONLY:

A. During the patient history/prenatal lab data collection, RN shall:

1. Perform careful screening of the patient's prenatal care or lack of prenatal care
2. Review the patient's prenatal form for results of the prenatal HIV test. If documented test results are negative or are positive with the woman being currently treated, document results in the medical record.
   a. Refer to the WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission for patients in labor with positive results.
3. If no test results are available:
   a. Contact the provider's office and obtain the HIV test results if the prenatal indicates the test was done, but results not on the chart.
   b. Assess patient's risk factors and offer HIV testing for the following indications:
      i. Pregnant patients who have unknown HIV results
      ii. Pregnant patients who declined HIV testing in a prenatal setting, and have risk factors associated HIV exposure
      iii. Pregnant patients who are at high risk for becoming infected and have negative HIV results in the clinic setting may be offered a second HIV test in the third 3rd trimester
   c. For patient's meeting the indications listed for the Rapid HIV screen discuss the following in a confidential setting:
      i. The purpose and rationale for the test
      ii. The risk and benefits of the test
      iii. Her ability to decline the test
4. Provide the patient with a copy of the Protecting Yourself and Your Baby information form provided by the California Department of Health Services and the Office of AIDS.
5. Obtain consent. Only verbal consent is required for running the test.
6. Document any refusal of the HIV test in the medical record and note the reason why if possible.
7. After obtaining verbal consent for the HIV test, draw the tubes of blood (small red and purple top tubes) for prenatal labs (RN or lab)
   a. **Place** Aan order **for HIV testing**~~shall be generated as a task for the L&D RN~~
   b. A rapid HIV test shall be run STAT by the chemistry lab when labeled tubes are received and accompanied with the completed requisition
   c. Results will be called to the attending provider by the chemistry lab. Expect the results in about 2 hours (Chemistry lab, ext. 7909).
8. The attending provider will provide test results to the patient. The lab will automatically run a confirmatory HIV test with results available with 7-10 days.
   a. If the result is negative, no further treatment is necessary.
   b. If the result is positive and the woman is not in labor:
      i. Physician will review treatment options, and discuss antiretroviral prophylaxis with the mother in a confidential manner.
      ii. The patient will be referred to the UCSD maternal child adolescent HIV program as soon as possible to review therapy/method of delivery, infant care, and follow-up.
   c. If the results are positive and the woman is in labor, obtain order for antiretroviral therapy
      i. Refer to WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission, and PPO: "HIV Intrapartum Treatment"
9. Contact the **Women and Newborn Services** Social Work/**designee** ~~department~~ and submit a consult order for crisis intervention or postpartum counseling using the key words "Rapid Test Response." This wording alerts the Social Work staff that the patient

is a newly screened HIV patient who may need referral to the appropriate community resources, i.e., WE CARE, County Social Services, etc.

IV. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Initial Evaluation: Orientation
C. Ongoing Evaluation: Annually

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, OB/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 the requirements as outlined above are authorized to direct and perform HIV Identification and Screening, Prevention of Perinatal Transmission Standardized Procedure.

VII. RELATED DOCUMENT(S):

A. Protecting Yourself and Your Baby - Sample (available via external link: http://www.sbcounty.gov/uploads/dph/publichealth/documents/mcah_cpsp_hiv_testing_information.pdf)
B. WNS Procedure: HIV Intrapartum, Postpartum and Newborn Treatment for the Prevention of Perinatal Transmission

VIII. REFERENCE(S):

A. American Academy of Pediatrics on Fetus and Newborn and American College of Obstetricians and Gynecologists Committee on Obstetric Practice Guidelines for Perinatal Care, 8th Edition, 2017. *Guidelines for Perinatal Care Sixth Edition.* Washington, DC
B. AAP Policy Statement, Committee on Pediatric AIDS 120(6) e1547. Diagnosis of HIV-1 Infection in children younger than 18 months in the United States. Washington, DC
C. 682 Assembly Bill –CHAPTERED
D. ACOG Committee Opinion # 635, Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations. Obstetrics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547
E. ACOG Committee Opinion #389, Human Immunodeficiency Virus*, December, 2007
F. California Law: Assembly Bill No. 1676
G. California Perinatal Quality Care Collaborative, 2008 Standards of Care for the Prevention of Perinatal Transmission (HIV Toolkit)
H. AAP Redbook 30th Edition 2015
I. Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States, May 30, 2018. https://aidsinfo.nih.gov/guidelines/html/3/perinatal/508/maternal-hiv-testing-and-identification-of-perinatal-hiv-exposure
J. Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings. MMWR Recommendations and Reports, September 22, 2006/55 (RR14); 1-17.Revised CDPH Perinatal Policy (2008)
K. National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765
L. UCSD Medical Center, Woman's and Infant's Department Policy/Procedure: "HUMAN IMMUNODEFICIENCY VIRUS PREVENTION OF PERINATAL TRANSMISSION" (8/15/09).
M. ACOG Committee Opinion #595, Preexposure Prophylaxis for the Prevention of Human Immunodeficiency Virus. May 2014.

N. ACOG Committee Opinion # 635, Prenatal and Perinatal Human Immodeficiency Virus Testing: Expanded Recommendations Obsterics & Gynecology: June 2015 – Volume 125 – Issue 6 – p 1544 - 1547

O. Simpson, K. R., & Creehan, P.A. Perinatal Nursing 4th edition 2014, pp. 679-680 Association of Women's Health Obstetric and Neonatal Nurses

P. "Aids info" from Department of Health and Human Services: aidsinfo.nih.gov

SAMPLE

State of California—Health and Human Services Agency
California Department of Public Health

MARK B HORTON, MD, MSPH
Director

ARNOLD SCHWARZENEGGER
Governor

Protecting Yourself and Your Baby

If you are pregnant or think you may be pregnant, you need to know about HIV, the virus that causes AIDS.

Pregnancy is a time to take care of yourself and get regular medical checkups for your health and your baby's health. Your health care provider will ask you questions and check you for conditions so that you and your baby can be as healthy as possible. As part of your routine prenatal care or when you are in labor and delivery, you will be tested for HIV unless you decline. HIV testing during pregnancy is the best choice for you and your baby.

What is HIV?
Human Immunodeficiency Virus (HIV) is a disease that weakens the immune system, making it hard for the body to fight infections.

How is HIV transmitted?
HIV is primarily spread by having unprotected sex or sharing needles with an HIV-infected person. Most women in the US have been infected with HIV through sex with men.

A pregnant woman who is HIV infected or who has AIDS can pass HIV to her baby during pregnancy, delivery, and while breastfeeding.

How will an HIV test help my baby?
An HIV test will help you and your baby by alerting you to the need for treatment if your HIV test is positive. Treatment during pregnancy, labor and delivery can help decrease the risk of transmitting HIV to your baby.

Doctors have learned that if you are infected with HIV, treatment with appropriate medication can greatly reduce your chances of giving HIV to your baby.

What if I test HIV positive?
If you are HIV positive, you will want to discuss treatment options with your health care provider. They will likely recommend medication that is considered safe in pregnancy. You may be encouraged to continue the medication after delivery for your own health, depending on a number of factors.

You can protect yourself from HIV by:
- Using a latex/polyurethane condom (male or female) when you have sex even if you are pregnant. Use only water-based lubricants. Oil-based lubricants will weaken condoms and make them less effective.
- Not sharing needles for injecting drugs, steroids, vitamins, tattooing, or piercing.

Other resources for help:
Call the California HIV/AIDS Hotline at 1-800-367-2437 (AIDS) for HIV referral and consultation resources including experts of prenatal HIV treatment in your local area.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**NEWBORN IDENTIFICATION BANDING AND ELECTRONIC ALARM DEVICE**
Purpose:	**To establish guidelines for applying a Newborn Identification Band and Electronic Alarm Device to each newborn in order to protect against removal from the facility by unauthorized person(s).** ~~To outline the nursing responsibilities in identification of the mother/primary caregiver's /and baby couplet or of the infant in the Emergency Room Department, as required by Title 22 of the California Code~~
Supportive Data:	**The total number of infants abducted related to the healthcare setting from 1964 to September 2021, in the USA is 335. Of those abducted children, 140 (41.8%) were taken from healthcare facilities.** ~~All newborns will be identified with baby band(s) containing the birth mother's/primary caregiver's last and first name as noted below (with the possible exception being with Adoption and Surrogacy) before leaving the room the birth occurred in Labor and Delivery or, and the Obstetrical Operating room and ED???) to ensure proper identification. Newborns born outside the hospital will be banded on admission to Tri City Medical Center (TCMC). All infants admitted to the Emergency Department (ED) will be banded per hospital policy.~~
Equipment:	Newborn Identification Bands ~~(two for the newborninfant, one for the mother/primary caregiver and another for the significant other).~~ ~~In the event of computer down time a blank identification wrist band set will be utilized in Women's and Newborn Services (WNS) or per the Adoption policy.~~ **Electronic Alarm Device (EAD) with Band** ~~ED will follow the hospital procedure for banding: Identification, Patient Policy.~~

A. POLICY:

1. **All newborns and mothers are to receive newborn identification (ID) bands as soon as possible after delivery and prior to transferring either person from the delivery room.**
   a. **All newborns/infants delivered outside the hospital, or being readmitted, shall be banded upon admission.**
   b. **All newborns/infants are required to have an EAD band attached to one ankle as soon as possible after delivery and prior to transferring.**
      i. **Exceptions may include newborns/infants cared for in the NICU that are in an isolette or on radiant warmer beds who are critically ill, requiring procedures or have lines that would prohibit the use of EAD.**
         ~~A.~~**1) Once the newborn/infant is transferred to an open crib/bassinet the EAD will be applied.**

~~1. All newborns shall be banded before separation from his/her birth mother/primary caregiver.~~

~~2. All newborns born outside the hospital, or if being readmitted, shall be banded upon admission to the (WNS) or Neonatal Intensive Care Unit (NICU).~~

~~3.~~**2.** If an ~~newborn or~~ infant is admitted to the Emergency Department (ED) it will be banded per the ED Registration process. ~~and Identification, Patient Policy.~~

~~4.~~**3.** For the following situations see **the related**~~these~~ policyies:

a. Safe Surrender: See Administrative Policy New**born** Abandonment #380
b. Adoption: See WNS Procedure: Adoption
c. Surrogacy: See WNS Procedure: Surrogacy
~~c.~~**d. Suspected or Confirmed Infant Abduction: See Code Adam Policy**
~~d.~~**e.** Release of Minor to Other Than Birth Mother: See WNS Procedure: Release of Minor to Other Than Birth Mother Procedure

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/93, 09/09, 07/13, 08/18, **03/22**	08/06; 09/09; 07/13, 09/18, **04/22**	10/06, 11/09; 08/13, 11/18, 05/22	n/a	n/a	n/a	01/19, **05/22**	11/06, 1/10, 9/13, n/a	12/93, **03/97**, 10/97, 07/00, **06/03**, 04/04, 12/06, **01/10**, 09/13, **01/19**

B. **PROCEDURE:**

1. Following delivery of the **newborn**~~newborn~~infant, a set of four **identical** bands ~~with matching Mother Parent~~**or primary caregiver**/~~Baby ID numbers~~ will be ~~printe~~**printed with** ~~d. They will contain at the minimum~~ the following information:
   - **a. Mother's last name, first name "s" gender of newborn (boy/girl)**
     - **i. Example: DOE, JANESBOY**
     - **ii. For multiples A, B, C etc. will follow the gender**
       - **1) Example: DOE, JANESBOY A and DOE, JANESBOY B**
   - **b. Date and time of birth**
   - **c. Medical Record Number (MRN)**
   - ~~1.~~**d. Financial Identification Number (FIN)**
   - ~~a. Mother's/primary caregiver's last and first name~~
   - ~~b. Newborn's Medical Record or Financial Number~~
   - ~~c. Sex of newborn: BOY or GIRL (with A or B if multiples)~~
   - ~~d. Date of birth.~~
   - ~~e. Time of birth (24- hour clock)~~
2. The identification bands **will**~~must~~ be verified ~~as complete and accurate~~ by two staff members ~~along with the mother/primary caregiver and/or support person~~.
   - **a. Initial verification will be documented in the mother's Electronic Health Record (EHR)** ~~The band number and verification process will be documented in the medical record~~**.**
   - ~~2.~~**b. Each shift the primary RN will verify the newborn ID band information on the newborn and mother/primary caregiver bands match then document in the newborns EHR.**
   - ~~a. Identification must be completed before any separation of mother/primary support person from the newborn. / baby couplet.~~
3. ~~Separate and a~~Attach the set of four ~~completed~~ **newborn** bands as follows:
   - a. One ~~large~~ band is applied to the mothers~~'s~~**/primary caregivers** ~~(per other policies mentioned above)~~ wrist. ~~next to her admission Aztec bar code band.~~
   - b. One ~~large~~ band is applied to a support person identified by the~~e birth~~ mother**/primary caregiver.**
   - **c.** Two~~he two smaller~~ bands will be applied to the newborn, **one on each** ~~extremities~~ **ankles.**
4. **The EAD will be applied to one of the newborn's/infant's ankle per manufacturer guidelines.**
   - **a. EAD number will be documented in the newborn/infant chart when applied and each shift with verification of proper placement and function.**
   - **b. Patient identifiers, which may include but are not limited to: name, room number and tag ID are entered into the EAD database after the initial application.**
5. **Whenever the newborn is separated from the mother/primary caregiver, the ID band must be checked prior to separation and upon returning the newborn to the mother/primary caregiver.**
   - **a. The date, time and reason the newborn was separated from the mother/primary caregiver will be documented in the newborn EHR.**
6. **Should the mother/primary caregiver or newborn lose a band a new ID band will be printed and verified by a second employee prior to application.**
7. **Upon discharge of the newborn/infant one ID band will be removed from the newborn/infant and attached to the form, Newborn Identification Verification Upon Discharge. The mother/primary caregiver will verify the information is correct and sign the form.**
   - **a. If mother/primary caregiver is discharged prior to the newborn, the newborn's mother/primary caregiver and/or support person need to continue to wear his/her ID band until the newborn is released from the hospital.**

i. When the newborn/infant is located in the NICU, individuals who cannot wear their band due to work requirements must be able to present ID band when entering the unit.

8. Upon discharge of the newborn/infant deactivate and remove the EAD per manufacturer guidelines.
   a. Clean the EAD with hospital approved cleaning solution and replace the EAD to the designated storage/ charging station.
   c.b. Complete the discharge process in the EAD database.
   d. ~~See the specific policies above for when the banding or naming on the band may occur differently such as by a Judgement.~~
   e. ~~When a newborn is transferred to the Mother /Baby Unit or other location such as to the Neonatal Intensive Care Unit (NICU), all bands must be verified as complete and accurate by two staff members. Verify the band number, baby name, MRN or FIN, date and time of birth.~~
   f. ~~Whenever a newborn is separated from the mother/or primary caregiver for any reason other than a transfer to NICU, the bands must be checked prior to separation and upon returning the newborn to the mother. The times will be documented in the medical record with the reason for separation.~~
   g. ~~Should the mother/primary caregiver or the newborn, lose a band, a new set of four bands with new identical numbers must be printed., and Aall old bands will be removed and the new bands must be applied and old bands removed.~~
   h. ~~If possible, re-banding should take place with the mother/primary caregiver and/or support person as a witness.~~
   i. ~~If new bands are issued, to the mother/baby couplet, one all of the newborn's old bands needs to be attached to the Newborn Identification Upon Re-Banding form. and have a The parent/banded support person must sign the form stating that the information on the bands areisis correct. This form is then placed in the chart. with the re-banding of the mother/primary caregiver, and/or support person and baby. Document the band number change in the electronic medical record with a comment including for the reason it is being for the changed on the document with all of the bands attached and in the medical record.~~
   ~~If mother/primary caregiver of infant is discharged prior to the newborninfant, the newborn's mother/primary caregiver and/ or support person need to should continue to wear his/her ID band (with matching numbers) until the newborninfant is released from the hospital.~~
   j. ~~If the newborn is discharged prior to the mother/primary caregiver, the mother/primary caregiver, the support person and the newborn need to continue to wear his/her ID band until the mother/primary caregiver is released from the hospital in order to allow the newborn to visit.~~

C. **CERNER DOWNTIME ~~IDENTIFICATION~~ PROCEDURE:**

1. In the event the EHR system is disabled:
   a. At delivery, a complete a set of four bands with preprinted matching numbers with the same information as the computer-generated newborn ID band will be hand written.
      i. The four bands must have identical numbers and all information must be legible.
      ii. The ID band number and verification will be documented on the downtime record and entered in the EHR when back online.
   b. An EAD will be applied to the newborns ankle and documented on the downtime record and entered in the EHR when back online.
2. In the event the Infant Security System is disabled:
   a. The unit identifying the problem will immediately notify:

i. The unit leadership person on call
ii. Security
iii. Administrative Coordinator
iv. IT department

b. The hospital security department will notify the alarm company and the IT department immediately to address the issue
i. An additional security officer will be dispatched to newborn areas to assist with surveillance while the system is disabled.
ii. While the system is disabled, instruct all visitors to check in at the unit desk when they arrive on the unit AND before leaving.
~~i.~~iii. In the event that the system is in complete failure or during a power outage, the unit will maintain awareness of visitors entering and leaving the unit at all times. While the system remains disabled, at no time will the reception desk or nursing station be left unattended. Bags and backpacks will be inspected by Security/WNS staff before patients and visitors leave the unit.

~~b. Identification must be completed before any separation of mother/ baby couplet.~~
~~2. Complete Hand-write the following information for placement on the band:~~
~~a. Mother's/primary caregiver's last and first name~~
~~b. Newborn's Medical Record Number or Financial Number~~
~~c. Sex of newborn: BOY or GIRL (with A or B if multiples)~~
~~d. Date of birth.~~
~~e. Time of birth (24- hour clock)~~
~~3. The four bands *MUST* have *IDENTICAL* numbers and all information must be accurate and legible. The band number will be documented in the medical record.~~
~~4. Proceed with remainder of procedure for placement of bands.~~

~~D. DOCUMENTATION:~~
~~1. At the time of delivery, document identification numbers on the electronic and physical medical record.Labor and Delivery Summary and the Newborn History and Physical.~~
~~2. Document presence and accuracy of newborn bands at time of transfer, in the Mother Baby Unit or Neonatal Intensive Care Unit when the mother/primary caregiver is separated from the newborn, infant and when the mother/primary caregiver is reunited with the newborninfant.~~
~~3. If re-banding occurs, document in the patient medical record in both the mother's and the infant's patient records with the new identification band number and add a comment stating the reason for re-banding, and complete the Newborn Identification upon re-banding form with all 4 bands attached and confirm with the significant others that the correct infant is being banded.~~
~~4. At discharge, identification is verified and one newborn ID band is attached to the Newborn Identification form. Record the mother/primary caregiver or support person and witness signatures with the date.~~

D. FORM(S):
~~E.~~1. Newborn Identification Verification Upon Discharge 7400-1008 English and Spanish
~~1. Newborn Identification & Discharge Instructions English – Sample Downtime only~~
~~2. Newborn Identification & Discharge Instructions Spanish – Sample Downtime only~~
~~3. Newborn Identification Upon Re-Banding form English – Sample Need updated form~~
~~Newborn Identification Upon Re-Banding form Spanish – Sample Need updated form~~
~~Newborn Identification English Sample with interpreter info update?~~
~~4. Newborn Identification Spanish Sample with interpreter info?~~

~~F.~~E. RELATED DOCUMENT(S):
1. Patient Care Services Policy: Identification, Patient

2. Women & Newborn Services Policy: Adoption
3. Women & Newborn Services Policy: Surrogacy
4. Women & Newborn Services Procedure: Release of a Minor to Other Than Birth Mother
~~4.~~5. **Patient Care Services Policy: Code Adam**

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

1. American Academy of Pediatricians, & American College of Obstetricians and Gynecologists (AAP, ACOG). (2017). *Guidelines for Perinatal Care* (8th Edition). Washington, DC.
~~1.~~2. **Cal. Code Regs. Tit. 22, § 70738-Infant Security**
~~2. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Templates for Protocols and Procedures for Maternity Services (2nd Edition). Washington, DC~~
3. The Joint Commission R3 Report: Distinct newborn identification requirement. Issue 17, June 25, 2018

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

CAREPLAN Problems resolved: Yes ☐ No ☐ If No, describe plan

Signature if other than parent | Relationship | Identification Verification

Affix Patient Label

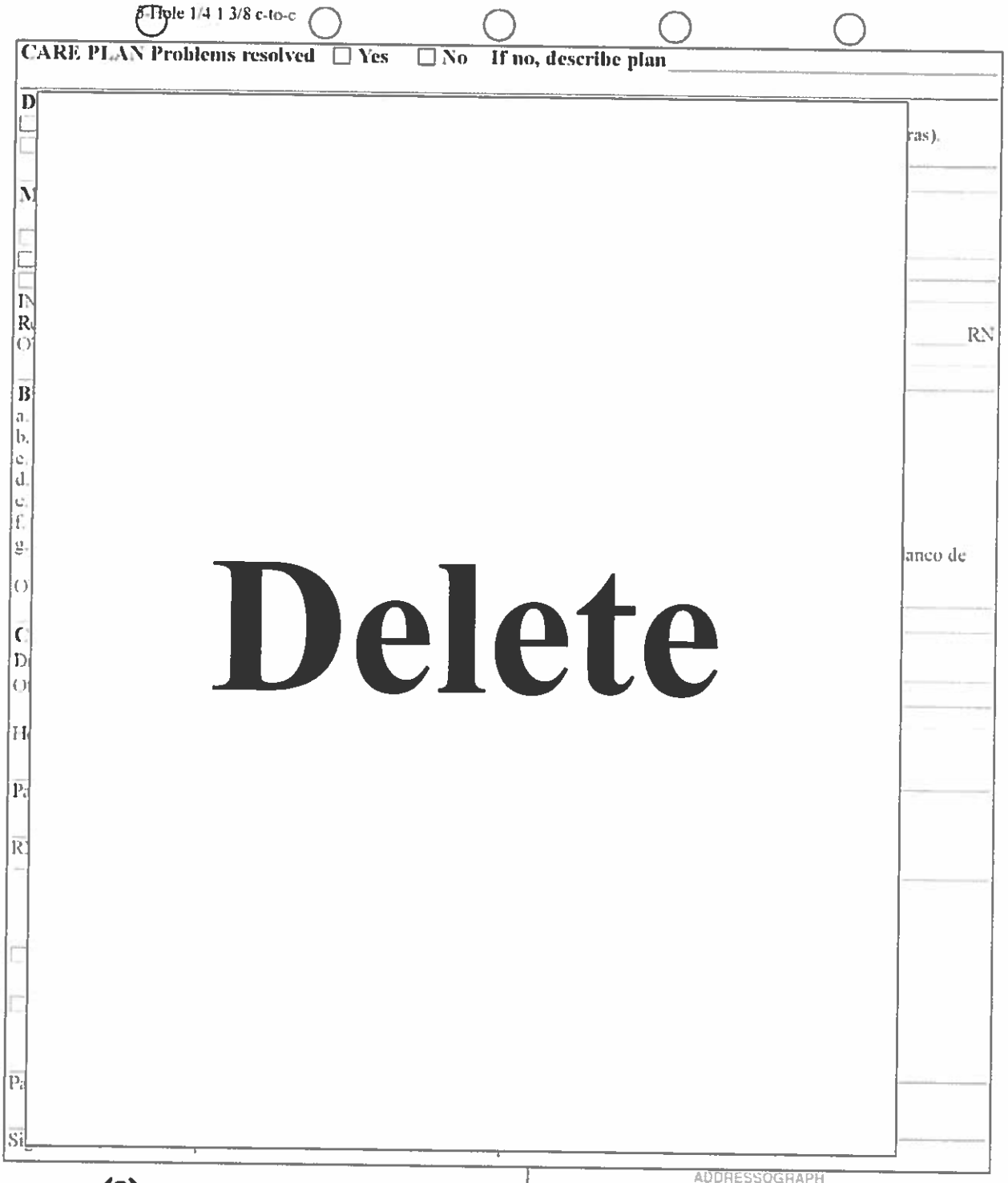
Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

7400-1008
(Rev 8/09)

NEWBORN IDENTIFICATION & DISCHARGE INSTRUCTIONS

White - Chart Yellow - Patient

SAMPLE



Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056
NEWBORN IDENTIFICATION &
DISCHARGE INSTRUCTIONS

ADDRESSOGRAPH

7400-4009 (5/05)

White - Chart Yellow - Patient

SAMPLE

NEWBORN IDENTIFICATION UPON RE-BANDING

Baby _____ is being re-banded.

I her re correct.

Old

New

Pa

If oth

Wr

Ident

Wi

Affix

Delete

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

6385-1010
(Rev. 11/13)

NEWBORN IDENTIFICATION UPON RE-BANDING

Affix Patient Label

SAMPLE

IDENTIFICATION DEL RECIEN NACIDO AL CAMBIARLE LAS PULSERAS

Delete

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

6385-1010
(Rev. 6/13)

NEWBORN IDENTIFICATION
UPON RE-BANDING

SAMPLE

NEWBORN IDENTIFICATION VERIFICATION UPON DISCHARGE

Check appropriate box below

☐ I hereby acknowledge that I have compared the identification band with my own numbered _____ and I am taking my baby from the hospital.

☐ I hereby acknowledge that I have checked the identification and I am taking the appropriate baby from the hospital.

_____	_____	_____
Parent	Witness	Date & Time
_____	_____	_____
Signature if other than parent	Relationship	Identification Verification

Affix infant's (and Mom's if appropriate) identification band(s) below

Tri-City Medical Center 4002 Vista Way ◇ Oceanside ◇ CA ◇ 92058 NEWBORN IDENTIFICATION 7400-1008	Affix Patient Label

SAMPLE

VERIFICACIÓN DEL RECIÉN NACIDO AL DARLE DE ALTA

Marque abajo el cuadrito apropiado

☐ Por la presente reconozco que he comparado la pulsera identificativa con mi propia pulsera número _____ y me llevo a mi bebé del hospital.

☐ Por la presente reconozco que he verificado la pulsera identificativa y que me llevo al bebé apropiado del hospital.

_____	_____	_____
Firma de uno de los padres	Testigo	Fecha y hora
_____	_____	_____
Signature if other than parent	Relationship	Identification

Affix infant's (and Mom's if appropriate) identification band(s) below

Tri-City Medical Center
4002 Vista Way ◇ Oceanside ◇ CA ◇ 92058
NEWBORN IDENTIFICATION
7400-1008

Affix Patient Label

SAMPLE

Bab

I he

Old

New

Pa

If ot

W

Ider

W

Affix

Delete

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

6385-1010
(Rev 11/13)

NEWBORN IDENTIFICATION UPON RE-BANDING

Affix Patient Label

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**INCENTIVE SPIROMETER (IS) INSTRUCT AND MONITORING**
Purpose:	To identify the Respiratory Care Practitioner (RCP) and Registered Nurse (RN) roles for providing instructions and monitoring patients requiring an IS.

A. **DEFINITION:**

1. Incentive Spirometer (IS) – a device used to encourage and assist patients at risk for pneumonia, post-operative pulmonary complications, and patients with declining pulmonary status to breathe deeply to achieve normal vital capacity. The device provides a visual feedback to patients about the depth of their breaths.

B. **POLICY:**

1. A physicians order is required for an IS.
2. Patients at risk for postoperative pulmonary complications (i.e., patients undergoing surgical procedures involving abdomen or thorax and patients with conditions predisposing to development of atelectasis, including immobility and abdominal binders) should have an order for an IS. Examples include but are not limited to the following:
   a. Abdominal Surgery
   b. Thoracic Surgery
   c. Prolonged bed rest
   d. Post-operative patients with Chronic Obstructive Pulmonary Disease (COPD)
   e. Presence of a thoracic or abdominal binder
   f. Restrictive lung defeat associated with a dysfunctional diaphragm or involving respiratory musculature
   g. Patients with an inspiratory capacity of less than (<) 2.5 liters
   h. Patients with neuromuscular disease
   i. Patients with pain level interfering with their ability to take deep breaths
3. RCPs and RNs will work collaborative to ensure patients are provided instructions for the use of an IS.
   a. RCPs will provide the initial education and two follow-up treatments with education.
      i. If RCP is unavailable to provide initial education, the primary RN assigned to the patient is responsible for ensuring education is provided.
   b. RCPs and RNs will use the teach-back method to assess the patient's understanding of the instructions provided.
4. RCPs and RNs will review Online Skills: Incentive Spirometry Procedure.

C. **PROCEDURE:**

1. RCP Role
   a. Identify patient's predicted volume based on gender, age, and height.
   b. Mark the predicted volume with a permanent marker on the IS to inform the patient and RNs.
      i. Approximate the patient's predicted value using clinical judgment when the patient's age and height are not within the predicted values chart.
   c. Inform patient the mark represents the goal they should achieve
   d. Instruct patient to cough to expectorate phlegm.
      i. Ensure patients with surgical incisions splint using a pillow.
   e. Provide hand-off to the RN after the initial education and the two subsequent treatments are completed.
   f. Document in the Electronic Health Record (EHR)
      i. Patient's responses to the treatments

Patient Care Content Expert Review	Clinical Policies & Procedures	Nursing Leadership	Division of Pulmonary	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/18, 10/21	9/14, 04/18, 11/21	10/14, 04/18, 12/21	05/15, 06/18, 03/22	n/a	06/15, 06/18, 04/22	05/22	08/15, 07/18, n/a	8/15, 07/18

ii. Patient's ability to participate with their therapy
iii. Hand-off provided

2. RN Role
   a. Obtain hand-off from RCP
   b. Ensure education is provided if task not completed by RCP
   c. Review Online Skills Incentive Spirometry Procedure for the following:
      i. Indications and contraindications
      ii. Expected and unexpected outcomes
      iii. Education topics
      iv. Patient instructions for use of the IS
   d. Encourage patient to use IS at least 5-10 times every hour while awake or as ordered.
   e. Assess patient's understanding of the instructions for using an IS using teach-back
   f. Document the use of IS each shift as appropriate
      i. Education provided to patient
      ii. Patient's response to using the IS
         1) Volumes achieved
         2) Frequency of use
      iii. Patient's ability to participate
3. Hand-off Process
   a. RCP and RN hand-off shall consist of the following:
      i. Patient's response to therapy
      ii. Predicted volume
      iii. Actual volume
      iv. Additional information appropriate to patient

D. **REFERENCE(S):**

1. Agency of Healthcare Research and Quality (AHRQ). (nd). National guideline clearinghouse: Incentive spirometry, 2011. Retrieved from http://www.guideline.gov/content.aspx?id=34793
2. American Association for Respiratory Care (AARC). (2011). Clinical practice guidelines, incentive spirometry: 2011. *56(10):* 1600-4
3. Elsevier Inc. (2006-2014). Mosby's skills: Incentive spirometry. Retrieved from Tri-City Medical Center (TCMC) Intranet.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: PRE-OPERATIVE MEDICATION INSTRUCTIONS TO SURGICAL PATIENTS

I. **POLICY:**

A. Patients are to be provided instructions during the Pre-Operative Education appointment regarding their prescription medication management, as applicable, before surgery.

1. This education may occur through an appointment in-person or via telephone.

II. **PROCEDURE:**

A. The Registered Nurse (RN) in the Pre-Operative Education Department shall instruct patients to:

1. Stop phentermine seven (7) days prior to surgery.

~~1.~~**2.** Stop angiotensin converting enzyme (ACE) inhibitors and angiotensin II receptor blocker (ARB) agents twenty four (24) hours prior to surgery.

~~2.~~**3.** Consult with their surgeon, primary care physician and/or cardiologist for medications that can affect bleeding (e.g., anticoagulants, platelet inhibitors, herbal medications) for discontinuation guidelines.

~~3.~~**4.** Take all of their morning medications prior to surgery, except the following:

a. Insulin

b. Oral hypoglycemic agents

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

A. Initial training: Orientation

B. Ongoing: Annually ~~through Skills Validation process.~~

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

A. This procedure has been developed by Surgical Services, with approval from Nursing Leadership and the Operating Room (OR) Committee.

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

A. RN's in the Pre-Operative Education Department.

Patient Care Services Content Expert	Operating Room Committee	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
10/12, 07/13, 09/17; 03/18; **09/20**	**12/15, 07/18, 09/20**	10/12, 07/13, 09/15, 08/18, **08/21**	10/12, 07/13, 09/15, 09/18, **10/21**	11/12, 07/13, 09/15, **11/21**	01/13, 02/14, 01/16, 01/19, **01/22**	02/13, 02/14, 01/16, 02/19, **04/22**	03/19, **05/22**	02/16, n/a	02/13, 02/14, 02/16, 03/19

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/06

SUBJECT: **Provision of Education for Adolescents During Hospitalization**

REVISION DATE~~(S)~~: 02/09, 02/11, 03/16, 02/19

Patient Care Services Content Expert Approval:	~~12/18~~03/22
Clinical Policies & Procedures Committee Approval:	~~01/19~~04/22
Nursinge Leadership~~Executive Committee~~ Approval:	~~01/19~~05/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~01/19~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. To address the specific academic education needs of adolescents by supporting continuity of education during hospitalization.

B. **POLICY:**

1. Parents will be informed upon admission that assistance in communicating with the adolescent's school during hospitalization will be provided after the 14th day of hospitalization.
2. Collaboration with the adolescent's school will be facilitated upon parental request and permission.
3. The Case Manager will:
   a. Communicate with the adolescent's school regarding coordination of appropriate educational services to meet both the adolescent's academic and medical needs during hospitalization.
   b. Facilitate coordination of educational services provided by the school district.
   c. Contact the school district representative/ adolescent's teacher to assist with transition upon the adolescent's return to regular school or for home follow-up after discharge.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: WOUND, OSTOMY, CONTINENCE NURSE (WOCN

I. **POLICY:**

A. Function: Wound, Ostomy, Continence Nurse (WOCN) consult or referral for wound team evaluation and treatment of patients with partial or full thickness wounds, ostomies, incontinence associate impaired skin integrity, fungal rashes, incontinence, pressure injury prevention and treatment.

B. Circumstances:

1. Setting: Tri-City Medical Center acute care setting
   a. Assessment management of high risk patient for pressure injuries, acute and chronic wounds, ostomy and peristomal problems, impaired skin integrity, and incontinence.
   b. Collaborating with physicians, and other health care disciplines including, but not limited to physical therapy, dietary consultation.
2. Supervision: None required
   a. The WOCN shall communicate with the physician for the following situations and any others deemed appropriate.
      i. Emergent conditions requiring prompt medical interventions.
      ii. Acute decompensation of patient situation
      iii. Problem that is not resolving as anticipated
      iv. Any adverse episode

II. **PROCEDURE:**

A. This Standardized procedure covers the assessment, management, and treatment of patients with acute and chronic wounds including, but not limited to pressure injuries, venous ulcers, arterial ulcers, diabetic foot ulcers, post-operative wounds, traumatic wounds, skin tears, superficial burns, ostomies, fistulas, and percutaneous tubes. Associated skin conditions may include, but are not limited to stasis dermatitis, moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).

B. Acute and Chronic Wounds:

1. Assessment data may include, but is not limited to:
   a. Historical information
   b. Review of previous treatment of current condition and response to treatment
   c. Review of current medications
   d. Review of associated risk factors
   e. Wound measurement: Length x width x depth
   f. Wound bed appearance: granulating, necrotic, presence of slough
   g. Wound drainage including amount, color, and consistency
   h. Periwound skin surface (intact, denuded, macerated)
   i. Presence of edema
   j. Circulatory status
   k. Wound type of stage / deep tissue exposed
   l. Consultation may be conducted remotely at wound team discretion
   ~~k.~~**m. Assessment and plan in collaboration with wound team**
2. Plan:
   a. Therapeutic regimen:

Department Review	Clinical Policies & Procedures Committee	Nursing Leadership Executive Council	Pharmacy & Therapeutics Committee	Interdisciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/07, 06/11	03/11, 05/17, **08/21**	03/11, 05/17, **10/21**	06/11, 05/17, **11/21**	06/11, 07/17, **01/22**	06/11, 03/18, **04/22**	**05/22**	06/18, n/a	06/1, 06/18

i. Dependent upon the conclusion of the assessment process

b. Patient education regarding:
   i. Disease process
   ii. Prevention and treatment of pressure injuries
   iii. Risk factors / change in behavior and routine
   iv. Procedures
   v. Diagnostic testing
   vi. Medications

c. Treatment appropriate to the condition and status of wound, including but not limited to:
   i. Wound Culture as clinical indicated aerobic / anaerobic and gram stain
   ii. Application of dressings to maintain moist wound bed
   iii. Negative pressure wound therapy
   iv. Conservative sharp debridement and autolytic debridement
   v. Compression therapy
   vi. Use of equipment
   vii. Specialty mattress and bed selection as clinical indicated

3. Consultation:
   a. Consultation and referral to the appropriate specialist or health care professional is initiated when the condition necessitates.

4. Follow-up:
   a. Follow-up shall be initiated by the WOCN at his/her discretion as indicated to evaluate the patient's condition at appropriate time intervals.
   b. Evaluate for possible referral to the TCMC Center for Wound Healing and Hyperbaric Medicine.

C. Pressure Injuries:
1. A pressure injury is any lesion caused by unrelieved pressure resulting in damage of underlying tissue.
2. Pressure injuries are usually located over bony prominences or under a medical device excluding mucosal membranes and are graded or staged to classify the degree of tissue damage observed.
3. Treatment:
   a. Apply a prevention foam composite dressing to high risk areas or under a medical device to prevent injury. Assess under the dressing q shift and with a change in condition.
   b. Turn and reposition patient at least every 2 hours or more frequently as needed to prevent injury.
   c. Assure the appropriate selection of support surface.
   d. Educate staff, patient and or family on pressure injury prevention and treatment per hospital policies.
   e. Dry Wounds:
      i. Topical wound care to include, but not limited to the use of hydrogels, ointments, creams, cover dressings.
   f. Wet Wounds:
      i. Topical wound care to include, but not limited to use of absorptive fillers, granules, paste, powder, alginates, ointments and absorptive cover dressings.
   g. Prevention of Pressure Injuries is a comprehensive and collaborative approach involving the staff and the patient. This includes but is not limited to: product evaluation, patient recommendations for care, staff education and in-services, specialty bed selection, and as indicated Consultation with Wound Physician, Plastic Surgeon Service, Dietician, Physical Therapy.
4. Adjunctive therapies:
   a. Vacuum Assisted Closure (VAC) or Veroflo

b. Wound debridement:
   i. Autolytic
   ii. Enzymatic
c. Topical therapy for odor management and reduction of bacterial burden.

D. Ischemic (Arterial) Ulcers:
1. Arterial ulcers are caused by lack of blood flow and tissue perfusion. Pressure, trauma and other factors may precipitate their development.
2. Treatment:
   a. Circulatory status will determine treatment and management of arterial ulcers
   b. Assessment of circulatory status to include but not limited to:
      i. Palpation of pulses
      ii. Assessment of skin color, skin temperature, and capillary refill time
         1) Atrophy of the skin; skin cool to touch; absent hair
      iii. Presence of hair and toenail changes
      iv. Dependent rubor
      v. Sensation, pain
      vi. Arterial duplex study to evaluate physiologic wave forms for wound healing
   c. Topical dressings may include hydrogels, absorptive wound fillers, matrix dressing, nonocclusive absorptive dressings, and hydrophilic dressings.
   d. Enzymatic debridement or conservative sharp tissue debridement after vascular status is established and has been ordered by the physician.
   e. Consultation with Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.
   f. Arterial wound should not be classified as pressure injury.
3. Educate patient and staff on pressure reduction and trauma prevention to lower extremities.

E. Venous Ulcers:
1. Venous ulcers may be defined as ulceration secondary to chronic venous insufficiency. Veins can be normal, but patient may have poor venous return, due to calf muscle pump incompetence, i.e., paraplegics or rheumatoid arthritis.
2. Treatment:
   a. Assessment of circulatory status to include but not limited to:
      i. Presence of edema
      ii. Stasis dermatitis
      iii. Lipodermatosclerosis
      iv. Hyperpigmentation
   b. Topical wound care to absorb excess drainage and maintain moist wound bed.
   c. Compression therapy, if arterial circulation is satisfactory
      i. Stockings or tubular elastic bandage, compression socks, stockings or tubular elastic bandage
      ii. 2 or 4 layered wraps
      iii. Pneumatic compression device
      iv. Foot pumps

F. Alteration in Skin Integrity: moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).
1. Alteration in skin integrity may be the result of the following factors:
   a. Excessive exposure of the skin to moisture due to but not limited to:
      i. Perspiration
      ii. Wound drainage
      iii. Urine and Fecal Incontinence
   b. Mechanical trauma due to pressure, friction and shear
   c. Adhesive tape removal

d. Fungal/yeast infections
e. Allergic
f. Contact dermatitis

2. Treatment of partial or full thickness skin loss:
   a. Partial or full thickness skin loss may present as maceration, redness, denudation, itching, dermal stripping, flaking, rash, macular or popular pustules, fluid-filled blisters, and skin tears due to trauma.
   b. Cleanse with normal saline or commercially prepared dermal cleanser.
   c. Treatment appropriate to the condition and status of the wound, such as application of wound gel, oil emulsion gauze, hydrocolloids, and/or transparent dressing.
3. Treatment of fungal/yeast infections:
   a. Fungal infections are classified as dermatophyte or yeast infections that grow in moist, warm, dark surfaces such as in skin folds or between toe webs.
   b. Cleanse with normal saline or use commercially prepared skin cleansers.
   c. Thoroughly dry skin and skin folds.
   d. Apply anti-fungal ointment, powder, or cream, per manufacturer's recommendations.
4. Treatment of hypergranulation:
   a. Hypergranulation is when granulation tissue exceeds the height of the epidermal layers.
   b. Cleanse wound with normal saline or commercially prepared dermal cleanser and pat dry.
   c. Moisten tip of silver nitrate stick with water.
   d. Apply to affected area. Neutralize with normal saline.
   e. Reassess treatment effectiveness with next dressing or ostomy pouch change.
5. Treatment of Incontinence related Skin Damage:
   a. Cleanse the perineal area with ph balanced peri wipes.
   b. Apply protect ointment or paste to affected area as needed to repel urine and stool.
   c. Consider implementation female urinary diversion device or male urinary diversion device.
   d. Consider a fecal containment device for liquid stool incontinence.
   e. Reevaluate placement and patency to ensure a medical device does not cause injury.

G. Diabetic Foot Ulcers or Neuropathic Wounds:
1. Diabetic Foot Ulcer (DFU) is a combination of local and systemic risk factors that result in ulceration in the foot. Wound healing and limb salvage outcomes are based on identifying the causative and contributing factors. Five key areas: patient, skin, circulation, limb, and wound. These factors influence wound treatment modality and limb salvage.
   a. Peripheral Sensory Neuropathy:
      i. Semmes-Weinstein monofilament exam. This tests for neuropathy resulting in loss of protective sensation.
   b. Peripheral Arterial Disease:
      i. Evaluate vascular status by history of symptoms of intermittent claudication, ischemic rest pain, and peripheral vascular surgery; clinical signs of ischemia, such as skin temperature, dependeant rubor, pallor, hair loss, and shiny skin and a clinical assessment of lower extremity pulses, ABI, or arterial duplex waveform study to determine perfusion status.
   c. Mechanical trauma due to pressure, friction and shear:
      i. Evaluation of skin and nail changes
      ii. Musculoskeletal examination

d. Infection:
   i. Soft tissue and bone infection
      1) X-ray or MRI
e. Prevention:
   i. Evaluate risk factors and risk stratification to prioritize the patient's treatment according to the patient's needs. Preventive Education to reduce Diabetic Foot Ulcers.
   ii. Protective Footwear and Pressure Redistribution
      1) Primary role of therapeutic footwear is to protect the foot from repetitive injuries and eliminate the shoe as a source of pathology.

2. Treatment of Diabetic Foot Wound:
   a. Antibiotic therapy and revascularization of ischemia will be initiated by Physician Team.
   b. Sharp Debridement of the ulcer removes the devitalized tissue, reduces the bacterial load, eliminates proteases from the wound bed, and provides bleeding to the wound bed. Enzymatic debridement or autolytic debridement may be an option if sharp debridement is not possible or PAD.
   c. Cleanse with normal saline or commercially prepared dermal cleanser, promote moist wound healing.
   d. Treatment appropriate to the condition and status of the wound, such as application of wound vac or veroflo, ointments, enzymatic debridement ointments, composite dressings, silver dressings and/or foam dressing.
   e. Off – Loading of wound to allow for wound healing.
   f. Consultation with Wound Physician, Vascular Service, Dietician, Physical Therapy, Podiatrist, Orthotist, as indicated.
   g. Diabetic Foot Wounds should not be classified as pressure injury.
   h. Educate patient and staff on pressure reduction and trauma prevention to Diabetic Foot Wounds.

H. Ostomies, Fistulas, and Percutaneous Tubes
   1. Treatment:
      a. Assessment will include, but not limited to:
         i. Description and evaluation of ostomy, fistula, peristomal skin, or percutaneous tube status
         ii. Review of previous treatment of current condition and response to treatment
         iii. Access stoma, fistula, or percutaneous tube drainage
         iv. Presence of hernia or other stomal complications
      b. Treatment appropriate to the condition:
         i. Ostomy care and associated skin irritation
         ii. Evaluation of stoma and peristomal skin condition to determine appliance choices
         iii. Peristomal skin irritation, contact dermatitis interventions, such as:
            1) Cleansing and application of protective skin barrier paste, powder, or barrier rings
            2) Treatment of peristomal hypergranulation with silver nitrate cautery
         iv. Management and removal of stents, drains, or stomal bridges as ordered by the physician
         v. Evaluate fistula and perifistular skin condition to determine appropriate method to contain drainage
         vi. Treatment of perifistular skin irritation, contact dermatitis, and skin erosion due to drainage
         vii. Cleansing and application of wound containment device or topical wound product

viii. Barrier ointments or dressings to treat and protect the surrounding skin

c. Percutaneous tube skin treatment:
   i. Cleansing, use of barrier powder, creams or ointments
   ii. Dressing changes appropriate to drainage volume, or
   iii. Use of containment devices.

III. DOCUMENTATION:

A. The WOCN shall document services provided and patient response to treatment in the medical record.

IV. REQUIREMENTS FOR RNS INITIATING STANDARDIZED PROCEDURE:

A. Current California RN license.
B. Education:
   1. Be a graduate of an approved Wound, Ostomy, Continence Education Program or
   2. Participate in 30 hours of continuing education every 2 years.
C. Annual Competency Assessment including Sharp Conservative Debridement Validation

V. 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.

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 Wound, Ostomy, and Continence Nurse Standardized Procedure.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 10/02

SUBJECT: Plan to Manage and Estimate Project Cost

REVISION DATE: 02/03, 04/06, 06/09, 07/11, 03/15 01/18

POLICY NUMBER: 8610-277

Department Review	~~11/17~~08/21
Administrative Policies & Procedures Committee Approval:	~~11/17~~12/21
Finance & Operations Committee Approval:	~~01/18~~05/22
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. To create a policy and process for all hospital personnel to submit an accurate project cost proposal to administration for request for approval.

B. **POLICY:**

1. Once a project has been discussed within a department, a Director/Manager will accurately describe the scope of the project and submit a renovation request to his/her Vice-President for scope approval. Project must be reviewed by Facilities and Information Technology for feasibility. Upon review and approval by the ~~Vice-President~~**Administration Representative** of the project scope the written request will be submitted to the Facilities Department for cost analysis.
2. After receiving direction from the ~~Vice-President~~**Administration Representative**, the Facilities Department will:
   a. Meet with all personnel involved to determine the complete construction scope of the project.
   b. Provide an initial estimated cost and projected completion time to Administration, if needed.
3. If ~~Vice-President~~**Administration Representative**'s decision is to approve a further investigation of the potential project, the following items will take place:
   a. If the project scope warrants, an architect will be called in to begin design development.
   b. If the project scope warrants, a construction manager will be called in to value engineer and put together a project budget, as well as manage the construction of the project.
4. Facilities will keep Administration abreast of design and budget details as the project develops.
5. After the project is completely designed, approved by the Authorities Having Jurisdiction and bid out to contractors or a professional construction estimate is completed, a project budget will be finalized, a capital purchase requisition (CPR) will be submitted by the Facilities Department with the total estimated project cost to the Capital Budget Committee for review and approval. Any necessary bidding or bidding provisions will be finalized and necessary Board approvals will be completed.
6. Upon Administration/Board approval, the approved CPR will be submitted by the Facilities Department to the Finance Department for approval and assignment of a budget number.
7. Once the project has been approved and assigned a budget number, it will be assigned a project number (CIP Number) and construction administration will begin.
8. If the project scope changes at any point during the project, Administration must give written approval for the additional architectural/engineering fees and construction costs associated with these changes. This supplemental CPR will follow the same process of approval as the original

project request.

9. If approved, the supplemental CPR will be submitted to Administration for review and approval. Any associated costs will be added to the total project budget.
10. During the fiscal year budget development process, the Facilities Department will utilize both in-house estimating resources as well as outside contractor resources to develop budget estimates Administration can depend on for the next fiscal year.
11. Once Administration and the Finance Department have approved a project, it is the responsibility of the Director of Facilities to coordinate the project's progress and schedule all project related meetings. If any other departments are affected or involved, it is the responsibility of the area's Director/Manager and Director of Facilities to keep everyone informed of progress and responsibilities.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 11/08 **SUBJECT: Smoke-Free Environment**

REVISION DATE: 05/12, 03/15, 06/18 **POLICY NUMBER: 8610-205**

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~03/18~~01/22
Administrative Policies & Procedures Committee Approval: ~~04/18~~03/22
Medical Executive Committee ~~05/18~~04/22
Administration Approval: 05/22
Professional Affairs Committee Approval: ~~06/18~~ n/a
Board of Directors Approval: 06/18

A. **PURPOSE:**

1. To provide adequate guidelines regarding Tri-City Healthcare District's commitment to providing a safe and healthful work environment for all employees, contracted staff, medical staff, vendors, patients, visitors and other customers
2. Smoke inhaled from direct smoking, as well as, indirectly from other's who are smoking nearby is a major cause of preventable disease and death. The hospital serves as a model for our community in the area of promoting good health of our staff and influencing public attitudes about smoking. It is therefore, TCHD's policy to provide a smoke free environment.

B. **DEFINITIONS:**

1. Tobacco products: Any product containing tobacco intended to be lit, burned, or heated to produce smoke as well as any device used to smoke the tobacco, including but not limited to a pipe, cigar, or cigarette, (including electronic cigarettes).
2. Electronic cigarette: Any electronic device designed or intended to produce smoke or vapors for inhalation.

C. **POLICY:**

1. It is the policy of TCHD to provide a safe, healthful and comfortable work environment for all employees, contracted staff, vendors, patients visitors and physicians by prohibiting smoking or all tobacco based products at all facilities owned or operated by TCHD.
2. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products on or in any TCHD facility, adjacent grounds, including parking lots and TCHD leased or owned vehicles. Employees, contracted staff, patients, vendors, visitors and physicians are prohibited from smoking or utilizing tobacco based products in their own or others vehicles when they are parked on TCHD property.

D. **PROCEDURES:**

1. Communication of Policy
   a. Signs bearing the message "Smoke-Free Campus" are posted at strategic locations around the property (as applicable), and each building owned or leased in full will display a decal that states "Smoke Free Facility." No ashtrays or smoking shelters are provided on the campus property.
   b. Patients and their families/friends will be informed of this policy upon arrival or as soon thereafter, as is medically appropriate.
   c. All employees are authorized to communicate this policy with courtesy and diplomacy to other employees, medical staff, patients and visitors.
2. Tobacco Cessation Programs
   a. TCHD is committed to providing support to all TCHD employees who wish to stop using

smoking products. TCHD is committed to ensuring that TCHD employees have access to smoking cessation assistance.

b. Supervisors are encouraged to refer employees and other personnel to Employee Health for information on available services.

3. Responsibilities
   a. Adherence to this policy is the responsibility of all individuals working, visiting, or receiving medical care within TCHD as cited above. Compliance with this policy is mandatory and will be strictly enforced. Policy violations by employees will be subjected to the standard TCHD disciplinary actions.
   b. Employees who choose to use smoking products must do so on their own time
   c. Respectful monitoring of this policy will be shared by all TCHD staff and Security.
4. Enforcement - Employees
   a. This policy will be enforced through administrative action by supervisors and managers.
   b. Once the employee's supervisor has been notified of a violation by an employee under their direction, the supervisor is responsible for discussing the violation with the employee and taking appropriate disciplinary action.
   c. Standard disciplinary procedures will be followed for compliance with staff. Violations of this policy will result in progressive disciplinary actions, up to and including termination.
   d. All personnel are responsible for adherence to and enforcement of the smoke free policy
5. Enforcement – Patients and Visitors
   a. Patients, visitors, and any other guests who fail to comply with this policy will be reminded that TCHD is a smoke-free facility and will be advised of resources available to assist with compliance while they are on TCHD property.
   b. Patients will not be permitted to smoke during hospitalization. Refer to Patient Care Policy, *Patient Smoking* for management of patients refusing to comply with this policy.

E. **RELATED DOCUMENTS:**

1. Administrative Policy 424: Coaching and Counseling for Work Performance Improvement
2. Administrative Policy 234: Security Department Incident Notification
3. ~~Behavioral Health Services Policy: Smoke Free Environment~~

F. **REFERENCES:**

1. Centers for Disease Control and Prevention. *Healthy Workforce Initiative:* Implementing a Tobacco-Free Campus Initiative – United States 2004. Available at: www.cdc.gov/nccdphp/dnpa/hwi/toolkits/tobacco/index.htm
2. The Joint Commission (2011). *Keeping your hospital Property Smoke-Free: Successful strategies for effective policy enforcement and maintenance.* Retrieved from: http://www.jointcommission.org/assets/1/18/Smoke_Free_Brochure2.pdf
3. The Joint Commission (2015). Caution: E-Cigarettes pose potential hazards: Follow standards and update smoking policies to maintain compliance. *The Joint Commission Perspectives*

Tri-City Medical Center	~~Distribution:~~Cardiac Cath**eterization** Lab
PROCEDURE:	**AUTOMATIC IMPLANTABLE CARIOVERTER-DEFIBRILLATOR (AICD) CHECK**
Purpose:	Outline procedural steps for AICD Check
~~Supportive Data:~~	~~None~~
Equipment:	Monitoring equipment with redundant back up to include NIBP, 02 sat probe, EKG, defibrillator and back-up defibrillator available in department; ~~wrist immobilize, leg strap~~ ,R2 pads, ambu-bag~~, sedation flow sheet~~.**ETC02 cannula and monitor**
Issue Date:	06/04

A. **PROCEDURE:**

1. The patient ~~is delivered~~ **arrives** to the cath lab via gurney. The chart is checked for consents, pre-op meds, blood work and EKG.
2. ~~Staff greets the patient. Introductions are made, patient education is provided and any questions are answered.~~ Timeout identification of the patient is verified by confirming patient name, number and birth date verbally and by checking the patient's wristband.

~~1. The patient is positioned on the x-ray table.~~

3. The patient's gown is unbuttoned; **Electrodes and EKG leads are hooked-up,** blood pressure cuff and oxygen saturation monitor is applied.

~~B. Electrodes are applied and EKG leads are hooked up.~~

~~C.~~**4.** Apply defib (R2) pads according to the product user instructions, set joules to **physician**~~MD~~'s preference.

~~1. Apply wrist and leg immobilize.~~

~~D.~~**5.** Apply **an ETC02** nasal cannula ~~per MD's preference~~, have ambu-bag available.

~~1.~~**6.** The **Registered Nurse** (RN) is responsible for patient comfort, checking vitals, **verifying patent intravenous access (IV),** administering medications **and IV fluids per physicianMD's orders** ~~and documenting on sedation flow sheet. The RN checks for patent IV and starts fluids for all AICD checks per MD's orders~~.

~~2. The RN will have on hand vials of Valium, Versed, Lidocaine and Romazicon.~~

~~3. The circulating technicians responsibilities include the use and knowledge of the defibrillator, management of airway and CPR when necessary and emergency defibrillator is ready and in working order.~~

~~4.~~**7.** The monitor technician is responsible for accurately monitoring the procedure and assisting in airway management, defibrillation and **cardiopulmonary resuscitation (CPR**~~CRP~~) when necessary.

~~5.~~**8.** Anesthesia or RN administers sedation when ~~electrophysiologist~~ **physician** indicates the device is ready and after communication to vendor proper shock parameters.

~~6.~~**9.** Devisce is tested two times with staff member, RN or ~~cardiovascular~~ **cath lab technician** ~~(CVT)~~ as backup if device fails to convert rhythm.

~~7.~~**10.** ~~Upon successful test, physician closes wound, if not yet closed.~~

~~8.~~**11.** End of procedure.

~~Issued:~~	~~Reviewed:~~		~~Revised:~~	~~Approved:~~	
~~06/04~~	~~06/04; 05/05; 04/09; 03/09~~		~~06/05; 03/09~~		
Cardiac Catheterization Lab Review	**Division of Cardiology**	**Pharmacy & Therapeutics Committee**	**Medical Executive Committee**	**Administration**	**Professional Affairs Committee**	**Board of Directors**
06/04; 06/05; 03/09, 09/18, **05/20**	**04/22**	**n/a**	**4/22**	**05/22**	**n/a**	**08/11**

Tri-City Medical Center	~~Distribution:~~Cardiac Cath**eterization** Lab
PROCEDURE:	**ELECTROPHYSIOLOGY STUDY**
Purpose:	To outline a procedure to be followed with all patients having an EP Study, which a physician's order is required.
Supportive Data:	None
Equipment	~~Cardiolab 7000; Medtronic stimulator~~**EP-4 Stimulator, Claris Amplifier, Velocity Amplifier, Ampere Ablator, Ensite and Claris Workstations**; 12 lead EKG machine; Pulse oximeter; Automatic blood pressure machine; Defibrillator; Prepackaged cath tray; Heparinized saline solution 500 ml; ~~Xylocaine~~ **Lidocaine**1%; Sterile gloves for physician and scrub technician; Sheaths,~~ and~~ diagnostic **and ablation** catheters (chosen by Physician); Zoll stat pads; Electrodes; Back-up patient monitoring equipment to include, NIBP, EKG, 02 sat probe, and back –up defibrillator in department.
Issue Date:	**06/97**

A. **PROCEDURE:**

1. **Staff greets the patient. Introductions are made and any questions are answered.**~~The patient is delivered to the cath lab via a gurney.~~ The chart is checked for consents, pre-op meds, blood work and EKG.
2. **The patient is delivered to the cath lab via a gurney.**~~Staff greets the patient. Introductions are made and any questions are answered.~~
3. The patient is positioned on radiologic table.
4. The patient's gown is removed, blood pressure cuff and oxygen SAT is applied.
5. Apply electrodes for regular leads for 12 lead ECG Cardiolab II Plus amplifier and Zoll defibrillator.
6. Apply defib **and mapping** pads according to diagram and instructions on the **back** ~~front~~ of the packages.
7. The scrub tech puts on lead apron, x-ray badge, hat,~~ and~~ mask, **eye protection,** and then proceeds with sterile scrub procedure.
8. A staff member will prep both groins according to department policy.
9. **After the sterile scrub, the scrub technician dries hands with a sterile towel. A sterile gown and gloves are put on and then the scrub technician assists physician with theirs.** ~~A sterile drape is applied in the usual manner, exposing the sterile sites.~~
10. **A sterile drape is applied in the usual manner, exposing the sterile sites.**~~After the sterile scrub, the scrub technician dries hands with a sterile towel. A sterile gown and gloves are put on and then the scrub technician assists physician with theirs.~~
11. The scrub technician assists the physician with the insertion of wires, sheaths, ~~and~~ pacing,~~ or~~ diagnostic **and ablation** catheters. ~~After pacing initiates, the technician will break scrub to assist with circulating responsibilities and patient care.~~
12. The RN is responsible for patient comfort, checking vitals~~,~~ **and** administering medication.~~ and documentation of the procedure.~~ The RN checks for patent IV and that the crash cart and emergency resuscitation equipment is in working order.
13. The RN will need to have on hand vials of Valium, Versed, Lidocaine and Romazicon.
14. The circulating/monitoring technician responsibilities include **documentation of the procedure,** the use and knowledge of the defibrillator, management of airway and CPR if necessary.
15. The monitor technician is responsible for assisting the physician with set-up and troubleshooting of all EP equipment.

B. **ROOM SET-UP:**

Cardiac Catheterization Lab Review	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
10/00; 04/03; 06/05; 04/09; 9/12, 05/20	04/22	n/a	04/22	05/22	n/a	08/11

1. ~~Unplug Pruka monitor from wall and move to foot of table. Plug into wall receptacle (not extension cord).~~**Turn on Velocity Amplifier and EP-4 Stimulator.**
2. ~~Set up Bloom stimulator to the left of the Pruka monitor~~**Turn on Claris Amplifier and Ampere Ablator.**
3. ~~Plug in Bloom cable to amplifier box from Pruka monitor~~ **Turn on Ensite and Claris workstations.**
4. ~~Plug in external fiberoptic cable into back of Bloom~~ **Set up remote mapping monitor at the base of the radiologic table.**
5. ~~Plug in power cable from amplifier on bed to extension cord and turn on amplifier under x-ray table~~ **Start a new case in both Claris and Ensite workstations. Input patient identifying information along with patient height and weight.**~~.~~
6. ~~Plug in 12 lead blue ECG cable, a~~Attach 12-lead to patient.
   ~~1.~~**a.** ~~Plug in blue box cable (Cardiolab II Plus amplifier) under foot of the bed.~~
7. Check to make sure both amplifiers **and EP-4** are on.~~ and Bloom is on.~~
8. The patient is connected to the 12-lead EKG machine ~~(optional)~~ and a baseline ECG is taken to insure proper placement and a clean diagnostic trace is produced.
2. ~~Select F7 for basic EPS set up. Enter all patient's data and turn on the audible ECG trigger. Run a baseline strip. If unable to obtain signal of any kind or error code is present: a. Check all connections (see operator's manual, section 3-3 and appendix A-5). B. Inform cardiologist of delay if no signal or error still present. C. Contact cath lab manager. D. Call system support to trouble shoot problem. Technical support (800) 558-7044 and Clinical support (888)477-8252. Tower serial number for lab #1 is F1PX1064F and for lab #2 F1PX1058F. E. If error code is cleared and/or signal is present, procedure may proceed.~~
9. After placement of the sheaths and appropriate location of diagnostic catheters, the pins are positioned in the junction cable, which is secured to the drape and the other end is passed off to be plugged into the PIIB.
10. Assign the intracardiac leads according to physician's orders. Use the size and limiter functions to achieve the desirable tracing for visualizing atrial, ventricular and His' signals.
11. Recordings will be made per physician's orders on the ~~Pruka computer~~ **Claris Workstation.** ~~Select Cardiolab, then New Patient, and then specific Physicians Protocol.~~
12. Completion of procedure, catheters and sheaths are pulled. Pressure is held and pressure bandage is applied. Patient is transported via gurney with monitor to room.
13. After case, close and save study.

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

Tri-City Medical Center
Oceanside, California

CARDIAC CATHETERIZATION LABORATORY

ISSUE DATE: NEW~~1.24.2022DRAFT~~

SUBJECT: Scheduling Cardiac Catheterization Cases Policy~~Procedures~~

REVISION DATE(S):

Department Approval:	**04/22**
Cardiology Division Department Approval:	**04/22**
Pharmacy &Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide scheduling guidelines for Cardiac Procedures (Heart angiogram, Device Implants, Electrophysiology, Structural Heart, transesophageal echocardiogram (TEE), and elective Cardioversion) with and without an anesthesia provider.

B. **DEFINITIONS:**

1. Add-On Cases: Additions to the Cardiac Cath lab (CCL) schedule after the "final schedule" has been published. The "final schedule" is published by 2:00pm for the next day.
2. Elective Case: Procedure can be scheduled at the time best suited for the Cardiologist and the patient.
3. Urgent Case: Cardiac Procedure is needed within 4-6 hours of presentation. Urgent procedures are placed in an available time on the CCL schedule.
4. Emergent Case: Cardiac intervention is needed within one hour of presentation and may require that another scheduled or add-on case is bumped.
5. ON Call: Cardiac Cath lab team 1 RN, 1 RT and 2 other members CVT, RN OR RT – Call begins 1530-0700 weekdays and 24/7 weekends
6. First Case Start: 0730 Patient in room
7. STEMI: ST Elevation Myocardial infarction
8. Normal business hours: 0700-1530

C. **SCHEDULING ELECTIVE CASES:**

1. All elective outpatient cardiac procedures will be scheduled through the Cardiology scheduling office.
2. Inpatient elective procedures are only scheduled by the ordering Cardiologist thru the CCL charge RN on duty.
3. There are 2 rooms in the Tri-City Medical Center (TCMC) CCL suite which are utilized as follows:
   a. Room 1 can accommodate all Cardiac Procedures except for Electrophysiology
   b. Room 2 can accommodate all Cardiac Procedures
4. Procedural expected times in the CCL during normal business hours. (times may fluctuate based on staffing, CCL volume and CCL acuity)
   a. Heart cath blocked for 60 min
   b. Heart cath with intervention 90 min
   c. Electrophysiology without Ablations 90 min
   d. Electrophysiology with Ablations 180 min
   e. Device Implant 90 min

f. TEE's 45 min
g. Cardioversion 30 min
h. Structural heart 180 min
i. Turn-around time 30 min with Anesthesia 60 min
j. Break and lunches staff 60 min

5. The process for scheduling an elective case is as follows:
   a. The Cardiologist's office calls the TCMC Cardiology Scheduling department to reserve a case time (Hours of Operation 0730-1600 Mon-Fri)
   b. The Cardiologist's office completes a written "TCMC Cardiology Services form" (reservation sheet) and written orders. Forms to be faxed to the TCMC Cardiology department fax server (Fax # 760-940-4040).
      i. Documents to be Faxed:
         1) Orders
         2) Reservation form
         3) H&P (Valid within 30 days of procedure) if Available
   c. Upon receiving the written booking forms, the TCMC Cardiology Scheduler will schedule the case and obtain a financial account number (FIN#)
   d. Cases are reserved in the CCL suites based on (C.3. **and C.4**) expected times and the order in which they are received.
      i. **Case 1 and 2 expected start time 7:30 Unless an anesthesiology case is scheduled, which then case 2 is an 9:00 approximate Start**
      ~~a.~~ii. **Case 3 and 4 expected start time 9:00 Unless an anesthesiology case is scheduled then case 2 start 9:00, case 3 start 10:30 and case 4 at 12:30**
   ~~d.~~**e.** The cardiology scheduler will notify the office that the reservation is booked and will provide the following information:
      i. Date of Procedure
      ii. ~~Estimated time of reservation~~**Case number**
   ~~e.~~**f.** The Cardiologist's ~~office~~ will enter electronic orders or fax written orders to the TCMC Cardiology Scheduling department fax server prior to ~~booking~~ **finalizing the** appointment.
6. Elective cases are performed during normal business hours.
   ~~2.~~**a.** Last elective case scheduled time is 1400
7. Patient Requirements:
   a. Cardiology patients must be at least 18 years of age at the time of Cardiology, except in the case of emergency.
   b. Any requested patients who is under 18 years of age **accepted under the care of the cardiologist** must **also** be reviewed/approved prior to scheduling by the Chief of Anesthesia or designee.
8. The Cardiologist must have the appropriate privileges granted to be allowed to schedule a procedure.
   a. Current privilege lists are maintained through the E-PRIV system, accessible through TCMC Intranet.
   b. If the physician's privilege status is still not clear, the Medical Staff Office is contacted for clarification. The Administrative Supervisor may be contacted for assistance outside of Medical Staff Office hours.
   c. It is the responsibility of the Cardiologist to acquire an assistant or proctor as necessary for designated procedures.

D. **START TIMES:**
1. All first case start times will be at 0730 unless ~~prohibited~~ **limited** by Anesthesia availability
   a. All Physicians should arrive no later than 30 minutes prior to scheduled Anesthesia cases
      i. Anesthesia start time is patient in room time
         ~~i)~~**1)** Example: 11:15 start, requires Cardiologist to arrive at 10:45am

ii. The Start time of elective or add-on case requested for after the first case or later cannot be guaranteed. In those instances refer to (C.3 a).of this protocol for suggested time slots and proposed times. The cardiologist preferred start time will be noted, and the cardiologist will be given on hour's notice of expected start time. If the cardiologist cannot start at the expected time, the next cardiologist will be offered that time.

2. Cases are scheduled on a consecutive, first-come first-served basis based on (3.a.) of this protocol.
3. Start time of first cases are tracked and reported to the Cardiology Division committee monthly.
   ~~3.~~a. Three (3) or more late starts for the first case will lose first case Start for 30 days
4. All cases must follow the Patient Care Service Universal protocol Procedure
   a. 0730 cases, the patient must be ready for transfer to the CCL Suite by 0715, if all elements of the pre-procedure verification ~~i~~ares not available, the next scheduled case may replace the delayed case.
   b. Possible Delays include, but are not limited to:
      i. NO H&P
      ii. NO Orders
      iii. NO Consent
      iv. Physician not available (not on site)
5. If physician leaves the CCL area prior to patient entering the room
   a. The c~~C~~harge RN **or charge RN on duty** will communicate directly with the ordering physician via text **or phone** when patient is ready for procedure.
   b. Physician is to respond to the charge RN or ~~C~~charge RN on duty after hours within 10 minutes.
   c. Patient will be removed from the CCL room if physician does not arrive within 15 minutes (with anesthesia) or 30 minutes without anesthesia of initial notification, that patient is ready.

E. **PRE-OPERATIVE SCHEDULING CALLS:**

1. Patients are called the day before their appointment and provided instructions on the following:
   a. Time of arrival
   b. Location of registration
   c. Medication management

F. **SCHEDULING ADD-ON URGENT OR EMERGENCY PROCEDURES:**

1. STEMI procedures will bump any scheduled case ~~within~~ **for** the first available room
2. Urgent and Emergent cases may be performed at any time.
   a. If the Urgent or Emergent procedure must bump the current scheduled procedure then the physician adding the urgent/emergent case must communicate the bump to the affected physician.
      i. **Examples of Urgent or Emergent include:**
         1) **Persistent chest pain presumed to be due to coronary insufficiency but not meeting criteria for STEMI**
         2) **Recurrent chest pain despite medical therapy for coronary insufficiency**
         3) **symptomatic bradycardia or heart block requiring temporary pacing**
         4) **A patient who clinical condition is such that they require urgent or emergent access to the cath lab at the discretion of the attending cardiologist**
         5) **List is not inclusive**
   ~~a.~~**b.** **If the attending cardiologist and the cardiologist being bumped disagree the medical director of the cath lab may be requested to discuss the case**
3. Urgent and Emergent cases shall be scheduled through the PBX Operator ~~for off hours~~

or by calling the Charge RN on Duty. ~~during normal working hours~~.

4. Required information when scheduling an add-on case includes:
   a. Patient name, date of birth, age, and medical record number
   b. Order entered into Cerner (excludes outpatient)
   c. Patient phone number, Social Security number, and insurance information (excludes in- house patients) **and authorization number when needed.**
   d. Patient current location in the hospital (Excludes out-patients)
   e. NPO status
   f. Pre-Op diagnosis and Procedure to be performed
   g. Physical needs/mobility limitations
   h. Relevant cardiac/medical history
   i. Time of Cardiologist availability
   j. Vendor information if applicable
5. Same day outpatient elective and inpatient elective add on procedures will be added to the end of the day.
   ~~a. If a scheduled or add-on procedure must be bumped for a more urgent procedure the physician adding the more urgent case must communicated the bump to the affected physician.~~

~~B. WEEKEND/HOLIDAY CASES:~~

~~1. For Saturday and Sunday 24/7, 1 room are available for On Call Urgent, Emergent, and Emergency cases. No elective procedures are scheduled on weekends or after hours.~~

~~2. Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, New Year's Day and Presidents Day have 1 room available for On Call Urgent, Emergent, and Emergency cases. No elective procedures are scheduled on these holidays.~~

~~3.~~G. SCHEDULING ELECTIVE OUTPATIENT ADD ON CASES:

~~6.~~1. Add-on cases are started in order of scheduling, providing the Cardiologist is available and the patient is ready for the procedure.

~~7.~~2. If the first scheduled add-on case cannot be performed in the first available time, the next case's Cardiologist will be contacted and offered to start at the available time. Upon availability of the next time to start an add-on case, the Cardiologist for the first case will again be contacted and offered the time.
   a. The first available time is 0730. If a physician requests a specific time, e.g., 0900 to start a case, ~~then~~**and** another physician is available to start at 0730, the physician requesting the 0900 start time will be contacted to move up to 0730, or will start after the preceding case is finished.
   ~~a.~~b. **An open cath lab will not be held more than 30 min to accommodate a requested start time.**
3. Requests may be approved on an individual basis by the Cardiovascular Service Line Director/designee and/or the Invasive Medical Director.

H. WEEKEND/HOLIDAY CASES:

1. **For Saturday and Sunday 24/7, 1 room is available for On Call Urgent and Emergent cases. No elective procedures are scheduled on weekends or after hours.**

~~8.~~2. **Memorial Day, Labor Day, July 4th, Thanksgiving, Christmas, New Year's Day and Presidents Day have 1 room available for On Call Urgent and Emergent cases. No elective procedures are scheduled on these holidays.**

~~G.~~I. CANCELING CASES/DELAYS:

1. Outpatient
   a. To cancel an outpatient case contact the cardiology scheduler
   b. If a patient cancels his/her procedure upon the Pre-operative call, the RN Making the call will notify the cardiology scheduler **and the cardiologist.**

~~a.~~**c.** The cardiology scheduler will notify the MD's Office of the reason and work with the MD's office to reschedule the outpatient

~~c.~~**d.** Under no circumstance will an RN cancel a case without an order from the physician

2. Inpatient
   a. MD to notify the CCL charge RN of the cancelled case immediately upon notification
3. Cardiologist will notify the CCL they will be late for their scheduled start time and must provide an expected time of arrival. Delays of more than 30 minutes, or delays that will impact another Cardiologist**'s** schedule will cause the **delayed** ~~first~~ Cardiologist to be bumped back to the next available start time.
4. **A** Cardiologist who ~~are~~**is** not in ~~the hospital~~**CCL** ~~30~~ **15 minutes past the** ~~minutes past the~~ scheduled time of Procedure and/or are unable to be contacted will be bumped back to the next available start time once they either arrive at the hospital or contact the CCL.

~~H.~~**J.** **STRUCTURAL HEART CASES:**

1. Structural Heart cases ~~are~~ **may be** performed Monday through Friday during normal business ~~hours. Structural Heart cases are performed on Wednesday (preferred)~~
2. All Cases must be worked up **in a multi-disciplinary fashion per CMS guidelines and the national standard of care.** ~~with the Structural Heart Coordinator, Cardiologist and Cardiothoracic Surgeon~~.
3. Structural Heart cases are scheduled in the same manner as Cardiac procedures.
4. ~~Structural Heart cases are performed on Wednesday (preferred)~~
5. ~~4.~~ Cardiologist performing the procedure **is responsible for ensuring availability of the physicians, vendors and staff prior to scheduling.** ~~will notify the cardiothoracic surgeon for his availability prior to scheduling as well as the vendor~~.
6. Elective Structural Heart cases are not to be scheduled on holidays or weekends.
7. **Cardiac Anesthesia is preferred for structural heart cases.**

Tri-City Medical Center	~~Distribution:~~Cardiac Cath**eterization** Lab
PROCEDURE: SET UP FOR STERILE TABLE FOR HEART CATH	
Purpose: ~~To be performed by all CCL staff~~ **To ensure uniform setup for all sterile tables**	
Supportive Data:	None
Equipment	~~Disinfectant wipes;~~ One sterile disposable Cath Lab Pack Three pair of surgeons gloves One sterile towel pack **Two bags** Heparin **sodium** solution (1,000 units in 0.9% sodium chloride 500ml bag, **2 units/ml**); One/Two sheath introducer set-~~french~~**French** size determined by procedure being performed; 1% Lidocaine 10mg/ml~~-with 5ml Sodium Bicarbonate; 10ml Heparin 1000units/ml; add appropriate~~-catheters for procedure being performed.
Issue Date:	**05/88**

A. PROCEDURE:

1. Table is wiped with disinfectant and allowed to dry for ~~2~~ **3 ~~minutes~~ manufacturer's recommended time.**
2. **Perform surgical hand scrub according to hospital policy**
3. ~~1.~~ **Scrub person will don sterile gloves, hat and mask to organize table**
4. ~~2.~~ CCL pack is opened in sterile fashion and draped over the table.
5. ~~3.~~ Equipment is added in a sterile manner.
6. ~~Scrub person with don sterile gloves, hat and mask to organize table~~.
7. ~~4.~~ **All bowls, syringes and cups will be labeled with medication concentration/strength**
   ~~Circulator will:~~
   a. Add 1 bag of heparinized **saline** solution (500ml) to labeled Large Basin.
   b. Add 1 bag of heparinized **saline** solution (500ml) to labeled Small Basin
   c. 10ml 1% Lidocaine ~~with 5ml Sodium Bicarbonate added to~~ **to** labeled cup.
   d. ~~10ml Heparin added to labeled cup per MD request~~.
8. ~~5.~~ ~~Scrub person will receive catheter kit from the circulator~~.
9. ~~6.~~ All sheaths, catheters, ~~arterial~~ **vascular access** needles and wires will be wiped down and flushed with Heparin**ized saline** -solution ~~from the large basin~~.

~~8ml of Lidocaine is drawn up in a 10ml syringe with a 21 guage needle from the Lidocaine labeled cup.~~
~~5ml of Lidocaine is drawn up in a 10ml syringe with a 25 guage needle from Lidocaine labeled cup.~~
~~Syringes are labeled with medication.~~
~~Heparin will be drawn up into 10ml control syringe and labeled per MD request.~~

10. **Lidocaine to be drawn up in 2-10 ml syringes, 1 with a 21 gauge needle and the second with a 25 gauge needle**
11. **Verify all connections on the manifold assembly are tight (heart Cath)**
12. **Hand off fluid lines (sterile) to be spiked with contrast and Heparinized saline solution (2u/ml) Drape x-ray handle, lead shield, control panel with sterile bags**
    ~~1.~~ ~~Verify all connedctions on the manifold assembly are tight.~~

~~Issued~~	~~Reviewed~~	~~Revised~~	~~Approved~~
~~5/88~~	~~6/97; 10/00; 3/03; 5/05; 1/09; 9/12~~	~~6/97; 4/03; 6/05; 1/09; 9/12~~	~~5/88~~

Cardiac Catheterization Lab Review	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/97; 10/00; 04/03, 06/05, 01/09; 09/12, 05/20	04/22	n/a	04/22	05/22	n/a	08/11

Tri-City Medical Center	Cardiac Catheterization Lab
PROCEDURE:	**TEMPORARY PACEMAKER ELECTRODE REMOVAL**
Purpose:	**Guidelines for the removal of a temporary pacemaker electrode, which requires a physician's orders. To be performed by Cardiac Catheterization Lab (CCL) personnel Registered Nurse (RN), Cardiovascular Technician (CVT), or Cath Lab-Rad Tech, when orientation and competence is validated.**
Equipment	**Suture removal kit (PRN)** **Sterile dressing, chloraprep**
Issue Date:	05/87

A. **PROCEDURE:**

1. Verify order and explain procedure to patient after identifying patient.
2. Place patient in supine position.
3. Remove dressing, clean site using the chlora-prep solution.
4. Remove sutures.
5. Aspirate approximately 5 ml of blood and saline from venous side port.
6. Make sure the balloon is deflated (if present).
7. Observe monitor for any arrhythmias.
8. Grasp electrodes at insertion site and withdraw in a smooth and steady fashion. If resistance is met, stop procedure, apply a sterile dressing and notify the physician
9. After electrode removal, apply pressure distal to puncture site for 5 minutes or until hemostasis is achieved.
   a. **NOTE:** Remove sheath with electrode when applicable.
10. Apply sterile dressing.
11. Record in McKesson Procedure Record.

Cardiac Catheterization Lab Review	**Division of Cardiology**	**Pharmacy & Therapeutics Committee**	**Medical Executive Committee**	**Administration**	**Professional Affairs Committee**	**Board of Directors**
06/97; 10/00; 04/03; 05/05; 08/09; 09/12, 05/20	04/22	n/a	04/22	05/22	n/a	

Tri-City Medical Center	~~Distribution:~~Cardiac Catheterization Lab
PROCEDURE:	**VENOUS SHEATH REMOVAL**
Purpose:	**To remove a venous sheath post cardiac catheterization. To be performed by ~~department~~ members of the Cardiac Cath Lab team that have been ~~properly trained~~educated ~~-~~in the procedure of venous sheath removal.**
Supportive Data:	**~~None~~The Cardiac Catheterization Handbook, 2016, Drs. Kern, Sorajja, Lim**
Equipment	**Sterile gloves~~;~~** **Sterile 4 x 4's~~;~~** **~~Tape~~ tegaderm~~,~~** **10 mLl syringe~~,~~** **personal protective equipment**
Issue Date:	**04/88**

A. **PROCEDURE:**

1. Explain the procedure to the patient.
2. **~~1.~~ ACT requirement is per physician preference.**
3. ~~2.~~ Don gloves.
4. ~~3.~~ Aspirate approximately **five** (5) mLl from venous side port.
5. ~~4.~~ Grasp the sheath and remove it from the vein using slow, steady motion.
6. ~~5.~~ Immediately press firmly below the site and maintain firm pressure for **ten (10~~5~~)**minutes.
7. ~~6.~~ After **ten (10~~5~~)** minutes, check the site for bleeding
8. ~~7.~~ If bleeding not contained, hold pressure another **five** (5) minutes.
9. ~~8.~~ When bleeding contained, check for hema~~e~~toma, notify physician if hema~~e~~toma is present.
10. ~~9.~~ Apply **a folded sterile 4 x 4 and tegaderm**~~pressure dressing (preferably elastoplast) or band-aide per physician request~~.
11. ~~10.~~ Palpate distal pulse to assure adequate circulation.
12. ~~11. McKesson Procedure Records: record procedure and status of the site.~~
13. Precautions:
    a. Instruct the patient to stay in bed at least 2 hours **to prevent**~~for venous~~ bleeding at the site of puncture. Notify the **physician**~~nurse~~ **for any active bleeding or hematoma formation**~~if any oozing hematoma occurs~~.

~~Issued:~~	~~Reviewed~~		~~Revised:~~	~~Approved:~~
~~04/88~~	**~~: 06/97; 10/00; 03/03; 05/05; 9/12~~**		**~~06/97; 10/00; 04/03; 06/05; 08/09, 9/12~~**	**~~04/88~~**

Cardiac Catheterization Lab Review	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/97; 10/00; 04/03; 06/05; 08/09, 9/12, 05/20	04/22	n/a	04/22	05/22	n/a	

Tri-City Medical Cen
Oceanside, California

DELETE - Cardic Rehab Phases is already incorporated into Cardiac Rehab Policy: Scope of Practice

CARDIAC REHABILITATION SE

ISSUE DATE: 10/93

SUBJECT: Definition of Cardiac Rehabilitation

REVISION DATE: 6/97, 10/00, 11/07, 12/12

Cardiac Rehabilitation Approval:	**12/20**
Division of Cardiology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/12**

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

~~1. To establish guidelines for the development of phases of cardiac rehabilitation based on length of time of recovery from a cardiovascular event.~~

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

~~1. All patients shall be classified by specific phases of the Cardiac Rehabilitation Program according to their clinical status.~~

~~C. **GENERAL GUIDELINES:**~~

~~1. The phases of the Cardiac Rehabilitation Program are as follows:~~

~~a. Phase I – The Cardiac Rehabilitation Program for hospitalized patients diagnosed with coronary artery disease, Coronary Artery Bypass Graft Surgery, valvular heart disease (aortic or mitral valve repair/replacement), heart transplant, coronary artery stenting and/or angioplasty, or acute MI. It extends from the time a diagnosis is made until hospital discharge.~~

~~b. Phase II – The Cardiac Rehabilitation Program performed as an outpatient from discharge through 12 weeks or 36 visits. This phase shall ideally begin immediately or soon after discharge, although patients may be referred for Phase II Cardiac Rehabilitation for up to 1 year following discharge. Comprised of telemetry monitored exercise sessions and educational lectures.~~

~~c. Phase IV The lifetime maintenance Cardiac Rehabilitation Program extending indefinitely after Phase II completion.~~

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 12/05

SUBJECT: Emergency Response System

REVISION DATE: 10/07, 01/08, 12/12

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To insure patient safety and ensure appropriate response in the event of a medical emergency.

B. **POLICY:**

1. In the event of a cardiopulmonary emergency, the participant shall be placed in a safe position. The TCMC emergency response system shall be activated by dialing 66 on the hospital phone or by dialing 911 at Tri City Wellness, Carlsbad. The remaining participants in the gym shall be instructed to cease exercising and asked to clear the immediate area. ACLS shall be initiated until the code team (for hospital site) or paramedics/ambulance (for Carlsbad facility) arrives. A charged cell phone shall be kept at nurse's station in the Cardiac Wellness Center gym for emergency purposes. The nurse or staff member shall adhere to the proceedings described in the following guidelines.

C. **GUIDELINES:**

1. ACLS shall be initiated by ACLS certified staff until code team or ambulance/paramedics arrive.
2. Exercising participants shall be instructed by staff to discontinue exercising and clear the immediate area
3. A cellular phone shall be kept at nurses' station at all times to use as backup to contact the CODE team in case of power failure to main phone system.
4. As part of the annual review, employees shall be asked to demonstrate their understanding and ability to use the system and annual "mock code blue" shall be conducted in collaboration with the education department a minimum of four times a year.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 7/04

SUBJECT: Maintenance and Repair of Equipment

REVISION DATE: 12/05, 01/08, 12/12

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for the repair and maintenance of exercise equipment that has developed a malfunction or is otherwise not suitable for use in it's current condition in the Cardiac Rehabilitation Program.

B. **POLICY:**

1. In the event of a malfunction of a piece of exercise equipment, the machine shall be unplugged, if electrically powered and shall be prominently tagged with a "Sorry Out of Order" laminated sign found in the miscellaneous items folder at the nurses' station.
2. Utilize the ~~Tamis~~ **Tri-City Medical Center intranet** work order system, and submit a work order to BioMed department. Following their assessment of the problem, BioMed shall determine if the repair can be completed in-house or if it needs to be outsourced to a vendor. **Contact outside vendor to conduct repair as necessary.**
3. Yearly preventive maintenance of the equipment is currently under the oversight of Tri-City Medical Center BioMed ~~(Aramark)~~ Department. **Outside approved vendor to conduct yearly preventative maintenance.**

C. **GENERAL GUIDELINES:**

1. Tag all malfunctioning equipment with large, plain view signs not to use.
2. Record the equipment information and possible problem in TCMC intranet work orders. Print out requested work order and place in work order binder at nurses' station area.
3. For minor maintenance issues, (e.g. loose pedals) describe problem in Biomed department work order on TCMC intranet and place printed request in work order binder for review by contracted preventive maintenance vendor.
4. Contact BioMed or specific vendor for warranty repairs.
5. Follow up on issue to make sure repair is done and equipment is put back into service.

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93 **SUBJECT: Patient Chart Requirements**

REVISION DATE: 6/97, 3/03, 12/05, 01/08, 12/12, 2/20

Cardiac Rehabilitation Approval:	**02/20**
Division of Cardiology Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administrative Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for initiating, identifying forms and completing patient's cardiac rehabilitation charts to ensure that necessary information is available to the physicians, Nursing Administration, Business Office, and Medical Records.

B. **POLICY:**

1. All Cardiac Rehabilitation Program patients shall have a complete cardiac rehabilitation chart.

C. **GENERAL GUIDELINES:**

1. Completed charts shall include, but not be limited to, the following:
   a. Assessment Forms (Nutrition, /Duke Activity Index/ Beck Depression Inventory)
   b. History and Physical, OR Discharge Summary
   c. Physician's Order Sheet with admitting diagnosis
   d. Laboratory, X-ray, ECG results as ordered and if available
   e. Cardiac Rehabilitation Nursing Care Plan
   f. Cardiac Rehabilitation Daily Report
   g. Registration/Admitting department face sheet
   h. Exercise Consent Form
   i. Insurance authorization if necessary/required
   j. Outpatient Cardiac Rehabilitation Progress Notes
   k. Physician Initial Evaluation
2. The medical record is reviewed following each visit by Medical Director as indicated by a physician signature on the daily report.
3. The Cardiac Wellness staff shall review medication changes and additional medical history on each visit.
   a. If changes occur they are noted in the computer and on the face sheet of the chart, followed by initials of the staff member noting the changes.
4. The completed chart includes all the necessary and applicable forms documented with signatures of the cardiac rehabilitation team members and physicians.

Tri-City Medical
Oceanside, Califor

DELETE: Refer to Patient Care Services Policy: Patient Valuables Liability and Control

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93

SUBJECT: Safekeeping of Patient Valuables during Outpatient Procedures

REVISION DATE: 6/97, 3/03, 04/06, 01/08, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

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

~~1. To establish a protocol for the handling and safekeeping of patient valuables during outpatient Cardiac Rehabilitation.~~

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

~~1. The Cardiac Rehabilitation staff is responsible for communicating to the patient they are to keep valuables on their person, or store them in a locker provided for them in the patient locker room. The patient shall supply his/her own combination lock.~~

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

~~1. Upon the initiation of the patient's first visit, a Cardiac Rehab staff member shall instruct the patient to keep his/her valuable on their person or store them in the individual lockers in the Cardiac Wellness Department.~~

~~2. If the patient is unable to comprehend the above, secondary to decreased cognition, the primary caregiver shall be instructed to be responsible for the patient's belongings during the rehabilitation sessions.~~

~~3. The Cardiac Wellness Center is not responsible for the loss of, or storage of, patient's valuables.~~

Tri-City Medical Center
Oceanside, California

DELETE: incorporated into Scope of Practice

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 11/05	**SUBJECT:** Staffing
REVISION DATE: 01/08, 12/12, 2/20	~~**POLICY NUMBER: 7593-118**~~
Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To define staffing needs and to provide safe care to participants in both monitored and unmonitored exercise sessions.~~

~~B. **POLICY**~~

~~1. The Cardiac Wellness Center shall meet or exceed AACVPR Staffing Guidelines~~

~~2. Phase II (high to intermediate risk) monitored sessions are staffed at a ratio of 4 participants to one staff member (Phase I inpatients are staffed per hospital policy).~~

~~3. Phase IV (low risk) maintenance, unmonitored sessions, are staffed at a ratio of 10 participants to one staff member.~~

~~4. Two staff members shall be present in the department at all times while participants are exercising. One staff member must be ACLS certified.~~

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

~~1. Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs, 4th edition, Chapter 10, page 195.~~

Tri-City Medical Center
Oceanside, California

DELETE: incorporated into Scope of Practice

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 10/93

SUBJECT: Transfer & Integration into Cardiac Rehabilitation Phase IV maintenance Program

REVISION DATE: 6/97, 3/03, 1/08, 12/12

Cardiac Rehabilitation Approval:	02/20
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. PURPOSE:~~

~~1. To provide continuity of patient care through safe and efficient integration of patient transferring into our Maintenance Cardiac Rehabilitation Program from other Cardiac Rehabilitation Programs.~~

~~B. POLICY:~~

~~1. All patients shall meet standards for patient selection criteria and shall be subject to terms of current Cardiac Rehabilitation Program.~~

~~C. GENERAL GUIDELINES:~~

~~1. Request transferring patient's records from the previous program.~~
~~2. Attendance to education lectures is voluntary, not mandatory.~~
~~3. Limited Intake shall be obtained.~~
~~4. Physician directed Exercise prescription shall be obtained.~~
~~5. Monitored exercise (first three sessions).~~
~~6. Supervised exercise (next nine sessions).~~
~~7. Fee for first month of the sessions includes a monthly maintenance charge as well as a one time enrollment fee.~~
~~8. Sessions thereafter are the same as the Monthly Maintenance Program.~~

~~**NOTE:** Policy is subject to modification per the Medical Director of Cardiac Rehabilitation Services.~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
INFECTION CONTROL

DELETE – follow Infection Control policies

SUBJECT: Prevention of Exposure to Blood Borne Diseases

ISSUE DATE: 04/91
REVIEW DATE(S):
REVISION DATE(S): 11/94; 02/97; 05/00; 05/03; 06/06; 05/09; 06/12

Department Approval:	~~07/18~~02/22
Environmental Health & Safety Committee Approval:	~~11/18~~03/22
Infection Control Committee Approval:	~~04/19~~04/22
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/19~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

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

~~1. Universal Blood/Blood Precaution (Universal Precautions): The concept now referred to simply as "universal precautions" stresses that all patients should assumed to be infectious for HIV and other blood-borne pathogens HBV.~~

~~2. In the hospital and other health care settings, "universal precautions" should be followed when workers are exposed to blood, certain other body fluids (amniotic fluid, pericardial fluid, peritoneal fluid, pleural fluid, synovial fluid cerebrospinal fluid, semen and vaginal secretions), or any body fluids visibly contaminated with blood. Since HIV an HBV transmission has not been documented from exposure to other body fluids (feces, nasal secretions, sputum, sea tears, urine and vomitus), "universal precautions" do not apply to saliva, except in the dental setting, where saliva is likely to be contaminated with blood.~~

~~B. **AUTHORIZED TO PERFORM PROCEDURE:**~~

~~1. Any health care worker with potential risk for exposure to blood or certain other body fluids via non-intact skin, mucous membranes or other tissues.~~

~~C. **PURPOSE:**~~

~~1. Universal precautions should be followed to reduce risk of occupation exposure to blood-borne diseases, Hepatitis Virus (HBV) and Human Immunodeficiency Virus (HIV).~~

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

~~1. Protective equipment, including personal protective equipment for eyes, face, head and extremities, protective cloth respiratory devices, and protective shields and barriers will be provided for the health care worker's use to prevent potential exposure to blood, certain other body fluids, or any fluid visibly contaminated with blood.~~

~~2. It will be mandatory for employees who participate and/or who work in defined high risk areas to use appropriate barrier precautions to prevent skin and mucous membrane contact with blood and other body fluids from all patient defined high risk areas include,~~

~~a. Laboratory - Employees who are at risk for mucous membrane contact with blood or body fluids.~~

~~b. Inpatient/Outpatient Surgery - team members working in the sterile field area.~~

~~c. Labor and Delivery Rooms - Assisting with vaginal deliveries or with surgical procedures during which bleeding may occur.~~

~~d. Emergency Room - Where there is risk for splash of blood or body fluid.~~

~~e. Pulmonary Lab - Assisting with bronchoscopy and ABG procedures.~~

f. Cardiac Catheterization Lab - Invasive procedures with splash factors.
g. Dialysis Unit - During any exposure to blood and body fluids.
h. Imaging Services - Invasive procedures with splash factors.
i. Engineering - Waste clean out.

E. GENERAL GUIDELINES:

1. Gloves:
   a. Gloves should be worn for touching blood and body fluids, mucous membranes, or non-intact skin of all patient for handling items or surfaces soiled with blood or body fluids.
   b. Gloves should always be worn when the health care worker's hands are abraded or active dermatitis is present.
   c. Gloves should be removed and replaced if a glove is torn or a needle stick injury occurs.
   d. Gloves should be changed after contact with each patient and in-between procedures on the same patient.
   e. Gloves must be used when handling bagged materials and obviously contaminated linen.
   f. Hands should be washed immediately after gloves are removed.
2. Masks and Protective Eye Wear or face shields should be worn during procedures that are likely to generate droplets of blood or other body fluids to prevent exposure of mucous membranes of the mouth, nose and eyes. Masks and protective EYE WEAR or face shields must be worn for procedures that commonly result in the generation of droplets, splashing of blood or other body fluids, or the generation of bone chips.
3. Gown or Aprons should be worn during procedures that are likely to generate splashes of blood or other body fluids.
4. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated with blood or other body fluids.
5. Resuscitative bags are to be used to provide respiratory support and to minimize the necessity of mouth-to mouth resuscitation ventilation devices should be available for use in areas in which the need for resuscitation is predictable.
6. All specimens of blood and body fluids should be put into a well constructed container with a secure lid to prevent leaking during transport. Care should be taken when collecting each specimen to avoid contaminating the outside of the container and the laboratory form accompanying the specimen. Collected specimens are to be placed into plastic bag for transport to the laboratory. Laboratory form is attached to the outside of the plastic bag.
7. "Blood and Body Fluid Precautions" will continue to be used, as well as universal precautions for patients know to be infected with blood-borne pathogens (HIV, HBV).
8. All places of employment, passageways, storerooms and service rooms will be kept clean and orderly and in a sanitary condition. The floor of every workroom will be maintained in a clean condition and be as dry as possible Blood spills will be cleaned immediately with a chemical germicide or a solution of sodium hypochlorite (a 1: 1 dilution of household bleach).
9. All sweepings, solid or liquid wastes, refuse, and garbage will be removed in such a manner as to avoid creating a menace to health, and as often as necessary or appropriate to maintain the place of employment in a sanitary condition.

F. CORRECTIVE ACTION:

1. Failure to follow recommended practices of wearing protective EYE WEAR and dress apparel in high risk areas and/ assisting with invasive procedures may result in corrective action up to and including an intent to terminate action
2. Purpose for corrective action:
   a. To assure protection for those employees who work in high risk areas.
   b. To minimize workman's compensation claims that arise from noncompliance with protective EYE WEAR and dress apparel.
3. Corrective action steps:
   a. First occurrence - will result in verbal counseling. Counseling should be non-punitive and safety oriented in nature

b. Second occurrence - will result in written counseling.
c. Third occurrence - will result in suspension action.
d. Fourth occurrence - will result in an intent to terminate action.

G. **REFERENCE(S):**

1. CDC. Recommendations for Prevention of HIV Transmission in Health-Care Settings. MMWR, August 21, 1987. 36:2S.
2. Department of Labor. Federal Register: Occupational Exposure to Hepatitis B Virus and Human Immunodefi ciency Virus, November 27, 1987; 58:228.
3. Hospital Infection Control. OSHA Enforcement Document E=hasizes Protection, Education, March 1988; 350-
4. CDC. Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Blood-borne Pathogens in the Health Care Settings, MMWR, June 24, 1988; 37:24.

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services

SUBJECT: Clinical Nutrition Dietitian Staffing

ISSUE DATE: 04/3/06
REVISION DATE~~(S)~~: 10/11, 03/18

Department Approval ~~Date(s)~~:	~~02/17~~10/21
Medical Staff Department/Division Approval ~~Date(s)~~:	n/a
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~: -	n/a
Administration Approval:	05/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~03/18~~ n/a
Board of Directors Approval ~~Date(s)~~:	03/18

A. **POLICY:**

1. Clinical dietitians are scheduled to assure continuity and consistency of nutrition care provided to patients.
2. Clinical dietitians are scheduled daily to assure consistency of care to patients.
3. A dietitian is scheduled for **weekend** coverage. ~~for every weekend~~.
4. A dietitian is scheduled for **holiday** coverage ~~for each holiday~~.

~~Clinical dietitians . complete a nutrition assessment within 72~~48 hours for patients identified at nutrition risk by nursing upon completion of initial admission assessment. ~~Consults are completed by clinical dietitians within 48 hours of receipt of consult.~~

Staffing of clinical dietitians is adjusted to patient census and workload; ~~i.e. staffing is increased on Mondays/Fridays and as needed with increase/decrease in patient census.~~

B. **EMERGENCY OPERATION CLINICAL NUTRITION STAFFING**

1.
~~2.~~ **Phase 1 (Conventional Capacity)**
   - a. **In-patient - Clinical staffing at least 80% with dietitians working regularly scheduled hours.**
     - i. **Follow currently approved facility nutrition assessment policy.**
     - ii. **Review clinical care processes and associated documentation to identify opportunities for potential adjustments.**
   - b. **Outpatients**
     - i. **If facility remains open to outpatients, continue business as usual**
     - ii. **Implement tele-health nutrition MNT options**

2. **Phase 2 (Crisis Capacity) Clinical staffing at 79% or less and/ or volume of patients with nutrition concerns is elevated.**
   - a. **Inpatients**
     - i. **Adjust assessment and reassessment time frames to prioritize severe nutrition risk patients including and limited to:**
       - 1) **Patients on new nutrition support**
       - 2) **Malnutrition/Pressure Injuries Stage III & IV/ BMI < 18**
       - 3) **Ventilated patients**
       - 4) **In the event that all severe nutritionally at risk patients are addressed, Dietitian will prioritize additional patients per clinical judgement.**
     - ii. **Outpatients**
       - 1) **Closed**

Tri-City Medical Center
Oceanside, California

FOOD & NUTRITION MANUAL

DELETE – incorporated into Patient Care Services Policy:Meals, Patients – Times, Menus, Substitutions and Nourishments

SUBJECT: Patient Meals - Hours

ISSUE DATE: 05/78
REVISION DATE: 10/11, 02/12

Department Approval:	02/20
~~Clinical Policies & Procedures Committee Approval:~~	~~11/11~~
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/12

~~A. PURPOSE:~~

~~1. To define sequencing of meal delivery to patients.~~

~~B. POLICY:~~

~~1. Food and Nutrition Services provides three (3) patient meals daily, and offers between-meal nourishments three (3) times daily. No more than 14 hours will elapse between the serving of the dinner meal and the breakfast meal of the following day.~~

~~2. Patient trayline will operate according to the following schedule:~~

~~i. Breakfast: 7:00 AM - 8:15 AM~~
~~ii. Lunch: 11:00 AM - 12:15 PM~~
~~iii. Dinner: 4:45 PM - 6:15 PM~~
~~iv. (all finish times are approximate)~~

~~3. Patient trays will be loaded on food carts and delivered to the nursing units in a predetermined sequence.~~

~~C.A. Clinical Policies & Procedures Committee Approval: 11/11~~
~~D.B. Board of Directors Approval: 2/12~~

Tri-City Medical Center
Oceanside, California

Food and Nutrition Service

DELETE: Qualifications listed in Job Descriptions

SUBJECT: Personnel Qualifications for Management of Food & Nutrition

ISSUE DATE: 08/18/10
REVISION DATE(S): 10/11

Department Approval Date(s):	**~~3/17~~02/20**
Medical Staff Department/Division Approval Date(s):	**n/a**
Pharmacy and Therapeutics Approval Date(s):	**n/a**
Medical Executive Committee Approval Date(s):	**n/a**
Administration Approval:	**05/22**
Professional Affairs Committee Approval Date(s):	**n/a**
Board of Directors Approval Date(s): 2/12	

~~A. DEFINITION:~~

~~Management of Food & Nutrition Services is provided by a full-time Registered Dietitian.~~

~~1. The Registered Dietitian must have obtained a Bachelor's or advanced degree from an accredited institution with a major in foods and nutrition, or dietetics as well as completion of a dietetic internship or graduate of a coordinated undergraduate program or other approved method of attaining eligibility for Registered Dietitian.~~

~~2. ServSafe certification is required.~~

~~3. 5 years management experience in hospital food and nutrition services is required. Proficiency and knowledge with JCAHO standards, CA DPH healthcare regulations, HIPPA, and all other applicable regulatory requirements is mandatory.~~

~~4. Continuing education to maintain dietetic registration is required (75 hours over five (5) years).~~

~~B. REFERENCE:~~

~~California Department of Public Health. R03-PSLS Reference Appendix B rev 06-08-10. Standard 1265.4 (a) and 1265.4 (b).~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**04/08**	**SUBJECT:**	**Credentialing Policy, Processing Medical Staff Reappointments**
REVISION DATE~~(S)~~:	**04/08, 04/10, 01/12, 08/12 07/16, 06/19**	**POLICY NUMBER:**	**8710–548**

Medical Staff Department Approval:	**~~02/19~~01/22**
Credentials Committee Approval:	**~~04/19~~02/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/19~~04/22**
Administration approval:	**~~06/19~~05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/19**

A. **PURPOSE:**

1. To provide an objective, evidence-based credentialing process that enables the Medical Staff to make informed recommendations to the governing body ensuring candidates for Medical Staff membership renewal are credentialed according to The Joint Commission, CMS, and Medical Staff Bylaws requirements.
2. The Medical Staff shall consider each application for reappointment using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and Rules and Regulations appropriate for each department. The Medical Staff shall perform this function also for reappointment of privileges for Allied Health Professionals. The Medical Staff shall investigate each application for reappointment and make an objective, evidence-based decision based upon assessment of the applicant's general competencies before recommending action to the Board of Directors. The Board of Directors shall ultimately be responsible for granting membership and privileges. By applying to the Medical Staff for reappointment, the applicant agrees that regardless of whether he/she is reappointed or granted the requested privileges, he/she will comply with the responsibilities of Medical Staff membership and the Medical Staff Bylaws and Rules as they exist and as they may be modified from time-to-time.

B. **REAPPOINTMENT PROCESS:**

1. **Schedule for Reappointment**
   a. As described in the Medical Staff Bylaws Article IV, §4.6, at least 90 days prior to the expiration date of each staff member's term of appointment, the Medical Staff office shall provide the member with a reappointment application form . Completed reappointment application forms shall be returned to the Medical Staff office at least sixty (60) days prior to the expiration date. Failure, without good cause, to return the form within the specified timeframe shall result in termination of privileges and prerogatives at the end of the current staff membership.
2. **Content of Reappointment Form**
   a. The reappointment application shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the application shall request an update of all of the information and certifications requested in the appointment application form with the exception of that information which cannot change over time; such as information regarding the member's premedical and medical education, date of birth, and so forth. The application shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for

additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.

i. If the staff member's level of clinical activity at this hospital is not sufficient to permit evaluation of his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at another institution in whatever form the Medical Staff may require.

b. In addition to completing the information requested on the reappointment form, the staff member shall submit his or her Medical Staff dues as described in the Medical Staff Bylaws Article XIII, §13.2. Application for reappointment will be considered incomplete if dues (or other fine or assessments) are not paid within the time frame as described in §4.6 of the Medical Staff Bylaws and the member is deemed to be voluntarily resigned without the rights to a hearing as described in Article VII §7.2 of the Bylaws.

3. **Verification and Collection of Information** (Medical Staff Bylaws §4.6)

a. The Medical Staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Department/Division Chair, Credentials Committee, Medical Executive Committee, or Board of Directors. The information shall address without limitation:

i. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

ii. Participation in relevant continuing education activities.

iii. Level/amount of clinical activity (patient care contacts) at the hospital. Patient care activities include:

1) Inpatients:
   a) Admitting
   b) Attending
   c) Assisting at Surgery
   d) Consulting
   e) Operative and other procedures

2) Outpatients:
   a) Assisting at Surgery
   b) Operative and other procedures
   c) Emergency Room visits

iv. Sanctions imposed or pending including, but not limited to, previously successful or currently pending challenges to any licensure or registration (State or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

v. Confirmation of the applicant's health status, both physical and mental, or substance abuse that could affect his or her ability to exercise the clinical privileges requested, or whether the applicant required any type of accommodation in order to exercise the requested privileges safely and competently.

vi. Attendance at Medical Staff Department/Division and committee meetings.

vii. Participation as a staff officer and committee member/chair.

viii. Timely and accurate completion and preparation of medical records as outlined in Medical Staff Policy: Medical Record Documentation Requirements 8710-518.

ix. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel, and patients as described in the Medical Staff Policy: Professional Behavior 8710-570.

x. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims in the past 5 years.

xi. Compliance with all applicable Medical Staff and hospital bylaws, rules, and policies.
xii. Two Professional references are required, at least one (1) from a practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.
xiii. Any other pertinent information, which may include, the staff member's activities at other hospitals and his or her medical practice outside the hospital.
xiv. Teleradiologists - Hospital affiliations shall be selected for 5 institutions and verified.
xv. Information concerning the member from the State licensing board and the Federal National Practitioner Data Bank.
xvi. Information from other relevant sources.

4. **Department Action**
   a. The Department/Division Chair shall review the application and all other relevant available information. The Department/Division Chair will then forward his or her written recommendations to the Credentials Committee.
5. **Credentials Committee Action**
   a. The Credentials Committee shall review the application, all other relevant available information and the Department /Division Chair's recommendations. The committee shall transmit to the Medical Executive Committee its written recommendations.
6. **Medical Executive Committee Action**
   a. The Medical Executive Committee shall review the Department/Division Chair's and the Credentials Committee's recommendations and all other relevant information available and shall forward recommendations to the Board of Directors.
7. **Board Closure**
   a. To ensure the Medical Staff reappointment credentialing process is completed; upon Board of Directors approval of the reappointments, board closure process shall be initiated to include notifying the practitioner of the decision regarding privilege(s) and/or Medical Staff membership.
8. **Reappointment Recommendations**
   a. Reappointment recommendations shall be written and shall specify whether the member's appointment should be renewed; renewed with modified membership category and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described.
   b. The Medical Staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

C. **SPECIAL CONSIDERATIONS:**

1. **Failure to File Reappointment Application:** As provided in Bylaws, Article 4, §4..6-4
   a. Members who automatically resign under this rule shall be processed as new applicants should they wish to reapply.
2. **Reapplication After Adverse Appointment:** As provided in Bylaws, Article 4, §4.5-10
3. **Relinquishment of Privileges**
   a. A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall notify the Credentials Committee identifying the particular privileges to be relinquished or limited.
4. **Additional Privilege Requests**
   a. Whenever a member desires to increase his/her clinical privileges, he/she shall indicate additional requested privileges on a privilege request form and submit the completed form to the Credentials Committee. The member's request must include documentation of training and/or experience as required by the Rules and Regulations. The request shall be processed in the same manner as an application for initial clinical privileges.

b. Prior to the consideration or granting of any privilege not currently delineated on the Delineation of Privileges it shall be determined, by the Department/Division Chair whether the resources necessary to support the requested privilege are currently available or are available within a specified time frame as stated in the Medical Staff Policy: Requests for New Privileges/Technologies New to TCMC 8710-526.

5. **Leave of Absence**

a. During any period of leave of absence, the requirement for reappointment as specified in the Bylaws, Article 4.4, shall continue unless waived by the Medical Executive Committee (MEC).

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

1. Medical Staff Policy: Medical Record Documentation Requirements 8710-518
2. Medical Staff Policy: Professional Behavior Policy 8710-570
3. Medical Staff Policy: Requests for New Privileges/Technologies New to TCMC 8710-526

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 07/01

SUBJECT: Medical Record Documentation Requirements

REVISION DATE(S): 07/07, 03/08, 09/08, 06/09, 09/09, 11/09, 07/11, 05/12, 08/12, 02/15, 12/15, 02/18, 08/18, 02/19, 10/21

POLICY NUMBER: 8710-518

Medical Staff Department Approval:	~~07/21~~03/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~09/21~~04/22
Administration Approval:	~~10/21~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/21

A. PURPOSE:

1. To establish the policy, procedure, and responsibilities for the completion of medical records.

B. POLICY:

1. It is the policy of Tri-City Medical Center that all medical records are current, authenticated, legible, and complete.
2. The intent does not support delay of care or rendering of services to the patient.

C. RESPONSIBILITIES:

1. General responsibilities are delegated as indicated in the following subsections:
   a. Hospital administration in conjunction with the medical staff, will determine the criteria for timely, authenticated, legible, and complete medical records.
   b. The Medical Records/Health Information Department will monitor to ensure that medical records meet the requirements for completeness as set in this policy.

D. PROCEDURE:

1. Electronic signature:
   a. It is expected that all members of the medical staff will authenticate documents maintained in Cerner electronically through use of a physician identifier.
   b. All members of the medical staff will be required to complete an Electronic Signature Certification Statement to document their acknowledgement of the proper use of their identifier in the authentication of documents.
   c. Dictated reports will be transcribed into the Medical Records transcription system. Upon transcription the report will be saved and sent electronically to the Cerner electronic medical record (EMR).
   d. Paper-based documents will be scanned to the EMR and will be assigned by HIM for signature when required.
   e. Physicians will utilize the Cerner Message Center to authenticate transcribed and in progress documents in a timely manner.
   f. Electronic signature of transcribed and scanned reports by the practitioner will update the medical records/health information profile system to eliminate the signature deficiency assigned by the department.
   g. The Message Center feature supports the following actions to be taken by the physician:

i. Sign/Review
   1) Physician reviews the document and selects the OK button that updates the status of the report to "Authenticated
   2) Only the responsible physician is eligible to sign a transcribed report.
      a) Physician Assistants will sign their reports in addition to the report being signed by the supervising physician.
      b) Resident reports will be signed by the supervising physician.
      c) All mid-level practitioners (e.g., Nurse Practitioners, Midwives) sign their reports in addition to the report being signed by the supervising physician within 48 hours but prior to patient discharge in the acute care setting

ii. Modify/Sign
   1) Physician may modify the document PRIOR to signature to correct/clarify any elements of the report.
   2) Addendums are to follow the structure of new information being bolded and deleted information noted as a strike-through
   3) Once modified and signed any new revisions to the document are noted as an Addendum

iii. Refuse
   1) Physician may refuse and redirect a document to Medical Records/Health Information (Med Rec Inbox) for review and reassignment of the deficiency to the correct physician via Cerner message center.

2. Written Signatures
   a. It is expected that members of the medical staff and allied health will utilize acceptable written signatures, including credentials for all paper-based documents being authenticated.
      i. This expectation relates to orders submitted for outpatient ancillary services as well as emergency, same-day surgery, observation, and inpatient documentation.
   b. Acceptable written signatures are as follows:
      i. Legible full signature
      ii. Legible first initial and last name
      iii. Illegible signature over a typed or printed name
      iv. Illegible signature where the letterhead or other information on the page indicates the identity of the signer
         1) Example: an illegible signature appears on a prescription. The letterhead lists multiple physicians' names. One of the names is circled.
      v. Initials over a typed or printed name
      vi. Unsigned handwritten orders where other entries on the same page in the same handwriting are signed
   c. Unacceptable written signatures are as follows:
      i. Signature stamps alone are not acceptable.
      ii. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement. Reports or any records that are dictated and/or transcribed, but do include valid signatures "finalizing and approving" the documents are NOT acceptable for reimbursement.
      iii. Unsigned typed note with provider's typed name
      iv. Unsigned typed note without provider's typed/printed name
      v. Unsigned handwritten note, the only entry on the page
3. The following criteria must be met before a chart is considered complete:
   a. A medical record must be legible for each patient; its content shall be pertinent and current. This record shall include:
      i. Identification data
      ii. Legal status if mental health patient;

iii. Emergency care given prior to arrival if any;
iv. Findings of assessment;
v. Conclusions or impressions from history and physical;
vi. Diagnosis or diagnostic impression;
vii. Reasons for admission or treatment;
viii. Goals of treatment and treatment plan;
ix. Known advance directives;
x. Informed consent for procedures and treatment;
xi. Diagnostic and therapeutic procedures and tests and their results;
xii. Operative and other invasive procedures performed;
xiii. Progress notes;
xiv. Reassessments if needed;
xv. Clinical observations;
xvi. Response to care;
xvii. Consultation reports;
xviii. Every medication ordered; every dose administered and any adverse reaction;
xix. Every medication dispensed to inpatient at discharge or to ambulatory patient;
xx. All relevant diagnoses established during care;
xxi. Any referrals/communications to other providers.

4. All patient medical record entries must be legible, completed, dated, timed, and authenticated in written or electronic form by the practitioner responsible for providing or evaluating the service provided.
   a. All documentation is to be without the use of Do Not Use Abbreviations.
      i. A reference of Do Not Use Abbreviations is referenced on the TCMC intranet.
5. History and Physical
   a. A complete history and physical examination shall be present in the medical record no more than 30 days before or within twenty-four (24) hours of admission.
      i. Handwritten history and physicals are not acceptable and an electronic or printed H&P must be provided.
      ii. All history and physical examinations will be validated and authenticated by the attending physician with appropriate privileges.
      iii. The medical history and physical must be completed and documented by a physician, an oral maxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.
      iv. For patients with H&P's not more than 30 days old (in lieu of a new H&P), an examination of the patient, including any changes in the patient's condition, must be present in the medical record within 24 hours of admission.
      v. A history and physical completed more than 30 days prior to admission is not valid and must be completed.
      vi. A history and physical document completed outside Tri-City Medical Center is required to reflect date and time of the examination.
   b. The history and physical shall include the following elements:
      i. Chief complaint;
      ii. Personal, past medical and surgical history;
      iii. Allergy history;
      iv. Current medications;
      v. Family history;
      vi. History of present illness;
      vii. All-important findings resulting from a review of systems;
      viii. Physical examination;
      ix. Diagnosis or diagnostic impression;
      x. Plan of treatment.
   c. **Surgeries or procedures requiring anesthesia services**
      i. A history and physical shall be completed and documented in the medical

record no more than 30 days prior to, or within twenty-four (24) hours after admission/registration. The H&P must be completed prior to surgery or procedure requiring anesthesia services.

~~xi. Surgeries or procedures requiring anesthesia services must have a history and physical present in the medical record, no older than 30 days.~~

i. H&Ps performed within 30 days BEFORE admission/registration

a) An updated examination **(H&P Update)** of the patient, including any changes in the patient's condition~~,~~ must be completed and ~~an update to the H&P must be recorded~~ **documented** on the patient's medical record ~~on the day of surgery/procedure, prior to patient admission to the Operating Room or Procedural areas regardless of the date and time the history and physical was completed~~. **within 24 hours after admission/registration AND prior to surgery/procedure.**

ii. H&Ps performed within 24 hours AFTER admission/registration

a) **An H&P update is NOT required. Any changes to the patient's condition may be documented in the daily progress notes.**

~~xii.~~**iii.** If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record the:

1) H&P was completed
2) H&P was reviewed
3) The patient was examined and "No Change" has occurred in the patient's condition since the H&P was completed.

~~xiii.~~**iv.** When the required history and physical examination is not present before the time stated for the operation, the operation shall be postponed until the history and physical is present in the medical record or the physician has documented that such a delay would constitute a hazard to the patient.

~~c.~~**d.** History and physical for hospital outpatient procedures:

i. Ambulatory surgery patients undergoing invasive procedures with anesthesia, procedural sedation, or procedures that could compromise the circulatory or respiratory status as determined by the practitioner, shall have a complete H&P as defined above prior to surgery.

ii. Hospital outpatients undergoing invasive procedures without a significant level of risk shall have at least a limited history and physical.

iii. A limited history and physical shall contain the same elements as an H&P, except the review of systems and physical examination elements may be abbreviated to include only that which is relevant, appropriate or pertinent to the procedure or intervention to be performed.

6. Dentists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside the limited license practitioner's lawful scope of practice.

a. A history and physical completed by the medical physician in addition to the history and physical completed by the dentist are necessary to be documented on the chart prior to any surgical procedure.

b. A qualified oral surgeon or podiatrist with specifically delineated clinical privileges may admit patients without significant underlying or potentially complicating medical problems, may perform the history and physical examination of those patients, and may assess the medical risks of proposed surgical procedures for such patients.

i. Completion of a history and physical examination by an oral surgeon or podiatrist who has the special privileges will NOT require completion of a history and physical by another qualified physician.

7. Medication reconciliation:
   a. Admission
      i. The admitting physician is required to review, complete and reconcile admission medication reconciliation information in Cerner collected upon admission of the patient within 24 hours.
      ii. If new information is later obtained, the clinician may update the medication by history list in Cerner.
   b. Transfer
      i. All medications will be reviewed and revised as appropriate when patient is being transferred to another level of care.
         1) Electronic Orders
            a) The physician will access the transfer medication reconciliation function and will reconcile each medication on the active medication list to either be continued or not continued for the next level of care.
   c. Discharge
      i. All medications will be reviewed against HOME medications in Cerner.
         1) Electronic Orders
            a) The physician will reconcile each medication on the active medication list and home list to either be continued or not continued upon discharge. New medications will be added as required.
            b) Prescriptions to be completed
               i) ePrescribe – electronic prescription transmitted to the patient's pharmacy
               ii) Printed on the unit and handed to the patient
               iii) Handwritten on personal (physician's) prescription pad
         2) Written Orders
            a) Physician handwrites prescriptions on personal (physician's) prescription pad.
            b) Physician updates physician medication changes on the electronic medication list through the medication reconciliation tool.
8. Daily progress notes must be documented and reflect medical care and visitation of the patient by the attending member on all patients in the hospital.
   a. All practitioners will document progress notes in any of the following methods:
      i. Hand-written progress notes are not acceptable;
      ii. An electronic note may be a progress note typed by the physician or a progress note generated using a voice recognition software application (e.g. Dragon).
   b. Progress notes recorded by mid-level providers are required to be co-signed by the supervising physician member within 48 hours but prior to patient discharge.
9. All surgical operations, invasive and diagnostic procedures (including blood transfusions) shall be performed with documented informed consent except in an emergency. The informed consent for hysterectomies and sterilization procedures must meet specific requirements as set forth in Title XXII.
   a. The informed consent documented will include the following:
      i. Discussion about potential benefits, risks, and side effects of the patient's proposed care, treatment, and services.
      ii. The likelihood of the patient achieving his or her goals.
      iii. Any potential problems that might occur during recuperation.
      iv. Reasonable alternatives including side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
      v. Name of the practitioner who will perform the proposed care, treatment, and services.
10. Physicians shall discuss a patient's Do Not Resuscitate (DNR) status with the patient and/or

decision-maker prior to a surgery or procedure that requires anesthesia. The discussion shall include possible temporary suspension of the DNR status during the surgery or procedure. The DNR status shall be reevaluated immediately after the procedure. This discussion shall be documented in the medical record and an appropriate order entered/written.

11. A pre-sedation or pre-anesthesia assessment is performed for each patient before beginning moderate or deep sedation and before anesthesia induction within forty-eight (48) hours prior to surgery.
12. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours after surgery for an inpatient and shall include:
    a. Respiratory function including rate, airway patency and oxygenation saturation;
    b. Cardiovascular function, including pulse rate and blood pressure;
    c. Mental status;
    d. Temperature;
    e. Pain;
    f. Nausea and vomiting;
    g. Anesthesia complications;
    h. Post-operative hydration; and
    i. Additional types of monitoring and assessment as may be necessary.
13. Operative or other high risk procedure reports shall be completed electronically or dictated immediately after surgery and shall include:
    a. Pre-operative diagnosis;
    b. Post-operative diagnosis;
    c. Date of procedure
        i. If the procedure is canceled, the operative report should include the reason and time of the cancellation.
        ii. Name of procedure;
    d. Anesthesia type;
    e. A detailed account of the procedure including approach and technique used;
    f. Estimated blood loss if any;
    g. Specimen removed if any;
    h. Name of the primary surgeon and any assistants;
    i. Complications;
    j. Patient status;
14. A post-operative/procedure note shall be completed immediately following surgery or other high-risk procedures when the operative/procedure report is dictated pending transcription. An operative note is not required if the operative/procedure report is completed electronically and immediately available in the medical record. Use of the electronic post-operative procedure note is necessary to document all required elements.
    a. Name of Procedure;
    b. Pre-Operative diagnosis
    c. Post-Operative diagnosis
    d. Patient status
    e. Name of primary surgeon and any assistants
    f. Anesthesia type
    g. Complications
    h. Findings
15. When the operative note is dictated, the electronic post-operative note must be completed by the surgeon prior to the patient being discharged or transferred from recovery.
16. An intraoperative anesthesia record containing the following elements shall be completed by an anesthesiologist:
    a. Name and hospital ID number of the patient
    b. Name of anesthesiologist who administered the anesthesia
    c. Vital signs reflecting patient status just prior to induction

d. Name, dosage, route, and time of administration of drugs and anesthesia agents
e. Techniques used and patient position(s), including the insertion/use of any intravascular or airway devices
f. Names and amounts of IV fluids, including blood or blood products
g. Time-based documentation of vital signs as well as oxygenation and ventilation parameters, and
h. Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

17. All orders, including verbal orders, must be dated, timed, and authenticated.
    a. All orders shall be completed, legible, dated and signed within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
    b. Physician co-signature is required within 48 hours, and/or prior to patient discharge, of and Allied Health Professional's order excluding those covered under an already approved standardized procedure.
18. Medical Records/HIM will assign a deficiency to unsigned orders via the Inbox/Message Center.
19. It is acceptable for physicians involved in the care of the patient to sign orders given by other physicians unless they object to the order. A physician may proxy Message Center to another physician for coverage purposes.
    a. Verbal orders are to be used infrequently, only to meet the immediate care needs of the patient when it is impossible or impractical for the ordering practitioner to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician to enter orders electronically into Cerner.
    b. All orders for treatment shall be entered electronically to the medical record. An order for treatment is considered entered if dictated by a member or his designee to a registered nurse and signed by the attending member through the Message Center. When orders are dictated over the telephone, they shall be signed by the responsible physician within forty-eight (48) hours for medication orders and fourteen (14) days post-discharge for all other orders.
    c. Physician orders for neonatal and pediatric populations will contain weight based dosing (e.g., mg/kg) along with the calculated dose and the patient's current weight with the exception of the following defined medication classes:
        i. Medications that are not determined by the patient's weight (e.g., iron sulfate).
        ii. Vaccines
        iii. Intravenous fluids
        iv. Medication doses that if weight based would equal or exceed normal adult doses.
20. When a patient is transferred from one level of care to another the physician is required to complete one of the following options:
    a. Electronic Orders
        i. Utilize the Merge View in Cerner to review and update all orders for the next level of care.
        ii. Complete the Transfer Medication Reconciliation function
        iii. The physician is not required to re-enter orders when a patient is undergoing one of the following minor procedures and returns to the same level of care:
            1) Heart Catheterization
            2) Interventional procedures including PICC line placement
            3) Endoscopy including bronchoscopies
            4) Inpatient dialysis
            5) Pain management
21. Consultations and recommendations shall include examination of the patient and a review of the patient's record by the consultant. The consultation shall be made a part of the patient's record. When operative procedures are involved, a consultation, except in an emergency, shall be recorded prior to the operation.
22. Discharge/Depart Process

a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
    i. Nursing will enter into the Depart Process application
    ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)

23. A Discharge Summary shall be completed for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
    a. Discharge Diagnosis
    b. Reason for hospitalization
    c. Significant findings
    d. Procedures performed and treatment given
    e. Condition on discharge
    f. Instructions given to the patient or patient representative
        i. Follow-up instructions
        ii. Diet instructions
        iii. Discharge medications
    g. A discharge note is acceptable for all patients with a length-of-stay less than forty-eight (48) hours, to include normal obstetrical deliveries, and normal newborn infants.
        i. Requirements of the note include:
            1) Discharge diagnosis
            2) Instructions given to the patient or patient representative:
                a) Follow-up instructions
                b) Diet instructions
                c) Discharge medications
            3) Physicians who have not completed a discharge summary at the time of discharge will be notified by Medical Records/HIM via the Message Center in Cerner and call to their office.

24. Physicians will be notified of all pending dictations and/or signatures via their Cerner Message Center and call to their office.
    a. Physicians will be suspended if the chart is not completed within 14 days of discharge per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).

25. Late entries, addendums or corrections to the medical record
    a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry, addendum, or correction will be made with the following required elements documented:
        i. A late entry, addendum or correction to the medical record, bears the current date of the entry and is signed by the person making the change or addition to the medical record.
        ii. A late entry supplies additional information that was omitted from the original entry. A late entry bears the current date and is added as soon as possible after the original entry was entered.
        iii. An addendum is used to provide information that was not made at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.
        iv. When making a correction to the medical record, the original entry must remain viewable. Documentation of the correct information should contain the current date and time and reference back to the original entry.
    b. It is not permitted to have entries "backdated" or "predated".
    c. The chart shall be completed within fourteen (14) days of discharge; it is expected no

late entries will appear after this time period.

E. **FORM(S):**

1. Electronic Signature Certification Statement - Sample

SAMPLE

Tri-City Medical Center

ELECTRONIC SIGNATURE CERTIFICATION STATEMENT

The purpose of this form is to certify that each physician identifier is kept confidential. This form also certifies that Tri-City Medical Center is committed to maintaining the confidentiality of the physician identifiers. If it is determined that an assigned identifier has been misused, the authorized hospital official will terminate a physician's use of his or her identifier.

The term 'misused' is defined to mean that the physician has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse must be documented by the authorized hospital official and actions to terminate the use of the physician identifier must be initiated immediately, including written notice to the physician involved.

PHYSICIAN CERTIFICATION:
I certify I will not disclose the identifier assigned to me to any other person or permit another person to use it.

_____ _____
Physician Signature Date

_____
Physician Name (Printed)

TRI-CITY MEDICAL CENTER CERTIFICATION
I certify that the identifiers assigned to physicians for purposes of the Compass Physician Inbox electronic signature process will be kept confidential and that I will terminate the use of a physician's identifier in the event that he or she misuses it.

_____ _____
TCMC Authorized Representative Date

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 08/03

SUBJECT: Standards for Seed Implants in the OR

REVISION DATE(S): 03/08, 02/19

POLICY NUMBER: 8710 – 524

Medical staff Department Approval:	~~07/17~~12/21
Department of Medicine Approval:	~~10/17~~03/22
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~04/22
Administration Approval:	~~01/19~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **STANDARDS:**

1. All cases involving Seed Implantation must meet the following minimum criteria for adequate facilities and physician skills:
   a. The minimum criterion for the facility is:
      i. Sonographic Equipment
      ii. A large Field of View image intensifier (15 or 16 inches) * with a 1024 matrix.
      iii. Appropriate supply of seed implants as determined by the radiation oncologist.
      iv. Appropriate level of sterility.
      v. Adequate space and facilities for anesthesia.
      vi. Circulating Registered Nurse (RN).
      vii. Scrub Technician or Scrub RN.
      viii. Radiologic technologist.
   b. The criterion for physician skills is:
      i. Interventional Radiologist must have current independent (has been released from proctoring) Tri-City Healthcare District (TCHD) privileges for placement of seed implants.
      ii. Interventional Radiologist must have met the minimum criteria for device-specific training/certification as defined by the manufactures of the device.
      iii. During all cases at least one physician credentialed in Interventional Radiology and one physician credentialed in Radiation Oncology must be present.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Abbreviations

ISSUE DATE: 08/96
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 05/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/14~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define the list of abbreviations applicable to Outpatient Behavioral Health.

B. **POLICY:**
1. When documenting in the patient medical record, clinical staff may use the following Program and the hospital approved abbreviations.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical Staff.

D. **RELATED DOCUMENT(S):**
1. Outpatient Behavioral Health Abbreviation List
2. Patient Care Services Policy: Abbreviations, Use Of

E. **EXTERNAL LINK(S):**
1. Neil-Davis Medical Abbreviation - MedAbbrev.com

Outpatient Behavioral Health Abbreviation List

Approved List

Abbreviation	Word(s)
ψ	Psychiatric
- with a circle	Negative
+ with a circle	Positive
B & C	Board and Care
BHOS	Behavioral Health Outpatient Services
CC	Clinical Coordinator
CLC	Community Liaison Coordinator
Clt	Client
CM	Clinical Manager
DR	Dual Recovery
EFR	Early Full Remission
EPR	Early Partial Remission
F with a circle around it	Father
ITP	Initial Treatment Plan
M with a circle around it	Mother
MFT or MFTI	Marriage and Family Therapist (Intern)
PI	Paranoid Ideation
RI	Resulting In
RCF	Residential Care Facility
SFR	Sustained Full Remission
SPR	Sustained Partial Remission
Th	Therapist
TPR	Treatment Plan Review

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Admission and Eligibility Criteria**

ISSUE DATE: **08/96**

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. Define the clinical criteria which determine eligibility for admission to the Behavioral Health Outpatient Services.

B. **POLICY:**

1. Persons may be admitted to the Behavioral Health Outpatient Services if they meet specific clinical criteria related to diagnosis, type of impairment and severity of impairment. The specific criteria are listed below. Generally, the criteria require the presence of a serious mental illness, significant functional impairment and a course of illness which, absent the proposed treatment, would likely result in psychiatric hospitalization.
2. Exclusion criteria generally relate to conditions in which the level of clinical risk warrants inpatient hospitalization, situations in which treatment could be reasonably provided at a less intensive level of care or there is an unstable non-psychiatric medical condition which cannot be appropriately managed in an outpatient setting.

C. **PRIMARY DIAGNOSTIC CATEGORIES:**

1. Serious Mental Illness-Diagnostic Criteria:
   a. Schizophrenia and Other Psychotic Disorders
   b. Anxiety Disorders
   c. Mood Disorders
   d. Somatoform Disorders
   e. Eating Disorders
   f. Personality Disorders
   g. Other Diagnostic Categories that significantly impair functioning and are authorized for treatment at IOP level of care.

D. **ADMISSION ELIGIBILITY CRITERIA:**

1. Current exacerbation of ~~symptoms of Axis I diagnosis~~**psychiatric symptoms**
2. Functional impairment resulting in difficulty performing ADL's
3. Treatment at lower level of care has been unsuccessful
4. Severity of the current symptoms is such that success resulting from a lower level of care is doubtful
5. Reasonable expectation that symptoms, behaviors and functional levels can be stabilized or improved
6. Risk to self, others, or property is present but is such that patient can be managed with the structure and support of the program

7. Despite the degree of impairment present, patient has sufficient intact functioning to benefit from an active treatment program (e.g. any cognitive deficit or other diagnosis indicating organicity will not preclude the patient from successful treatment.)
~~8. An adequate support system outside the program exists or patient is capable of creating such a support network~~
~~9.~~**8.** Recently discharged from an inpatient psychiatric hospitalization and requires this level of care to assist in reintegration into the community
~~10.~~**9.** Patient is capable of regularly attending program per treatment planning schedule

E. **CONTINUED STAY ELIGIBILITY:**
1. Persistence ~~of Axis I~~**psychiatric** symptomatology
2. Persistence of impairment in social, familial, residential, or vocational functioning.
3. ~~Persistent inability to perform~~**Psychiatric symptoms continue to negatively impact** ADL's
4. Continues to be reasonable expectation that patient will improve or be stabilized within a reasonable time frame
~~4.~~**5. Improvement in this context is measured by comparing the effect of continuing treatment versus discontinuing it; where there is reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further or require hospitalization, this criterion would be met.**
~~5.~~**6.** Patient is **attending and** participating in program **and showing a capacity to benefit.**
~~6. Patient is capable of attending program (including groups) per treatment plan~~
~~7. Patient is showing capacity to benefit~~

F. **EXCLUSIONARY CRITERIA:**
1. Deterioration in functioning represents a situational crisis, unrelated to the psychiatric condition
2. Patient is actively and seriously suicidal
3. Patient is actively and seriously homicidal or poses a threat of harm to others.
4. Patient is medically unstable
5. Patient has ~~dissocial~~ **antisocial** personality disorder or strong ~~dissocial~~ **antisocial** personality traits
6. Patient unable to follow ground rules (e.g. verbally/physically abusive to others)
7. Symptoms are transient and self-limiting
8. Patient requires inpatient level of care due to severity of psychiatric conditions
9. Current symptoms and impairment can be adequately managed at lower level of care
10. No reasonable expectation that condition can be stabilized or improved
11. Multiple absenteeism (from groups or program) and/or non-participation in program interfere with patient's ability to benefit from program
12. Substance abuse interferes with ability to benefit from Program
13. Program physicians unwilling to treat patient due to treatment non-adherence

G. **DISCHARGE CRITERIA:**
1. Symptoms/Impairments have decreased to a level indicating patient no longer requires treatment for their illness
2. Symptoms/impairments have been stabilized or patient is back to baseline
3. Patient is in need of or ready for a more intensive or less restrictive level of care
4. Patient is not able to benefit from the program
5. There is no reasonable expectation for improvement
6. Patient has achieved their established program goals and would not benefit from additional treatment goals
7. Patient is a danger to self or others and cannot be effectively or safely managed within the program needing a higher level of care
8. Patient does not have the capacity to benefit from program
9. Patient is not participating and/or not attending per treatment plan
10. Patient has achieved maximum benefit from this level of care
11. Patient presents a threat (physical or verbal) to the safety of the milieu

~~H. REFERENCE(S):~~

~~1.~~12. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Admission Assessment**

ISSUE DATE: **08/96**

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**

1. To identify the guidelines for the Psychiatric Admission Assessment.

B. **PROCEDURE**

1. Who may perform/responsible: Attending Psychiatrist
2. The Psychiatric Admission Assessment (or update of recent workup done within the last 90 days) must be completed by the attending physician within five program days (seven calendar days) from date of admission to the Intensive Outpatient Program and within 24 hours of admission to the Partial Hospitalization Program. ~~The Assessment should be filed in the chart and becomes a permanent part of the medical record.~~
3. If the patient has been discharged from an in-patient psychiatric setting fourteen (14) days prior to admission to Outpatient Behavioral Health Services (OPBHS), then the Discharge Summary from that hospitalization may be copied and placed in the patient's medical record in lieu of the Psychiatric Admission Assessment, with an update by the attending Program physician. Though preferable, it is not mandatory that the assessment be completed at the actual location of the Program.
4. An update to a recent work up or discharge summary should include the following:
   a. Reason for re-referral: information referencing recent hospitalization
   b. Current mental status
   c. Current Diagnosis, Axes I through V
   d. Plan of treatment including number of days per week of attendance, goals and medications
   e. Discharge plan

~~5. The physician reviews and signs the dictated assessment for content and thoroughness.~~

~~6.~~5. The physician~~,~~ **therapist and patient collaborate to help aid in the** ~~informs the primary therapist of any additional significant information so that the therapist has information from the admission assessment to~~ develop**ment** a thorough Master Treatment Plan~~.~~

~~7.~~6. The physician ~~should~~ **may** have the following information available to aid in the completion of the Psychiatric Admission Assessment:
   a. Community Liaison Coordinator (CLC) Referral and Screening Report
   b. Attempts will be made to obtain collateral including prior Program admission, treatment, and discharge information; last psychiatric inpatient hospital admission notes, history and physical, discharge summaries, medication sheet, and relevant treatment notes current psychosocial summary, face sheet, etc.
   c. The CLC or Registered Nurse (RN) provides a brief presentation of the patient to the

treatment team prior to admission.

~~8.~~7. It is critical that prior level of functioning and recent acute change in mental status be documented in the assessment in order to demonstrate current need for OPBHS. It is important that the physician be specific with regard to treatment plan recommendations so that physician driven treatment is evidenced.

~~9.~~8. If the patient is a re-admission, the above guidelines for the Psychiatric Admission Assessment should be followed. A copy of the prior assessment or discharge summary and the update should be filed in the patient's chart in the assessment section.

~~C. **REFERENCE(S):**~~

~~1. California Hospital Association (2017). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Age Appropriate Care**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~09/17~~ n/a**
Board of Directors Approval:	**09/17**

A. **PURPOSE:**

1. To provide guidelines to meet the age specific care needs of the patient and educate their caregiver and/or family.

B. **POLICY:**

1. Outpatient Behavioral Health Services (OPBHS) serves adults eighteen (18) and older. Efforts must be made to individualize the program to meet the specific needs of individuals and address age-related issues. Older adults may attend specialized groups to address issues related to their specific age group, such as aging and grief and loss issues. Likewise, young adults may be scheduled for groups with individuals of similar age to address issues that may arise for their age group, such as academic or job-related concerns. All employees shall demonstrate the skills and knowledge required to provide care appropriate to the age of the patients served. Caregiver/family shall be involved in treatment to meet the age specific needs of the patient.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS staff.
   a. Educational information including the principles of growth and development will be provided during orientation.
   b. The knowledge and skills necessary for providing age specific care will be reviewed annually.
   c. Knowledge, skill base, and ability to provide care appropriate to the age of the patient will be evaluated during orientation and at each annual performance review.
   d. Employees will include family/caregiver, as appropriate, in meeting age specific needs of the patient.
   e. Treatment approaches will be modified to meet the age specific physiological, psychological, educational and social needs of the patient.
   f. Medications will be prescribed in age appropriate medication dosages; therapeutic ranges can be obtained from the pharmacy and laboratory department as needed.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Clinical Assessment**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional special assessments which are completed, as necessary, by physician's/Allied Health Professional's (AHP) order.

B. **POLICY:**

1. All patients admitted to the program will routinely have an Admission Psychiatric Assessment, and a Biopsychosocial Assessment, which includes a Nursing Assessment and psychosocial assessment.

C. **PROCEDURES:**

1. Who may perform/responsible: Physicians, Therapy, and Nursing Staff
2. Intensive Outpatient Program Services:
   a. All core assessments will be completed by appropriately licensed and qualified personnel using Tri-City Healthcare District (TCHD) approved **electronic** medical records **or downtime** forms.
   b. Though the Psychosocial and Nursing Assessments are routine and part of the core assessments, they should be checked as ordered on the Physician Admission Order. ~~All assessments~~**Assessments** will include findings and treatment recommendations, which will take into consideration patient strengths. Prior assessments that are less than six months old may be updated and placed in the medical record.
   c. ~~All dual diagnosis patients receive a~~**All patients will be assessed for** substance abuse ~~assessment~~.
   d. All new patients will undergo a suicide **risk** assessment at intake and as needed during their treatment.
   e. If the patient is a re-admission and the prior assessments are less than six months old, an update can be written and attached to the original assessment and placed in the medical record.
   f. A general health statement by the attending psychiatrist or patient's medical doctor must be made on admission. If the patient has been hospitalized within the last 30 days for any reason, an effort must be made to obtain a copy of the H & P and any other pertinent data.
   g. If there are any special assessments**, such as the PHQ-9, GAD-7, PCL 5, or BPRS,** needed for diagnostic purposes, they are to be indicated on the Physician Admission Order.

h. If qualified personnel are not available on staff, then arrangements will be made for the special assessments to be completed by appropriately qualified independent practitioners.

D. **BIOPSYCHOSOCIAL ASSESSMENT AND ADMIT NOTE: OVERVIEW:**

1. Part A **Nursing Assessment:**
   a. Part A of the Biopsychosocial Assessment is the Nursing Assessment and it is completed within 24 hours of admission by the Program Registered Nurse (RN). It should speak to medical necessity for admission and provide information to be considered in the development of the Initial and the Master Treatment Plan. In addition, it should address medical concerns and medical diagnoses to be followed regularly.
   b. Part A of the Biopsychosocial Assessment shall contain patient identification and diagnosis and the following:
      i. Physical Data
      ii. Allergies and Sensitivities
      iii. Current Medications and Compliance
      iv. Nutritional Screening and History with a subsequent referral index for dietitian referral potential
      v. Functional Assessment
      vi. Sensory/Communication assessment
      vii. Surgical history
      viii. Medical Problems/History and Falls Risk Assessment
      ix. Contagious Diseases/exposure
      x. Pain Screening and subsequent Assessment with potential for reassessment
      xi. Suicidal and Homicidal Assessment: If at risk, safety goals will be initialed.
      ~~xii. Summary of Impressions to include recommendations for f/u for any Axis III diagnosis~~
      ~~xiii.~~**xii.** Fall Risk Assessment: If fall risk is indicated, then Fall Risk goals will be initiated along with treatment interventions

2. Part B: **Psychosocial Assessment**
   a. Part B of the Biopsychosocial Assessment is the Psychosocial Assessment and can be used as a rapport building opportunity between the Therapist and the patient. It is recommended, however, that it be conducted after the patient has had a few days to acclimate to the program but within one week of admission. It is also preferable that some rapport building occur between the Therapist and the patient prior to the assessment as the level of trust and the level of self-disclosure may be greater.
   b. This assessment should also be used as a springboard for exploring with the patient specific treatment plan problems and goals. This discussion should provide the patient with a thorough understanding of how a treatment plan is developed and revised and the role of the patient as an active participant in the treatment planning process. It may be useful during this discussion to share with the patient the impressions and recommendations of team members based on other assessments (e.g., the Psychiatric Admission Assessment; Part A of the Biopsychosocial Assessment) as you and the patient begin exploring potential treatment plan problems and goal areas. In doing so, the patient can perhaps better understand the connection between the assessment process and the treatment plan. Include in this discussion how the identified strengths of the patient will be incorporated into the treatment plan and reinforce patient active participation in the process.
   c. Part B of the Biopsychosocial shall contain the following:
      i. Source of information
      ii. Family relationships and current living arrangements
      iii. Brief psychiatric history
      iv. Developmental and family of origin history
      v. Ethnicity and Sexuality
      vi. Spirituality

vii. Substance Use History
viii. Adult social history
ix. Education / Learning ability
x. Employment / Vocational data
xi. Legal history
xii. Financial resources / Community support needs
xiii. Military Service history
xiv. Risk factors / Violent behavior / Abuse history
xv. Additional observations and/or Special needs

3. An admission note should also be included in the chart. This provides an introduction of the patient to the various team members in the narrative form. It should emphasize the reason for referral, recent change in mental status, and symptomatology. All of these support medical necessity for admission and help paint a clear picture for why the patient is being admitted to the program.
4. When a patient is a re-admission to the program and has had a full Behavioral Health Outpatient Services Biopsychosocial Assessment completed within the past 6 months, the Therapist has the option of simply updating Part B of the assessment. To do this, one needs to review the prior Biopsychosocial Assessment and, using an individual note, include any updated information. A copy of the prior Biopsychosocial Assessment and the new update page should be filed in the section of the chart for assessments. If the prior Biopsychosocial Assessment is more than 6 months old, a new Biopsychosocial Assessment must be completed for the re-admission.

E. ADMISSION NOTE OUTLINE:

1. Admission to include:
   a. Note: to be completed on day of admission
   b. Demographics (age, race, sex, who accompanied)
   c. Brief rationale for present admission to the program: Include observable psychiatric symptomatology and functional impairment.
   d. Remarkable observations of mood, affect, behavior
   e. Suicidal / homicidal / assaultive ideation or gestures upon presentation
   f. Patient Orientation to therapeutic milieu, schedule, staff, and Program (per Outpatient Behavioral Health: Orientation of New Patients Policy).

F. RELATED DOCUMENT(S):

1. Outpatient Behavioral Health Policy: Orientation of New Patients

~~G. REFERENCE(S):~~

~~1. California Hospital Association (2017). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.~~
~~2. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Contraband**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To maintain patient and staff safety within Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Contraband items are not allowed in program. Contraband is defined as items that can be injurious to self or others. Contraband includes weapons or potential weapons, illegal drugs and alcohol. Medications that are not needed during program hours are also considered contraband.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff
2. Contraband brought to the OPBHS will be removed from patient access and stored in a secure area. These items may be returned at the end of the day and the patient escorted out of the building. Contraband will be returned only if the Program Administrator feels that possession of the contraband item will not pose a threat to the patient or others. Items that are illegal to possess, such as illegal drugs and firearms, will be securely stored until their appropriate disposition is determined. The Operations Manager will notify the Director of Behavioral Health.
3. Patients who bring contraband to the OPBHS will be given one warning not to bring the item(s) back. Repeated violations of the contraband policy will result in suspension from the Program until the patient meets with his/her Therapist and the Operations Manager. At that time, the patient's noncompliance will be discussed as a treatment issue. A treatment contract will be written and the patient may be rescheduled if he/she agrees to stop bringing contraband to OPBHS.
4. Continued violations of the contraband policy may result in the patient's discharge from OPBHS.
5. If the patient refuses to relinquish the contraband, he/she shall be told to leave the premises and the attending physician shall be notified.
6. The incident should be documented on a Quality Review Report, and as applicable, in the patient's record along with the action taken.

D. **RELATED DOCUMENT(S):**
1. Security Policy: Seized Evidence or Contraband 231

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Daily Progress Notes**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**

1. To provide guidelines for the documentation of patient progress in the Outpatient Behavioral Health Services (OPBHS) Program.

B. **POLICY**

1. The Program is required by the fiscal intermediary to document progress for each intervention provided. The treatment plan problems can be identified within each note. Each intervention should be identified in terms of the focus, modality and the format and the facilitator / therapist name and credentials. Specific goals for each intervention, as well as symptoms, behaviors and/or responses should be documented.
2. Individual Therapy, a Family Session, and Crisis Intervention should also be documented as it occurs. Specific treatment, outcomes, and goals of the session should be documented in narrative form as an Interdisciplinary Progress Note.

C. **PROCEDURE**

1. Who may perform/responsible: Clinical Staff and Physicians
2. Per Service Notes:
   a. The note must clearly show how the various groups the patient is attending are focused on treating his/her specific psychiatric problems. The documentation must illustrate how the treatment relates to the problems stated in the treatment plan, what kind of improvement is shown and what still needs to be improved. Progress notes must reflect active treatment.
   b. When charting, refer to observable symptomatology, staff interventions and response/progress noted.
   c. Physicians should document patient progress toward treatment goals, need for continued treatment and discharge readiness.
3. Charting Basics:
   a. Individual and group therapy session notes should be entered in the electrnic medical record system.
   ~~a.~~b. In case of downtime, use downtime forms and u~~U~~se black ~~ink in the absence of an electronic form.~~ink.
   ~~b.~~c. Date and sign all documentation.
   ~~c.~~d. Write legibly.
   ~~d.~~e. Clinical staff must document daily on groups attended and patient progress/participation in the groups.

~~e.~~**f.** Special notes (i.e., nursing notes, **non-billable and collateral contacts**) are identified as such.

~~f.~~**g.** Charting needs to be descriptive, not interpretative. When documenting, include observed behaviors and patient statements.

~~g.~~**h.** Document all treatment rendered to the patient and the patient's response. Any quotations used are to be brief and relevant to the patient's problems.

~~h.~~**i.** Make chronological entries of the patient's clinical course - late entries must be identified as such.

~~i.~~**j.** All entries in the MR are completed by the writer.

~~j.~~**k.** On paper forms, errors must be indicated by using one line through the incorrect documentation, write "error" over the line, and initial the error. Never use white-out.

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

~~1. California Hospital Association (2017). California Hospital Consent Manual. Sacramento, CA: California Hospital Association.~~

~~2.~~4. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: ~~Destructive~~ **Aggressive or Potentially Violent Behavior**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**
1. To protect the safety of patients, staff, and visitors.

B. **POLICY**
1. All ~~destructive~~ **aggressive** and/or potentially violent behavior will be dealt with immediately to prevent any harm to patients, staff and visitors.

C. **PROCEDURE**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff
2. To maintain safety, any signs of escalation, increased psychiatric symptoms, or increased agitation need to be addressed immediately and if possible identified in the morning patient review meeting.
3. Staff is to contact 911 using the black emergency phone if there are any signs of danger, and risk to patients and staff members.
4. Staff is to attempt to remove the agitated patient away from other patients by calmly walking him/her away from other patients and toward a safe area where the patient and the therapist can escape easily.
5. If the patient refuses to leave group, staff is to instruct other patients to leave the group room.
6. Staff member is to request help from other available staff by sending a patient for assistance or using the whistle/walkie-talkie **or phones** to alert staff of danger.
~~6.~~**7.** **If the patient is in a Telehealth group, staff may remove an aggressive patient from the group, if necessary and must follow up with a phone call to assess for safety.**
~~7.~~**8.** The use of the whistle/walkie-talkie is a last resort to obtain help and only after failed attempts to de-escalate the patient or remove him/her from the group. Premature use of the whistle can further escalate an agitated or angry patient.
~~8.~~**9.** Staff, along with the operations manager or clinical coordinator will gather all information regarding the threatening behavior and assess the patient's mental status.
~~9.~~**10.** Implement the most appropriate response, which may be a time out, verbal de-escalation techniques, suspension, 911 call, or inpatient hospitalization.
~~10.~~**11.** If inpatient admission is required, follow the procedure outlined in the Patient Care Services: Admission Psychiatric Patients Policy and contact the program psychiatrist.
~~11.~~**12.** Physical restraint is not used as a clinical intervention. If a patient becomes violent 911 must be called immediately and the patient must be allowed to escape.
~~12.~~**13.** To help de-escalate the agitated or angry patient, staff is to calmly communicate the intent to help the patient, convey empathy, and attempt to remove the patient from group or milieu.

~~13.~~**14.** Staff must take safety precautions by sitting close to an exit, ensuring that they have an escape, and not placing self at risk by meeting with an agitated patient alone, walking in front of a patient that is agitated, or blocking the patient from escape.

~~14.~~**15.** The Operations Manager or designee will meet with all staff and patients involved to process the incident and address safety concerns. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.

~~15.~~**16.** Staff is to complete the on-line Quality Review forms, when necessary, and report any safety issues or violent behavior to the CNE and Risk Management department.

~~16.~~**17.** Staff is to document the incident and staff response in the patient's medical record.

~~17.~~**18.** Staff will discuss the incident in the treatment team meeting with the physician to determine the best course of action and to assess whether the patient is appropriate in the intensive outpatient program.

~~18.~~**19.** Patients that are unable to control anger and pose a risk to other patients or staff are not appropriate for Outpatient Level of Care and must be referred to a more appropriate setting.

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

1. Behavioral Health Services Policy: Management of Aggressive and Assaultive Behavior
2. Patient Care Services Policy: Admission Psychiatric Patients

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Disaster Plan**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To insure efficient Outpatient Behavioral Health Services (OPBHS) disaster procedures and to maintain adequate availability of personnel in the event of disaster.

B. **INTRODUCTION:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Health Care District (TCHD) has adopted the command structure of Hospital Incident Command Systems (HICS) the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the Environment of Care: Safety Plan Policy.

C. **NOTIFICATION:**
1. OPBHS will be notified of the main house Disaster Plan activation by telephone, cell phone, and/or email.

D. **DISASTER PLAN PROCEDURES:**
1. Operations Manager Responsibilities:
   a. The Operations Manager will take direction from the Director of Behavioral Health/**Chief Nurse Executive** and Safety Officer who has assessed the nature and extent of the disaster. In the event of the absence of the Operations Manager the Clinical ~~Coordinator~~**Supervisor** will assume the leadership role.
   b. The Operations Manager will complete the Personnel Inventory Form or make a list of all available staff and be prepared to send it to the HICS center at the main house, should it be requested.
      i. Note: Personnel Inventory Forms are found in the Safety and Disaster Manual. The Incident Command Center is located in the French Rooms.
   c. The Operations Manager will assemble all available staff to inform them of disaster procedures and standby to report to disaster priority areas at the main house in the event OPBHS staff is needed in the main House (after all OPBHS patients have been safely transported to their residences).
   d. The Operations Manager will designate one Administrative staff to contact all non-present staff of the disaster and prepare for call-in procedures should they be required.
   e. The Operations Manager **or designee** will contact ~~the Patient Transport Express and the Dispatcher if he/she is not present in the building to alert him/her to ready the vans for early departure from Program if the disaster allows for patients to be transported.~~**transportation vendors or PTE to ensure that patients are trasnsported safey to their homes.**

f. The Operations Manager will relay as much information as possible to the Incident Command Center.

2. Registered Nurse (RN) Responsibilities:
   a. RN's will notify the residential care providers of the disaster procedures and inform them that their residents will be leaving Program early.
   b. RN's will call Program physicians to inform them of the disaster procedures~~, and to obtain orders.~~.
3. Therapist Responsibilities:
   a. The Therapists will ~~assemble the patients in the Community Room to~~ inform ~~them~~ **patients** of the disaster procedures and ~~to organize them for~~**coordinate** departure from Program if they can exit safely.
   b. The Therapists will begin calling family members, Case Managers and Conservators to inform them of Program Closure for the day and the possibility of continued Program closure until the disaster has cleared.
   c. Therapists will attend to the medical records to insure that they are in proper order and the documentation is current~~ before securing them in the Chart Room~~.
   d. In the event patients cannot be safely exited from the Program and delivered to their residences by hospital vans, they will be contained within the building until notified of safe departure. Appropriate de-escalation techniques will be utilized to allay panic.
4. Dispatcher and Drivers:
   a. **If available, t**~~T~~he Dispatcher will contact Patient Transport Express supervisor to collaborate with the PTE Supervisor about the needs of the vans throughout the hospital.
   b. The Dispatcher will contact all available drivers to alert them for the possibility of reporting for duty.
   c. The Dispatcher will assemble the drivers on site and distribute the route sheets appropriately.
   d. The Drivers will safely transport patients to their residences as per the route sheets and return to base at the hospital.
5. Administrative and Support Staff:
   a. The Administrative and Support Staff will take direction from the Operations Manager who has assessed the need within the building.
   b. Administrative and Support staff will respond to phone calls and direct callers appropriately.
   c. The Administrative and Support staff will assist the Therapists and Drivers in boarding the patients on the vans.

E. **RELATED DOCUMENT(S):**
1. Emergency Operations Procedure: Emergency Operations Plan
2. Environment of Care Policy: Safety Plan

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Discharge Planning and Discharge

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE**

1. To define the discharge process as an integral part of treatment.

B. **POLICY**

1. Discharge planning will be an organized, coordinated process, with interdisciplinary treatment team, patient, physician and family/significant other input. The process identifies the patient's needs before and after discharge, delineates plans to meet these needs and engages the patient and family members in the process of plan implementation. Discharge planning will begin on admission.
2. Discharge criteria are tied to the long-term goals and will be established during the development of the Master Treatment Plan (MTP). At each treatment plan Update, the discharge criteria will be reviewed and modified as necessary, depending upon the rate of progress (or lack of progress) in treatment. A rationale for each change will be documented.
3. If a patient does not respond favorably to the Program or does not seem to be benefiting from the prescribed course of treatment, the issue is taken to the treatment team meeting to determine appropriateness of the treatment and identify possible changes in treatment plan or possible alternative referrals. However, lack of progress in treatment does not automatically imply the necessity for discharge. Treatment goals need to be re-evaluated and every effort must be put forth to insure that identified problems and target dates are appropriate and reasonable, prior to considering discharge.
4. Circumstances warranting discharge may include:
    a. Attainment of treatment goals, including a significant reduction in symptoms and functional impairment.
    b. Continued abusive and/or aggressive behaviors after clinical/behavioral interventions fail.
    c. Repeated substance abuse, after treatment interventions have been tried, to a point that substance abuse substantially interferes with the team's ability to address the primary Axis I diagnosis and patient does not appear to work towards harm reduction or abstinence as a goal.
    d. Repeated non-compliance with treatment or program rules.
    e. Discharge to inpatient due to:
        i. Suicide attempt or ~~high~~ **imminent** risk of suicide;
        ii. Serious injury;
        iii. Accidental injury;
        iv. Acute exacerbation of symptoms;
        v. Danger to others.

5. Patient refusal to continue in treatment.
   a. When patient ~~refuses~~ **declines** to continue in treatment, follow-up efforts will be made by the Therapist;
6. The patient will be discussed at the treatment team meeting and interventions planned in an effort to re-engage patient;
   a. Patients may be administratively discharged if they do not attend the Program on a regular basis and ~~have failed to~~ **do not** respond to repeated attempts to re-engage; and Program physician may discharge the patient due to lack of follow through with treatment recommendations.
7. All anticipated discharges from the Program will be discussed with the physician and significant others involved in the patient's care, before a discharge decision is made.
8. ~~The focus of discharge planning is to assist patients in achieving and maintaining their goals. This will be provided on a group/individual basis and will be related to the treatment plan. Assessing the potential of each individual, evaluating his/her progress in overcoming deficits, and counseling the patient to develop expectations for him/herself will be an ongoing part of treatment. Planning for a smooth transition from the Program will also be an ongoing part of treatment.~~**Indivdiual and group sessions will be utilized to assist patients in achieving and maintaining treatment goals and planning for a smooth transition from the Program.**

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical Staff
2. Patient progress toward goals and appropriateness for discharge will be discussed in treatment team meetings and the discharge plan will also be reviewed at the treatment team meeting.
3. A plan of transition will be developed, which includes contacting the appropriate referral agency, establishing a time-line for discharge from the program, actively involving the patient in the planning and a subsequent decrease in treatment days.
4. The plan of transition will be developed to limit the potential for separation related stress and/or increased symptomatology. The plan will be discussed with, and agreed upon by the patient.
5. When the transition is complete, with the approval of the treating psychiatrist, patient, and the treatment team, the patient will be discharged from the Program.
6. When discharging a patient:
   a. Complete the discharge checklist on the day of discharge
   b. Complete the **Discharge/**Aftercare plan, to include the discharge medications, discharge instructions, and follow up care. In the case of an unanticipated discharge, mail the patient and caregiver a copy of this Aftercare plan.
   c. Audit the chart and check for:
      i. ~~All pages~~**all downtime and paper forms** labeled/identified with name of patient, date of birth, date of admission, attending physician and Medical Record number;
      ii. All progress notes completed, dated and signed;
      iii. All orders noted and signed;
      iv. physician progress notes and treatment plan reviews are current
   d. The complete discharge summary must be written ~~and signed~~ within 3 days by the ~~physician/Allied Health Professional (AHP) on their next scheduled day~~**therapist**.
7. The medical record may be retained on site for up to ~~ten~~ **seven** days.
8. The discharge audit form is completed by the therapist within five days of discharge. The chart will then be sent to Medical Records to be scanned.

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

~~California Hospital Association (2017). *California Hospital Consent Manual.* Sacramento, CA: California Hospital Association.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Family Involvement

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE**
1. To identify the role of the family in the patient's treatment.

B. **POLICY**
1. When appropriate, the patient's family and or significant others will be involved in the patient's treatment.

C. **PROCEDURE**
1. Who may perform/responsible: Clinical staff
2. At the time of screening, the Community Liaison Coordinator (CLC) will discuss the opportunity for family participation in treatment with the potential patient and the family when appropriate.
3. With the patient's consent, family members will be encouraged to participate in the treatment process by participating in family therapy sessions as ordered by the attending physician.
4. With the patient's consent, the family will also be involved in the discharge planning process.
5. A Release of Information must be signed by the patient before any interaction is initiated with the family or significant other, or before any information is provided to them.

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Patient and Family Education

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Laboratory Services

ISSUE DATE: 08/96
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**
1. To provide laboratory services for patients attending the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. OPBHS provides patients access to Tri-City Healthcare District (TCHD) laboratory services as ordered by the attending physician/Allied Health Professional (AHP) or medical consultant.

C. **PROCEDURES:**
1. Who may perform/responsible: Registered Nurse (RN) and Laboratory Staff
2. The RN notes the physician/AHP order for laboratory services and ~~completes the appropriate lab requisition form indicating that results are either to be faxed or printed at the program.~~**coordinates completion of lab services with the patient.**
3. The RN refers to the physician/AHP order and hospital lab for any special provisions or preparations (i.e. fasting; hold a.m. prescription) and instructs patients prior to lab work.
~~4. The RN arranges with the patient the date and time of laboratory procedures.~~
~~5. The RN provides the phlebotomist with the completed laboratory requisition forms and assists in identifying the patients scheduled for laboratory procedures.~~
~~6.~~4. Same sex staff should supervise collection from patients of specimens for drug and alcohol urine screenings.
~~7.~~5. The RN is responsible for correctly labeling the urine specimen and arranging for safe transport to the laboratory.
~~8.~~6. All staff handling urine specimen are to utilize Infection Control: Standard and Transmission-Based Precautions.
~~9. The physician/AHP signs lab results and the labs are filed in the lab section of the medical record.~~
~~10.~~7. In the event of a critical lab value, the RN contacts the physician/AHP immediately, and proceeds with physician/AHP orders.

D. **RELATED DOCUMENT(S):**
1. Infection Control Policy: Standard and Transmission-Based Precautions

~~E. REFERENCE(S):~~
~~1. Joint Commission Safety Manual~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Medical Emergencies**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define appropriate methods of handling emergency medical situations.

B. **POLICY:**
1. Medical emergencies are managed by Outpatient Behavioral Health Services (OPBHS) Registered Nurse (RN). All clinical staff assisting in medical emergencies is required to maintain current Basic Life Support (BLS) Certification.

C. **PROCEDURE:**
1. Who may perform/responsible: Nursing Staff
2. For minor injuries (i.e., superficial cuts and bruises), the patient will be evaluated by the RN on duty. First aid treatment is provided by the RN. The patient is referred to his/her primary care physician for follow-up, as necessary.
3. For acute medical conditions requiring immediate attention, the RN will arrange for the most appropriate type of transportation for the patient, to the nearest Emergency Department.
4. In cases of severe suicide attempts or medical emergency, the RN will initiate lifesaving procedures (i.e., CPR, direct pressure, etc.) and have a staff member immediately dial 911.
5. Any first aid or other medical services provided to the patient must be documented by the RN in the patient's medical record.

D. **RELATED DOCUMENT(S):**
1. Outpatient Infusion Center Policy: Medical Emergencies

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Organizational Structure**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define lines of responsibility for clinical supervision and administrative supervision.

B. **POLICY:**
1. Outpatient Behavioral Health Services (OPBHS) staff operates using the guidelines of the organizational structure, and obtain both clinical and administrative supervision.

C. **PROCEDURES:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) Administrative Staff, Medical Directors, Operations Manager and Director of Behavioral Health or designee.
2. Clinical Supervision:
   a. All patients must be admitted by a psychiatrist who has the responsibility for supervising and periodically evaluating all treatment services provided to the patient under his/her care. The attending physician/Allied Health Professional (AHP) must also provide supervision and direction to any therapist involved in the client's treatment. The OPBHS Medical Director(s) has responsibility for overseeing and ensuring the quality of care provided to the patients. The Medical Director(s) reports administratively to the Operations Manager. The Medical Director(s) reports in all matters of a clinical nature to the TCHD Psychiatric Committee.
3. Administrative Supervision:
   a. The Operations Manager provides administrative supervision of all OPBHS staff and has administrative responsibility for all aspects of the OPBHS. The Operations Manager reports to the Director of Behavioral Health or CNE.
4. Site Management:
   a. Administrative and financial operation of the OPBHS is the responsibility of TCHD. The Operations Manager has responsibility for day to day operation of the site including staff recruitment, supervision, clinical services, nursing services, environmental maintenance, quality improvement and utilization of reviewed activities. Also included is monitoring of staff and physician documentation compliance and monitoring of compliance to all TCHD rules, policies and procedures.
   b. The Medical Director(s) has responsibility for overseeing the quality of medical care provided at the OPBHSs. The Medical Director(s) must be a Board Certified or Board Eligible Psychiatrist and be a member in good standing of the TCHD medical staff and a member of the appropriate TCHD medical committee. The Medical Director(s) attends weekly treatment planning meetings, clinical problem solving meetings and is available to the Operations Manager and staff to consult on cases, physician issues and clinical

programming. The Operations Manager and Registered Nurses (RNs) provide initial orientation and training of all Medical Director(s). The training includes:

i. responsibilities and duties of the Medical Director(s);
ii. documentation requirements;
iii. policies and procedures; and
iv. clinical program guidelines.

5. Quality Improvement and Utilization Review:
   a. The Operations Manager has responsibility for monitoring and reporting Quality Improvement and UR issues to TCHD Director of Behavioral Health and other medical staff committees. This includes an analysis of trends and a plan of correction when needed. Reports provide statistical analysis and trending of results across programs and recommend changes in programming, policies and procedures based upon an analysis of the results.
6. Personnel:
   a. Clinical and administrative personnel at OPBHS are TCHD employees. All employees must satisfy the personnel requirements set forth by TCHD (which may include) a pre-employment physical with a PPD test or chest x-ray. The operations Manager or designee provides an orientation for all new employees. Staff development is provided on a regular basis to all staff. The Operations Manager is responsible for overseeing compliance with:
      i. TCHD policies;
      ii. The Joint Commission, Medicare, or appropriate standards, and staff development requirements (i.e., TCHD orientation, Basic Life Support, fire/disaster training, etc.);
      iii. state and federal employee regulations; and
      iv. periodic and annual performance evaluations.
7. Community Development and Liaison (CLC):
   a. The CLC is responsible for screening each potential patient to determine clinical appropriateness for admission. The CLC also has responsibility for establishing and maintaining relationships with community agencies, residential care facilities, public and private mental health providers, advocacy groups and others involved in the treatment of the mental health patients in the community. The maintenance of these relationships is critical in providing a continuum of care for patients with psychiatric disabilities. Additionally, the CLC is responsible for developing community education programs for both professionals and non-professionals involved with patients.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Physician Admission Order**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To clarify what is necessary for admission to Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Admission to the OPBHS must be upon the order of a program physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) credentialed physicians.
2. A Physician Admission Order must be received on the day the patient is admitted to the OPBHS.
3. The patient may be admitted with a telephone order but must be seen by the physician within seven days of admission to Intensive Outpatient and within 24 hours of admission to Partial Hospitalization Program.
4. All assessments, OPBHS interventions (group therapy, individual and family therapies) must be ordered by a program physician.
5. On admission, the physician orders the duration of treatment, based on medical need.
6. Admission to OPBHS requires a general health statement by the admitting physician, indicating medical stability.

D. **REFERENCE(S):**
1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Referral and Admission Screening**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. Define the referral and admission screening process.

B. **POLICY:**
1. Referrals for outpatient services are accepted from professional sources, through self-referral, from family members or from residential care providers. It is the responsibility of the Community Liaison Coordinator (CLC) (or his/her designated backup) to determine eligibility for service. All individuals that are in need of service should be evaluated as quickly as possible.
2. Whenever it is determined that a person, who is referred, is not eligible for services, it is the responsibility of the CLC to assure that an appropriate referral for alternative service(s) is made.
3. All persons accepted into the Program must meet admission criteria (see Outpatient Behavioral Health: Admission & Eligibility Criteria Policy).

C. **PROCEDURE:**
1. Who may perform/responsible: CLC or designee
2. At the point of initial referral contact, the CLC makes an initial determination of eligibility and legal status (if on conservatorship, the CLC obtains the conservator's consent to treat by the first day of admission to program). The CLC, along with the prospective patient, establishes a suitable time and location for admission screening. Screening may take place in an inpatient setting, at the patient's home, the program site, or other convenient location.
3. If the patient is referred by a non-psychiatrist, the CLC, after obtaining a release of information, contacts the psychiatrist currently working with the patient to determine if he/she agrees with the recommendation for treatment. The CLC inquiries about whether the community psychiatrist will continue to follow patient during treatment or if a program psychiatrist will follow the patient.
4. The CLC conducts a screening and completes the "Referral and Screening Report" to establish eligibility and appropriateness for admission, to identify any special issues or concerns and to gather all essential background information. The CLC obtains the "Authorization for Release of Information" which can be used to obtain copies of clinical records from previous treatment providers.
5. The CLC will meet with the Operations Manager, Clinical Coordinator, RN or designees to triage the potential admissions or to coordinate the admission process for any new patients.
6. The clinical staff will be briefed on all new admissions in the daily morning meeting. Briefing should include the patient's history and presenting problems.
7. The CLC will contact referral sources and the patient to advise them of specific admission activities, day and time. The CLC is responsible for assuring that arrangements for physician coverage have been finalized.

8. In the case of a program re-admission, if the patient has been discharged from the program for more than 30 days, the CLC will complete the Re-Assessment Screening Form. In the event that a patient is discharged from the program for a period less than 30 days and is referred back to the Program, a new CLC assessment may not be necessary. The physician's Admission assessment, Psychosocial Assessment, and Nursing Assessment will suffice.

D. **CLC REFERRAL AND SCREENING REPORT: OVERVIEW:**

1. This report is used by the CLC for the purpose of evaluating clinical eligibility for admission to the Program. It is an important component to the admission process and should be thoroughly completed. This report is a document included in the medical record (in the admission section), and it should be filled out completely. The medical director and attending physicians should use this report as part of their orientation to any potential admission prior to completion of the Psychiatric Admission Assessment. The final decision whether to admit the patient to program is the psychiatrist's.
2. The report should support medical necessity for this level of intensity of treatment by documented evidence which identifies: recent inpatient hospitalizations; failed efforts to ameliorate symptoms through outpatient services/lower level of care; recent change in acuity of psychiatric symptomatology; a description of decrease in functioning level; and, evidence that the individual meets the diagnostic inclusion criteria and criteria related to type and severity of impairment.
3. The first page of this report is used primarily for billing purposes, transportation, and Therapist orchestration of services. Diagnosis, history of illness and psychiatric treatment, current symptomology, current risk factors, and the clinical admission criteria and summary of impressions are detailed in the screening report.

E. **FORM(S):**

1. Authorization for Release of Information
2. Referral and Screening Report

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

1. Outpatient Behavioral Health Policy: Admission & Eligibility Criteria

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Role of the Therapist**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To delineate the responsibilities of the Therapist in the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. A therapist is defined as a qualified mental health clinician authorized by the state to provide services, such as a psychologist, licensed clinical social worker, marriage family therapist, licensed professional clinical counselor, or license eligible therapists with California Board of Behavioral health registration.
2. On admission, all patients are assigned a Therapist. The Therapist acts as the primary OPBHS treatment coordinator for the patient, coordinating all treatment services provided to the patient, under the direction of the attending physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical staff
2. Responsibilities of the Therapist:
   a. Care Coordination:
      i. Develops therapeutic relationship with individual patients in caseload. Schedules regular 1:1 interaction to review patient goals and progress;
      ii. For each patient in caseload, the therapist has regular documented contacts with others involved in the patients care (i.e., physician, family members, residential care providers, case managers, conservators, etc.). Acts as liaison, as necessary, for information regarding treatment issues, changes in treatment plan, discharge plan, etc. These contacts may be both by phone and in person;
      iii. Monitors patient attendance at treatment program, following up in a timely manner when attendance problems develop;
      iv. Gathers information, initiates and implements behavioral contracts as needed;
      v. Assists in obtaining insurance authorizations and counseling patient on funding issues, as needed;
      vi. Coordinates with attending physician all treatment plan changes, reviews patient progress and discharge plan; and
      vii. Maintains patient satisfaction with the treatment program.
   b. Treatment and Documentation:
      i. Facilitates group treatment modalities within scope of practice, as assigned by the Operations Manager, using approved curriculum and standard group facilitation techniques.

ii. Conducts initial assessment of new patients within caseload and develops the treatment plan with patient and team collaboration. Develops master treatment plans in a timely manner as prescribed by OPBHS policies and procedures, using data from all assessments and with approval from treatment team.
iii. Reviews and updates treatment plans for patients within caseload, as defined in the OPBHS policies and procedures.
iv. Utilizes treatment planning meetings to review problems, progress and discharge plans for all patients on caseload.
v. Documents progress on a daily basis for all patients in groups facilitated by a Therapist. Progress notes are accurate; refer to problems identified on the treatment plan, and address group focus and patient response as related to treatment goals. All documentation must be legible.
vi. Documents each incident or unusual occurrence at the time it happens.
vii. Monitors medical records, for all patients within caseload, to insure completeness and accuracy. Notifies Operations Manager of any deficiencies and develops a plan of correction.
viii. Completes discharge summaries for all patients on caseload as prescribed by OPBHS policies and procedures.

c. Other Duties:
i. Participates in public relations and educational activities as assigned by the Operations Manager.
ii. Assists in the evaluation of patients referred for admission to OPBHS, as requested by Operations Manager.

D. **REFERENCE(S):**

1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Scope of Services

ISSUE DATE: 08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**

1. To define the specific plan and staff qualifications necessary to provide treatment in the intensive outpatient and partial hospitalization Program (PHP). Intensive Outpatient Treatment is a level of care that provides treatment for individuals with psychiatric illness who continue to require structured treatment but of lesser intensity than is offered in Inpatient Behavioral Health Treatment. Partial hospitalization is a level of care that is more intensive than IOP, provided for patients exhibiting severe and disabling symptoms.

B. **POLICY:**

1. In providing treatment in the Intensive Outpatient Treatment and partial hospitalization programs, the goal of the Behavioral Health Outpatient Services is to provide psychiatric treatment to individuals with psychiatric illness as defined in the current DSM of the American Psychiatric Association, in a less restrictive setting than an inpatient unit. The benefits of this type of care include: lessening the disruption of social, family and community ties; encouraging the patient to test new skills in a more natural environment than a hospital setting; providing a treatment milieu that fosters independence and self-reliance; soliciting feedback from the home environment thereby involving the patient's family or care providers in the treatment process and providing cost-saving benefits through a shortening of the inpatient stay or preventing the need for full hospitalization.

C. **SERVICES OFFERED:**

1. The Program philosophy of care is based on the belief that individuals with psychiatric symptoms can achieve recovery, maintain stability, and reach their maximum rehabilitation potential through the provision of quality, goal oriented treatment. Outpatient Behavioral Health Services (OPBHS) provides a highly structured treatment environment that is predicated on personal responsibility, individual dignity and respect for self-determination. Individuals served in OPBHS attend groups and activities based on an individualized assessment of their needs. Each patient is encouraged to participate with the staff and physician in planning their treatment, setting realistic, obtainable goals and assessing their progress in the Program.
2. The OPBHS utilizes a blend of psychosocial rehabilitation and the medical model of treatment to help individuals achieve recovery. The Program is continually evaluated, utilizing feedback from physicians, staff, and patients; and evidenced-based information. The Program is responsive to the needs of the patients and the community standard of practice.
3. A highly trained and motivated staff is the key to maintaining a quality clinical Program. Staff development is promoted through a comprehensive orientation Program, ongoing in-service education and continuing educational opportunities. The philosophy revolves around the patient,

his/her unique needs and assisting the patient to cope more effectively with psychiatric symptoms and life stressors. Assessment of a person's needs is based on past history and present level of functioning. Every area is assessed including physical, psychological, social, spiritual and environmental, so that a treatment plan is designed specific to each patient's needs. Through individual and group experiences in the OPBHS, progress will be assessed and the treatment interventions modified, as needed, to accomplish the goals defined by the patient and the treatment team. The OPBHS are designed to provide a series of successful experiences, allowing the patient to utilize skills learned, that result in enhanced symptom management and personal empowerment.

D. **CLINICAL PROGRAM:**

1. The clinical Program is based on the principles of recovery, crisis stabilization, psychiatric rehabilitation and relapse prevention. Programming includes group psychotherapy and individual psychotherapy, focusing on recovery, life management skill building, symptom management, functional skills development, relapse prevention and developing/utilizing a community based support system. Dual Recovery groups are also provided for patients with Co-Occurring Mental Health and Substance Use Disorders.

E. **POPULATION SERVED:**

1. The OPBHS treats persons from the age of 18 and up who have a DSM psychiatric disorder with a primary ~~Axis I~~ diagnosis of Schizophrenia, or other psychotic disorders, Anxiety Disorders, Mood Disorders, Somatoform Disorders, Eating Disorders, Personality Disorders, and other Diagnostic Categories that significantly impact functioning.

F. **ACCESSING SERVICES:**

1. A person may enter the OPBHS in several ways:
2. Referral by a discharge planner as a follow-up to inpatient treatment;
3. Self-referral in coordination with a treating physician/Allied Health Professional (AHP) (If the patient is not currently in treatment with a psychiatrist, one will be assigned from the medical staff);
4. Community referral from a family member, board and care manager, conservator, social worker, or therapist.
5. Physician referral (The primary psychiatrist is encouraged to follow the patient while in treatment and a co-treatment option may be available).

G. **HOURS OF OPERATION:**

1. The OPBHS will provide three to four hours of clinical programming a day, Monday through Friday, except major holidays. Patients in IOP usually receive no more than twelve (12) units of service per week. Patients in the PHP can receive more services, up to four per day, five days per week. Some exceptions can be granted for brief periods if the level of symptoms increase, and the insurance care manager approves.

H. **SCREENING:**

1. When an individual is referred for treatment in the OPBHS, an appointment is set for an initial screening. This is performed by the Community Liaison Coordinator (CLC), but may be done by another health care professional on the staff. The purpose of the initial screening is to determine if the patient meets the clinical admission criteria for OPBHS (Admission & Eligibility Criteria policy). If the results of the initial screening indicate that the patient is not appropriate for this level of care, the referral source is contacted and an appropriate referral is made.

I. **ASSESSMENT AND EVALUATION:**

1. Upon admission to the OPBHS, an initial psychiatric assessment, nursing assessment, psychosocial assessment, suicide risk assessment, and if indicated, a substance abuse assessment will be completed. When a person is evaluated for treatment, the following information is obtained:

a. Past psychiatric history;
b. Current psychiatric/medical diagnosis and any medications being prescribed;
c. Current symptoms;
d. Risk for suicide;
e. Risk for Falls;
f. Substance abuse history;
g. Identification of patient's strengths; and
h. Any special considerations.

J. **METHOD OF SERVICE DELIVERY:**

1. Clinical needs, once identified, will be addressed in group and on an individual basis. Structured psycho-educational and process groups will utilize appropriate materials to enhance learning and address specific issues related to symptom management and functional living skills. The focus is on recovery, medication management, symptom management, community-living skills, crisis management, managing relationships, personal care management, substance abuse recovery and other topics as needed.

K. **THERAPEUTIC PROGRAM:**

1. All services provided are appropriate for the treatment of the patient's identified problems. OPBHS will assist in the improvement of the patient's functional level and reduce the risk for exacerbation of symptoms, relapse on drugs or alcohol and hospitalization. Programming is individualized so that patients may initially attend two to five days per week as needed. As the patient improves, it is anticipated that he/she will move to a lower level of care. This will assist in maintaining stability and preventing psychiatric decompensation.

L. **TREATMENT PLANNING AND REVIEW OF GOALS AND OBJECTIVES:**

1. The treatment planning process involves the establishment of Master Treatment Plan within seven days of admission to the OPBHS. This individualized treatment plan is written based on the patient's identified symptoms, goals, and wishes, and in collaboration with the patient. The plan is written by the Therapist assigned to the patient, and is initiated under the direction of the admitting psychiatrist. Within seven days of treatment, a Master Treatment Plan (MTP) is completed by the Treatment Team, under the direction of the attending physician and/or Medical Director. After the completion of the MTP, the next treatment plan review will occur monthly for IOP or bi-weekly for PHP. The plan is also reviewed if the patient goes into crisis, or if their condition changes, so that treatment provided in the Program accommodates newly identified needs.

M. **DISCHARGE PROCESS:**

1. The patient's discharge needs are identified on admission to the OPBHS. As the patient's needs become more defined, programming and discharge planning for the patient will be modified to meet those needs. As part of the discharge planning process, the Therapist will follow-up with the referral source and those in the community providing support, as well as the patient, to assure a smooth transition back into the community and/or a transition to a lower level of care.

N. **ORGANIZATIONAL RELATIONSHIPS:**

1. The OPBHS staff is accountable to the Operations Manager. Each interdisciplinary treatment team member has input into the Program planning process. Staff meetings are held **bi**-monthly or as necessary to address problems as they relate to patient care.
2. The Operations Manager/designee has the authority to make operational decisions on a day to day basis. The Operations Manager is supervised by the Director of Behavioral Health or Chief Nurse Executive (CNE).

O. **EMERGENCY SERVICES:**

1. If a crisis or emergency psychiatric situation should occur at the site, immediate contact will be made by staff to de-escalate the situation. If attempts by staff at verbal de-escalation fail,

emergency procedures will be initiated (see Psychiatric Emergencies). If a medical emergency occurs, it will be evaluated by the Registered Nurse (RN) and 911 will be called, if necessary (see Outpatient Behavioral Health: Medical Emergencies Policy).

P. **AFTERCARE AND POST-DISCHARGE:**

1. Post discharge planning will be provided by the patient's Therapist in an effort to provide continuity of care. The Clinical Coordinator and CLC will maintain and make available to staff, a current list of community resources. An Aftercare group, facilitated by a program therapist, ~~will~~ **may** be offered one time per week as a free follow-up support service.

Q. **STAFFING QUALIFICATIONS AND PATTERNS:**

1. The OPBHS will provide clinical services delivered by qualified health care professionals to adequately assess and address the identified clinical needs of patients. These services are augmented by administrative and support staff necessary to maintaining a comprehensive and responsive treatment program. Professional staff meets all federal and state requirements for licensing, registration or certification. Clinical staffs providing services are Licensed Clinical Social Workers (LCSW), **Licensed** Marriage and Family Therapists (MFT), **Licensed Professional Clinical Counselors (LPCC),** Psychologists, and Master of Social Work (MSW), ~~and~~ MFT interns **and LPC interns** who are supervised on site by licensed practitioners. There will be availability of professional nursing services to meet the needs of those patients requiring such services. Nursing services are provided by Registered Nurses who provide, supervise and evaluate nursing care.
2. Each therapist working a forty (40) hour week will be responsible for managing an average total of sixteen to ~~twenty~~ **eighteen** patient cases (on their caseload) and facilitating ten groups per week.
3. When appropriate qualified professional staff members are not available or are not needed on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

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

1. Outpatient Behavioral Health Policy: Medical Emergencies

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

~~1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~
~~2. Joint Commission Safety Provision of Care 2017~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Smoke Free Environment**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To establish a smoke free environment.

B. **POLICY:**
1. It is the responsibility of the Outpatient Behavioral Health Services (OPBHS) to establish and maintain an optimally healthy and safe environment for its patients, employees, medical staff and visitors. Therefore, smoking is prohibited in all areas within the OPBHS.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff and patients
2. Tri-City Medical Center (TCMC) is a non-smoking facility.
3. All employees are expected to respect and assist in enforcing this policy. Failure to maintain a smoke free environment is a violation of various local and state ordinances.
4. Outside area of OPBHS is not a TCMC property and patients may choose to smoke outside the building.
5. Patients are encouraged to not smoke in the front of the building.
6. Staff will provide patients with information and referrals for smoking cessation.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: 205 Smoke-Free Environment

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Standards for Clinical and Professional Practice**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. To provide mandatory standards for Clinical and Professional Practice in Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**

1. All staff members must act in a professional and appropriate manner at all times at the OPBHS and must treat patients of the OPBHS, as well as each other, with respect and consideration. Accordingly, there are specific, clinically accepted and approved operating standards and principles that all staff members must follow, including, but not limited to, the following specific areas:
2. Community Outings and Diversional/Enrichment Activities:
   a. Certain diversional and enrichment activities can assist patients in developing tools to better understand and identify the natural support and opportunities available in the community after discharge from the OPBHS. However, community outings and diversional or enrichment activities are not a billable service and must not be billed for. Most times, outings are properly classed as enrichment or a diversional activity. Recognizing that at times it may be sensible and clinically appropriate to break up continuous treatment with diversional activities, however, the rule is simple—enrichment or diversional activities can occur, but must not be billed.
3. Token Economies, "Bonus" Stores, and Attendance Awards:
   a. Token economies and bonus stores, whether run by staff or patients, as a rule, are not allowed. Only under particular patient circumstances and based upon an individual patient's treatment plan (and appropriate physician order), might it be approved. Further, any incentive that is likely to influence or induce an individual to receive services, or to continue to receive services, is strictly prohibited. There shall be no attendance awards such as, certificates or award ceremonies, which "reward" a patient for perfect attendance.
4. Bribes and Contingencies:
   a. It is unacceptable for any staff member to bribe a patient in any way to improve attendance or participation in programming or for any other reason. It is equally unacceptable for any staff member to withhold from a patient any of the patient's personal possessions or any item to which the patient is entitled in order to improve the patient's attendance or participation in programming.
5. Recording of Services Provided:
   a. Groups are to be scheduled for a minimum of forty-five (45) minutes. To be credited for having provided a group therapy service to a patient, that patient must have participated in the group for a reasonable amount of time. The service is considered billable only if

the patient has participated based on level of symptomatology. These sessions must begin and end on time. There must be absolute integrity and accuracy in the recording of such services.

6. Group Size:
   a. Staffing standards allow for reasonably sized therapy groups. A range of between eight (8) and ten (10) patients per group is optimal for the type of group work being conducted.
7. Use of Stigmatizing Language/Gestures:
   a. It is clear that language not only reflects the nature of thinking, but it also shapes the quality of thinking and actions. It is with conviction that an OPBHS culture is created in which the language staff use is congruent with the view that consumers of OPBHS services are whole, adult people. Programs are designed to instill hope and support recovery.
   b. Accordingly, it is inappropriate for any staff member to use stigmatizing, or otherwise offensive, language or gestures in the treatment of patients at the OPBHS.
8. Professional Boundaries:
   a. All staff members are required to maintain professional boundaries with patients at all times. It is in the best interest of the patient for staff members to avoid a personal relationship of any kind with patients or any family members or significant others of a current patient who participated in the patient's treatment. No staff member shall socialize or fraternize, by phone, social media, in-person or otherwise, at any time with any patients of the OPBHS, or any family member or significant others of patients who participated in the patient's treatment.
   b. If there's an existing relationship between a staff member and a patient/family member prior to the patient beginning treatment, the staff member must maintain professional boundaries and not engage in any discussions regarding the patient outside of the OPBHS. In addition, the staff member must convey to the treatment team the nature of the existing relationship so that adequate precautions are taken to protect patient's confidentiality.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Staff
2. All clinical and administrative staff members must abide by the above standards in the planning or provision of services or in the operation of the OPBHS. Any practice that conflicts with the above standards is prohibited and could result in disciplinary action, up to and including, termination.
3. If an individual case arises where a patient's physician/Allied Health Professional (AHP) and treatment team believe a patient would clinically benefit from a particular incentive or specific behavioral contract (which appears to be contradictory to the above), the Operations Manager must obtain approval from the Director of Behavioral Health.
4. Any staff member who becomes aware of a suspected compliance issue with respect to the above standards and requirements must report it immediately to his/her Supervisor, or Tri-City Healthcare District (TCHD) Values Line.

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

~~1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

a. Electronic orders for discharge and follow-up care (including: activity, diet, equipment, follow-up, and medications) will be entered into the Depart Process application.
b. Written orders for discharge and follow-up care (including: activity, diet, equipment, and follow-up) will be recorded on the Physician Order sheet.
    i. Nursing will enter into the Depart Process application
    ii. Medication orders must be entered by the physician for Discharge Medication Reconciliation process (see section D.11.c.2)

23. A Discharge Summary shall be completed for all deaths regardless of length-of-stay, and in addition on all patients hospitalized over forty-eight (48) hours, except for normal obstetrical deliveries, and normal newborn infants. A discharge summary must contain:
    a. Discharge Diagnosis
    b. Reason for hospitalization
    c. Significant findings
    d. Procedures performed and treatment given
    e. Condition on discharge
    f. Instructions given to the patient or patient representative
        i. Follow-up instructions
        ii. Diet instructions
        iii. Discharge medications
    g. A discharge note is acceptable for all patients with a length-of-stay less than forty-eight (48) hours, to include normal obstetrical deliveries, and normal newborn infants.
        i. Requirements of the note include:
            1) Discharge diagnosis
            2) Instructions given to the patient or patient representative:
                a) Follow-up instructions
                b) Diet instructions
                c) Discharge medications
            3) Physicians who have not completed a discharge summary at the time of discharge will be notified by Medical Records/HIM via the Message Center in Cerner and call to their office.

24. Physicians will be notified of all pending dictations and/or signatures via their Cerner Message Center and call to their office.
    a. Physicians will be suspended if the chart is not completed within 14 days of discharge per Medical Staff Policy #8710-519 for Delinquent Medical Records and Medical Staff Bylaws Section 6.4-4(a).

25. Late entries, addendums or corrections to the medical record
    a. Documentation shall be recorded timely within the patient's medical record. When this is not possible a late entry, addendum, or correction will be made with the following required elements documented:
        i. A late entry, addendum or correction to the medical record, bears the current date of the entry and is signed by the person making the change or addition to the medical record.
        ii. A late entry supplies additional information that was omitted from the original entry. A late entry bears the current date and is added as soon as possible after the original entry was entered.
        iii. An addendum is used to provide information that was not made at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.
        iv. When making a correction to the medical record, the original entry must remain viewable. Documentation of the correct information should contain the current date and time and reference back to the original entry.
    b. It is not permitted to have entries "backdated" or "predated".
    c. The chart shall be completed within fourteen (14) days of discharge; it is expected no

late entries will appear after this time period.

E. **FORM(S):**

1. Electronic Signature Certification Statement - Sample

SAMPLE

Tri-City Medical Center

ELECTRONIC SIGNATURE CERTIFICATION STATEMENT

The purpose of this form is to certify that each physician identifier is kept confidential. This form also certifies that Tri-City Medical Center is committed to maintaining the confidentiality of the physician identifiers. If it is determined that an assigned identifier has been misused, the authorized hospital official will terminate a physician's use of his or her identifier.

The term 'misused' is defined to mean that the physician has allowed another person or persons to use his or her personally assigned identifier. Any proof of misuse must be documented by the authorized hospital official and actions to terminate the use of the physician identifier must be initiated immediately, including written notice to the physician involved.

PHYSICIAN CERTIFICATION:
I certify I will not disclose the identifier assigned to me to any other person or permit another person to use it.

_____ _____
Physician Signature Date

_____
Physician Name (Printed)

TRI-CITY MEDICAL CENTER CERTIFICATION
I certify that the identifiers assigned to physicians for purposes of the Compass Physician Inbox electronic signature process will be kept confidential and that I will terminate the use of a physician's identifier in the event that he or she misuses it.

_____ _____
TCMC Authorized Representative Date

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 08/03

SUBJECT: Standards for Seed Implants in the OR

REVISION DATE(S): 03/08, 02/19

POLICY NUMBER: 8710 – 524

Medical staff Department Approval:	~~07/17~~12/21
Department of Medicine Approval:	~~10/17~~03/22
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~04/22
Administration Approval:	~~01/19~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **STANDARDS:**

1. All cases involving Seed Implantation must meet the following minimum criteria for adequate facilities and physician skills:
   a. The minimum criterion for the facility is:
      i. Sonographic Equipment
      ii. A large Field of View image intensifier (15 or 16 inches) * with a 1024 matrix.
      iii. Appropriate supply of seed implants as determined by the radiation oncologist.
      iv. Appropriate level of sterility.
      v. Adequate space and facilities for anesthesia.
      vi. Circulating Registered Nurse (RN).
      vii. Scrub Technician or Scrub RN.
      viii. Radiologic technologist.
   b. The criterion for physician skills is:
      i. Interventional Radiologist must have current independent (has been released from proctoring) Tri-City Healthcare District (TCHD) privileges for placement of seed implants.
      ii. Interventional Radiologist must have met the minimum criteria for device-specific training/certification as defined by the manufactures of the device.
      iii. During all cases at least one physician credentialed in Interventional Radiology and one physician credentialed in Radiation Oncology must be present.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Abbreviations

ISSUE DATE: 08/96
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 05/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/14~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define the list of abbreviations applicable to Outpatient Behavioral Health.

B. **POLICY:**
1. When documenting in the patient medical record, clinical staff may use the following Program and the hospital approved abbreviations.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical Staff.

D. **RELATED DOCUMENT(S):**
1. Outpatient Behavioral Health Abbreviation List
2. Patient Care Services Policy: Abbreviations, Use Of

E. **EXTERNAL LINK(S):**
1. Neil-Davis Medical Abbreviation - MedAbbrev.com

Outpatient Behavioral Health Abbreviation List

Approved List

Abbreviation	Word(s)
ψ	Psychiatric
- with a circle	Negative
+ with a circle	Positive
B & C	Board and Care
BHOS	Behavioral Health Outpatient Services
CC	Clinical Coordinator
CLC	Community Liaison Coordinator
Clt	Client
CM	Clinical Manager
DR	Dual Recovery
EFR	Early Full Remission
EPR	Early Partial Remission
F with a circle around it	Father
ITP	Initial Treatment Plan
M with a circle around it	Mother
MFT or MFTI	Marriage and Family Therapist (Intern)
PI	Paranoid Ideation
RI	Resulting In
RCF	Residential Care Facility
SFR	Sustained Full Remission
SPR	Sustained Partial Remission
Th	Therapist
TPR	Treatment Plan Review

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Admission and Eligibility Criteria**

ISSUE DATE: **08/96**

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. Define the clinical criteria which determine eligibility for admission to the Behavioral Health Outpatient Services.

B. **POLICY:**

1. Persons may be admitted to the Behavioral Health Outpatient Services if they meet specific clinical criteria related to diagnosis, type of impairment and severity of impairment. The specific criteria are listed below. Generally, the criteria require the presence of a serious mental illness, significant functional impairment and a course of illness which, absent the proposed treatment, would likely result in psychiatric hospitalization.
2. Exclusion criteria generally relate to conditions in which the level of clinical risk warrants inpatient hospitalization, situations in which treatment could be reasonably provided at a less intensive level of care or there is an unstable non-psychiatric medical condition which cannot be appropriately managed in an outpatient setting.

C. **PRIMARY DIAGNOSTIC CATEGORIES:**

1. Serious Mental Illness-Diagnostic Criteria:
   a. Schizophrenia and Other Psychotic Disorders
   b. Anxiety Disorders
   c. Mood Disorders
   d. Somatoform Disorders
   e. Eating Disorders
   f. Personality Disorders
   g. Other Diagnostic Categories that significantly impair functioning and are authorized for treatment at IOP level of care.

D. **ADMISSION ELIGIBILITY CRITERIA:**

1. Current exacerbation of ~~symptoms of Axis I diagnosis~~**psychiatric symptoms**
2. Functional impairment resulting in difficulty performing ADL's
3. Treatment at lower level of care has been unsuccessful
4. Severity of the current symptoms is such that success resulting from a lower level of care is doubtful
5. Reasonable expectation that symptoms, behaviors and functional levels can be stabilized or improved
6. Risk to self, others, or property is present but is such that patient can be managed with the structure and support of the program

7. Despite the degree of impairment present, patient has sufficient intact functioning to benefit from an active treatment program (e.g. any cognitive deficit or other diagnosis indicating organicity will not preclude the patient from successful treatment.)
~~8. An adequate support system outside the program exists or patient is capable of creating such a support network~~
~~9.~~**8.** Recently discharged from an inpatient psychiatric hospitalization and requires this level of care to assist in reintegration into the community
~~10.~~**9.** Patient is capable of regularly attending program per treatment planning schedule

E. **CONTINUED STAY ELIGIBILITY:**
1. Persistence ~~of Axis I~~**psychiatric** symptomatology
2. Persistence of impairment in social, familial, residential, or vocational functioning.
3. ~~Persistent inability to perform~~**Psychiatric symptoms continue to negatively impact** ADL's
4. Continues to be reasonable expectation that patient will improve or be stabilized within a reasonable time frame
~~4.~~**5. Improvement in this context is measured by comparing the effect of continuing treatment versus discontinuing it; where there is reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further or require hospitalization, this criterion would be met.**
~~5.~~**6.** Patient is **attending and** participating in program **and showing a capacity to benefit.**
~~6. Patient is capable of attending program (including groups) per treatment plan~~
~~7. Patient is showing capacity to benefit~~

F. **EXCLUSIONARY CRITERIA:**
1. Deterioration in functioning represents a situational crisis, unrelated to the psychiatric condition
2. Patient is actively and seriously suicidal
3. Patient is actively and seriously homicidal or poses a threat of harm to others.
4. Patient is medically unstable
5. Patient has ~~dissocial~~ **antisocial** personality disorder or strong ~~dissocial~~ **antisocial** personality traits
6. Patient unable to follow ground rules (e.g. verbally/physically abusive to others)
7. Symptoms are transient and self-limiting
8. Patient requires inpatient level of care due to severity of psychiatric conditions
9. Current symptoms and impairment can be adequately managed at lower level of care
10. No reasonable expectation that condition can be stabilized or improved
11. Multiple absenteeism (from groups or program) and/or non-participation in program interfere with patient's ability to benefit from program
12. Substance abuse interferes with ability to benefit from Program
13. Program physicians unwilling to treat patient due to treatment non-adherence

G. **DISCHARGE CRITERIA:**
1. Symptoms/Impairments have decreased to a level indicating patient no longer requires treatment for their illness
2. Symptoms/impairments have been stabilized or patient is back to baseline
3. Patient is in need of or ready for a more intensive or less restrictive level of care
4. Patient is not able to benefit from the program
5. There is no reasonable expectation for improvement
6. Patient has achieved their established program goals and would not benefit from additional treatment goals
7. Patient is a danger to self or others and cannot be effectively or safely managed within the program needing a higher level of care
8. Patient does not have the capacity to benefit from program
9. Patient is not participating and/or not attending per treatment plan
10. Patient has achieved maximum benefit from this level of care
11. Patient presents a threat (physical or verbal) to the safety of the milieu

~~H. REFERENCE(S):~~

~~1.~~12. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Admission Assessment**

ISSUE DATE: **08/96**

REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**

1. To identify the guidelines for the Psychiatric Admission Assessment.

B. **PROCEDURE**

1. Who may perform/responsible: Attending Psychiatrist
2. The Psychiatric Admission Assessment (or update of recent workup done within the last 90 days) must be completed by the attending physician within five program days (seven calendar days) from date of admission to the Intensive Outpatient Program and within 24 hours of admission to the Partial Hospitalization Program. ~~The Assessment should be filed in the chart and becomes a permanent part of the medical record.~~
3. If the patient has been discharged from an in-patient psychiatric setting fourteen (14) days prior to admission to Outpatient Behavioral Health Services (OPBHS), then the Discharge Summary from that hospitalization may be copied and placed in the patient's medical record in lieu of the Psychiatric Admission Assessment, with an update by the attending Program physician. Though preferable, it is not mandatory that the assessment be completed at the actual location of the Program.
4. An update to a recent work up or discharge summary should include the following:
   a. Reason for re-referral: information referencing recent hospitalization
   b. Current mental status
   c. Current Diagnosis, Axes I through V
   d. Plan of treatment including number of days per week of attendance, goals and medications
   e. Discharge plan

~~5. The physician reviews and signs the dictated assessment for content and thoroughness.~~

~~6.~~5. The physician~~,~~ **therapist and patient collaborate to help aid in the** ~~informs the primary therapist of any additional significant information so that the therapist has information from the admission assessment to~~ develop**ment** a thorough Master Treatment Plan~~.~~

~~7.~~6. The physician ~~should~~ **may** have the following information available to aid in the completion of the Psychiatric Admission Assessment:
   a. Community Liaison Coordinator (CLC) Referral and Screening Report
   b. Attempts will be made to obtain collateral including prior Program admission, treatment, and discharge information; last psychiatric inpatient hospital admission notes, history and physical, discharge summaries, medication sheet, and relevant treatment notes current psychosocial summary, face sheet, etc.
   c. The CLC or Registered Nurse (RN) provides a brief presentation of the patient to the

treatment team prior to admission.

~~8.~~7. It is critical that prior level of functioning and recent acute change in mental status be documented in the assessment in order to demonstrate current need for OPBHS. It is important that the physician be specific with regard to treatment plan recommendations so that physician driven treatment is evidenced.

~~9.~~8. If the patient is a re-admission, the above guidelines for the Psychiatric Admission Assessment should be followed. A copy of the prior assessment or discharge summary and the update should be filed in the patient's chart in the assessment section.

~~C. **REFERENCE(S):**~~

~~1. California Hospital Association (2017). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Age Appropriate Care**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~09/17~~ n/a**
Board of Directors Approval:	**09/17**

A. **PURPOSE:**

1. To provide guidelines to meet the age specific care needs of the patient and educate their caregiver and/or family.

B. **POLICY:**

1. Outpatient Behavioral Health Services (OPBHS) serves adults eighteen (18) and older. Efforts must be made to individualize the program to meet the specific needs of individuals and address age-related issues. Older adults may attend specialized groups to address issues related to their specific age group, such as aging and grief and loss issues. Likewise, young adults may be scheduled for groups with individuals of similar age to address issues that may arise for their age group, such as academic or job-related concerns. All employees shall demonstrate the skills and knowledge required to provide care appropriate to the age of the patients served. Caregiver/family shall be involved in treatment to meet the age specific needs of the patient.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS staff.
   a. Educational information including the principles of growth and development will be provided during orientation.
   b. The knowledge and skills necessary for providing age specific care will be reviewed annually.
   c. Knowledge, skill base, and ability to provide care appropriate to the age of the patient will be evaluated during orientation and at each annual performance review.
   d. Employees will include family/caregiver, as appropriate, in meeting age specific needs of the patient.
   e. Treatment approaches will be modified to meet the age specific physiological, psychological, educational and social needs of the patient.
   f. Medications will be prescribed in age appropriate medication dosages; therapeutic ranges can be obtained from the pharmacy and laboratory department as needed.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Clinical Assessment**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. To identify the core assessments that must be completed for all patients entering the program and to identify optional special assessments which are completed, as necessary, by physician's/Allied Health Professional's (AHP) order.

B. **POLICY:**

1. All patients admitted to the program will routinely have an Admission Psychiatric Assessment, and a Biopsychosocial Assessment, which includes a Nursing Assessment and psychosocial assessment.

C. **PROCEDURES:**

1. Who may perform/responsible: Physicians, Therapy, and Nursing Staff
2. Intensive Outpatient Program Services:
   a. All core assessments will be completed by appropriately licensed and qualified personnel using Tri-City Healthcare District (TCHD) approved **electronic** medical records **or downtime** forms.
   b. Though the Psychosocial and Nursing Assessments are routine and part of the core assessments, they should be checked as ordered on the Physician Admission Order. ~~All assessments~~**Assessments** will include findings and treatment recommendations, which will take into consideration patient strengths. Prior assessments that are less than six months old may be updated and placed in the medical record.
   c. ~~All dual diagnosis patients receive a~~**All patients will be assessed for** substance abuse ~~assessment~~.
   d. All new patients will undergo a suicide **risk** assessment at intake and as needed during their treatment.
   e. If the patient is a re-admission and the prior assessments are less than six months old, an update can be written and attached to the original assessment and placed in the medical record.
   f. A general health statement by the attending psychiatrist or patient's medical doctor must be made on admission. If the patient has been hospitalized within the last 30 days for any reason, an effort must be made to obtain a copy of the H & P and any other pertinent data.
   g. If there are any special assessments**, such as the PHQ-9, GAD-7, PCL 5, or BPRS,** needed for diagnostic purposes, they are to be indicated on the Physician Admission Order.

h. If qualified personnel are not available on staff, then arrangements will be made for the special assessments to be completed by appropriately qualified independent practitioners.

D. **BIOPSYCHOSOCIAL ASSESSMENT AND ADMIT NOTE: OVERVIEW:**

1. Part A **Nursing Assessment:**
   a. Part A of the Biopsychosocial Assessment is the Nursing Assessment and it is completed within 24 hours of admission by the Program Registered Nurse (RN). It should speak to medical necessity for admission and provide information to be considered in the development of the Initial and the Master Treatment Plan. In addition, it should address medical concerns and medical diagnoses to be followed regularly.
   b. Part A of the Biopsychosocial Assessment shall contain patient identification and diagnosis and the following:
      i. Physical Data
      ii. Allergies and Sensitivities
      iii. Current Medications and Compliance
      iv. Nutritional Screening and History with a subsequent referral index for dietitian referral potential
      v. Functional Assessment
      vi. Sensory/Communication assessment
      vii. Surgical history
      viii. Medical Problems/History and Falls Risk Assessment
      ix. Contagious Diseases/exposure
      x. Pain Screening and subsequent Assessment with potential for reassessment
      xi. Suicidal and Homicidal Assessment: If at risk, safety goals will be initialed.
      ~~xii. Summary of Impressions to include recommendations for f/u for any Axis III diagnosis~~
      ~~xiii.~~**xii.** Fall Risk Assessment: If fall risk is indicated, then Fall Risk goals will be initiated along with treatment interventions

2. Part B: **Psychosocial Assessment**
   a. Part B of the Biopsychosocial Assessment is the Psychosocial Assessment and can be used as a rapport building opportunity between the Therapist and the patient. It is recommended, however, that it be conducted after the patient has had a few days to acclimate to the program but within one week of admission. It is also preferable that some rapport building occur between the Therapist and the patient prior to the assessment as the level of trust and the level of self-disclosure may be greater.
   b. This assessment should also be used as a springboard for exploring with the patient specific treatment plan problems and goals. This discussion should provide the patient with a thorough understanding of how a treatment plan is developed and revised and the role of the patient as an active participant in the treatment planning process. It may be useful during this discussion to share with the patient the impressions and recommendations of team members based on other assessments (e.g., the Psychiatric Admission Assessment; Part A of the Biopsychosocial Assessment) as you and the patient begin exploring potential treatment plan problems and goal areas. In doing so, the patient can perhaps better understand the connection between the assessment process and the treatment plan. Include in this discussion how the identified strengths of the patient will be incorporated into the treatment plan and reinforce patient active participation in the process.
   c. Part B of the Biopsychosocial shall contain the following:
      i. Source of information
      ii. Family relationships and current living arrangements
      iii. Brief psychiatric history
      iv. Developmental and family of origin history
      v. Ethnicity and Sexuality
      vi. Spirituality

vii. Substance Use History
viii. Adult social history
ix. Education / Learning ability
x. Employment / Vocational data
xi. Legal history
xii. Financial resources / Community support needs
xiii. Military Service history
xiv. Risk factors / Violent behavior / Abuse history
xv. Additional observations and/or Special needs

3. An admission note should also be included in the chart. This provides an introduction of the patient to the various team members in the narrative form. It should emphasize the reason for referral, recent change in mental status, and symptomatology. All of these support medical necessity for admission and help paint a clear picture for why the patient is being admitted to the program.
4. When a patient is a re-admission to the program and has had a full Behavioral Health Outpatient Services Biopsychosocial Assessment completed within the past 6 months, the Therapist has the option of simply updating Part B of the assessment. To do this, one needs to review the prior Biopsychosocial Assessment and, using an individual note, include any updated information. A copy of the prior Biopsychosocial Assessment and the new update page should be filed in the section of the chart for assessments. If the prior Biopsychosocial Assessment is more than 6 months old, a new Biopsychosocial Assessment must be completed for the re-admission.

E. ADMISSION NOTE OUTLINE:

1. Admission to include:
   a. Note: to be completed on day of admission
   b. Demographics (age, race, sex, who accompanied)
   c. Brief rationale for present admission to the program: Include observable psychiatric symptomatology and functional impairment.
   d. Remarkable observations of mood, affect, behavior
   e. Suicidal / homicidal / assaultive ideation or gestures upon presentation
   f. Patient Orientation to therapeutic milieu, schedule, staff, and Program (per Outpatient Behavioral Health: Orientation of New Patients Policy).

F. RELATED DOCUMENT(S):

1. Outpatient Behavioral Health Policy: Orientation of New Patients

~~G. REFERENCE(S):~~

~~1. California Hospital Association (2017). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.~~
~~2. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Contraband**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To maintain patient and staff safety within Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Contraband items are not allowed in program. Contraband is defined as items that can be injurious to self or others. Contraband includes weapons or potential weapons, illegal drugs and alcohol. Medications that are not needed during program hours are also considered contraband.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff
2. Contraband brought to the OPBHS will be removed from patient access and stored in a secure area. These items may be returned at the end of the day and the patient escorted out of the building. Contraband will be returned only if the Program Administrator feels that possession of the contraband item will not pose a threat to the patient or others. Items that are illegal to possess, such as illegal drugs and firearms, will be securely stored until their appropriate disposition is determined. The Operations Manager will notify the Director of Behavioral Health.
3. Patients who bring contraband to the OPBHS will be given one warning not to bring the item(s) back. Repeated violations of the contraband policy will result in suspension from the Program until the patient meets with his/her Therapist and the Operations Manager. At that time, the patient's noncompliance will be discussed as a treatment issue. A treatment contract will be written and the patient may be rescheduled if he/she agrees to stop bringing contraband to OPBHS.
4. Continued violations of the contraband policy may result in the patient's discharge from OPBHS.
5. If the patient refuses to relinquish the contraband, he/she shall be told to leave the premises and the attending physician shall be notified.
6. The incident should be documented on a Quality Review Report, and as applicable, in the patient's record along with the action taken.

D. **RELATED DOCUMENT(S):**
1. Security Policy: Seized Evidence or Contraband 231

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Daily Progress Notes**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**

1. To provide guidelines for the documentation of patient progress in the Outpatient Behavioral Health Services (OPBHS) Program.

B. **POLICY**

1. The Program is required by the fiscal intermediary to document progress for each intervention provided. The treatment plan problems can be identified within each note. Each intervention should be identified in terms of the focus, modality and the format and the facilitator / therapist name and credentials. Specific goals for each intervention, as well as symptoms, behaviors and/or responses should be documented.
2. Individual Therapy, a Family Session, and Crisis Intervention should also be documented as it occurs. Specific treatment, outcomes, and goals of the session should be documented in narrative form as an Interdisciplinary Progress Note.

C. **PROCEDURE**

1. Who may perform/responsible: Clinical Staff and Physicians
2. Per Service Notes:
   a. The note must clearly show how the various groups the patient is attending are focused on treating his/her specific psychiatric problems. The documentation must illustrate how the treatment relates to the problems stated in the treatment plan, what kind of improvement is shown and what still needs to be improved. Progress notes must reflect active treatment.
   b. When charting, refer to observable symptomatology, staff interventions and response/progress noted.
   c. Physicians should document patient progress toward treatment goals, need for continued treatment and discharge readiness.
3. Charting Basics:
   a. Individual and group therapy session notes should be entered in the electrnic medical record system.
   ~~a.~~b. In case of downtime, use downtime forms and u~~U~~se black ~~ink in the absence of an electronic form.~~ink.
   ~~b.~~c. Date and sign all documentation.
   ~~c.~~d. Write legibly.
   ~~d.~~e. Clinical staff must document daily on groups attended and patient progress/participation in the groups.

~~e.~~**f.** Special notes (i.e., nursing notes, **non-billable and collateral contacts**) are identified as such.

~~f.~~**g.** Charting needs to be descriptive, not interpretative. When documenting, include observed behaviors and patient statements.

~~g.~~**h.** Document all treatment rendered to the patient and the patient's response. Any quotations used are to be brief and relevant to the patient's problems.

~~h.~~**i.** Make chronological entries of the patient's clinical course - late entries must be identified as such.

~~i.~~**j.** All entries in the MR are completed by the writer.

~~j.~~**k.** On paper forms, errors must be indicated by using one line through the incorrect documentation, write "error" over the line, and initial the error. Never use white-out.

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

~~1. California Hospital Association (2017). California Hospital Consent Manual. Sacramento, CA: California Hospital Association.~~

~~2.~~4. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: ~~Destructive~~ **Aggressive or Potentially Violent Behavior**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE**
1. To protect the safety of patients, staff, and visitors.

B. **POLICY**
1. All ~~destructive~~ **aggressive** and/or potentially violent behavior will be dealt with immediately to prevent any harm to patients, staff and visitors.

C. **PROCEDURE**
1. Who may perform/responsible: Outpatient Behavioral Health Services (OPBHS) Staff
2. To maintain safety, any signs of escalation, increased psychiatric symptoms, or increased agitation need to be addressed immediately and if possible identified in the morning patient review meeting.
3. Staff is to contact 911 using the black emergency phone if there are any signs of danger, and risk to patients and staff members.
4. Staff is to attempt to remove the agitated patient away from other patients by calmly walking him/her away from other patients and toward a safe area where the patient and the therapist can escape easily.
5. If the patient refuses to leave group, staff is to instruct other patients to leave the group room.
6. Staff member is to request help from other available staff by sending a patient for assistance or using the whistle/walkie-talkie **or phones** to alert staff of danger.
~~6.~~**7.** **If the patient is in a Telehealth group, staff may remove an aggressive patient from the group, if necessary and must follow up with a phone call to assess for safety.**
~~7.~~**8.** The use of the whistle/walkie-talkie is a last resort to obtain help and only after failed attempts to de-escalate the patient or remove him/her from the group. Premature use of the whistle can further escalate an agitated or angry patient.
~~8.~~**9.** Staff, along with the operations manager or clinical coordinator will gather all information regarding the threatening behavior and assess the patient's mental status.
~~9.~~**10.** Implement the most appropriate response, which may be a time out, verbal de-escalation techniques, suspension, 911 call, or inpatient hospitalization.
~~10.~~**11.** If inpatient admission is required, follow the procedure outlined in the Patient Care Services: Admission Psychiatric Patients Policy and contact the program psychiatrist.
~~11.~~**12.** Physical restraint is not used as a clinical intervention. If a patient becomes violent 911 must be called immediately and the patient must be allowed to escape.
~~12.~~**13.** To help de-escalate the agitated or angry patient, staff is to calmly communicate the intent to help the patient, convey empathy, and attempt to remove the patient from group or milieu.

~~13.~~**14.** Staff must take safety precautions by sitting close to an exit, ensuring that they have an escape, and not placing self at risk by meeting with an agitated patient alone, walking in front of a patient that is agitated, or blocking the patient from escape.

~~14.~~**15.** The Operations Manager or designee will meet with all staff and patients involved to process the incident and address safety concerns. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.

~~15.~~**16.** Staff is to complete the on-line Quality Review forms, when necessary, and report any safety issues or violent behavior to the CNE and Risk Management department.

~~16.~~**17.** Staff is to document the incident and staff response in the patient's medical record.

~~17.~~**18.** Staff will discuss the incident in the treatment team meeting with the physician to determine the best course of action and to assess whether the patient is appropriate in the intensive outpatient program.

~~18.~~**19.** Patients that are unable to control anger and pose a risk to other patients or staff are not appropriate for Outpatient Level of Care and must be referred to a more appropriate setting.

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

1. Behavioral Health Services Policy: Management of Aggressive and Assaultive Behavior
2. Patient Care Services Policy: Admission Psychiatric Patients

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Disaster Plan**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To insure efficient Outpatient Behavioral Health Services (OPBHS) disaster procedures and to maintain adequate availability of personnel in the event of disaster.

B. **INTRODUCTION:**
1. Due to the varying types and magnitudes of emergency events, Tri-City Health Care District (TCHD) has adopted the command structure of Hospital Incident Command Systems (HICS) the decision has been made to activate the disaster plan, the HICS becomes the standard operating procedure. The complete plan is located in the Environment of Care: Safety Plan Policy.

C. **NOTIFICATION:**
1. OPBHS will be notified of the main house Disaster Plan activation by telephone, cell phone, and/or email.

D. **DISASTER PLAN PROCEDURES:**
1. Operations Manager Responsibilities:
   a. The Operations Manager will take direction from the Director of Behavioral Health/**Chief Nurse Executive** and Safety Officer who has assessed the nature and extent of the disaster. In the event of the absence of the Operations Manager the Clinical ~~Coordinator~~**Supervisor** will assume the leadership role.
   b. The Operations Manager will complete the Personnel Inventory Form or make a list of all available staff and be prepared to send it to the HICS center at the main house, should it be requested.
      i. Note: Personnel Inventory Forms are found in the Safety and Disaster Manual. The Incident Command Center is located in the French Rooms.
   c. The Operations Manager will assemble all available staff to inform them of disaster procedures and standby to report to disaster priority areas at the main house in the event OPBHS staff is needed in the main House (after all OPBHS patients have been safely transported to their residences).
   d. The Operations Manager will designate one Administrative staff to contact all non-present staff of the disaster and prepare for call-in procedures should they be required.
   e. The Operations Manager **or designee** will contact ~~the Patient Transport Express and the Dispatcher if he/she is not present in the building to alert him/her to ready the vans for early departure from Program if the disaster allows for patients to be transported.~~**transportation vendors or PTE to ensure that patients are trasnsported safey to their homes.**

f. The Operations Manager will relay as much information as possible to the Incident Command Center.

2. Registered Nurse (RN) Responsibilities:
   a. RN's will notify the residential care providers of the disaster procedures and inform them that their residents will be leaving Program early.
   b. RN's will call Program physicians to inform them of the disaster procedures~~, and to obtain orders.~~.
3. Therapist Responsibilities:
   a. The Therapists will ~~assemble the patients in the Community Room to~~ inform ~~them~~ **patients** of the disaster procedures and ~~to organize them for~~**coordinate** departure from Program if they can exit safely.
   b. The Therapists will begin calling family members, Case Managers and Conservators to inform them of Program Closure for the day and the possibility of continued Program closure until the disaster has cleared.
   c. Therapists will attend to the medical records to insure that they are in proper order and the documentation is current~~ before securing them in the Chart Room~~.
   d. In the event patients cannot be safely exited from the Program and delivered to their residences by hospital vans, they will be contained within the building until notified of safe departure. Appropriate de-escalation techniques will be utilized to allay panic.
4. Dispatcher and Drivers:
   a. **If available, t**~~T~~he Dispatcher will contact Patient Transport Express supervisor to collaborate with the PTE Supervisor about the needs of the vans throughout the hospital.
   b. The Dispatcher will contact all available drivers to alert them for the possibility of reporting for duty.
   c. The Dispatcher will assemble the drivers on site and distribute the route sheets appropriately.
   d. The Drivers will safely transport patients to their residences as per the route sheets and return to base at the hospital.
5. Administrative and Support Staff:
   a. The Administrative and Support Staff will take direction from the Operations Manager who has assessed the need within the building.
   b. Administrative and Support staff will respond to phone calls and direct callers appropriately.
   c. The Administrative and Support staff will assist the Therapists and Drivers in boarding the patients on the vans.

E. **RELATED DOCUMENT(S):**
1. Emergency Operations Procedure: Emergency Operations Plan
2. Environment of Care Policy: Safety Plan

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Discharge Planning and Discharge

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE**

1. To define the discharge process as an integral part of treatment.

B. **POLICY**

1. Discharge planning will be an organized, coordinated process, with interdisciplinary treatment team, patient, physician and family/significant other input. The process identifies the patient's needs before and after discharge, delineates plans to meet these needs and engages the patient and family members in the process of plan implementation. Discharge planning will begin on admission.
2. Discharge criteria are tied to the long-term goals and will be established during the development of the Master Treatment Plan (MTP). At each treatment plan Update, the discharge criteria will be reviewed and modified as necessary, depending upon the rate of progress (or lack of progress) in treatment. A rationale for each change will be documented.
3. If a patient does not respond favorably to the Program or does not seem to be benefiting from the prescribed course of treatment, the issue is taken to the treatment team meeting to determine appropriateness of the treatment and identify possible changes in treatment plan or possible alternative referrals. However, lack of progress in treatment does not automatically imply the necessity for discharge. Treatment goals need to be re-evaluated and every effort must be put forth to insure that identified problems and target dates are appropriate and reasonable, prior to considering discharge.
4. Circumstances warranting discharge may include:
    a. Attainment of treatment goals, including a significant reduction in symptoms and functional impairment.
    b. Continued abusive and/or aggressive behaviors after clinical/behavioral interventions fail.
    c. Repeated substance abuse, after treatment interventions have been tried, to a point that substance abuse substantially interferes with the team's ability to address the primary Axis I diagnosis and patient does not appear to work towards harm reduction or abstinence as a goal.
    d. Repeated non-compliance with treatment or program rules.
    e. Discharge to inpatient due to:
        i. Suicide attempt or ~~high~~ **imminent** risk of suicide;
        ii. Serious injury;
        iii. Accidental injury;
        iv. Acute exacerbation of symptoms;
        v. Danger to others.

5. Patient refusal to continue in treatment.
   a. When patient ~~refuses~~ **declines** to continue in treatment, follow-up efforts will be made by the Therapist;
6. The patient will be discussed at the treatment team meeting and interventions planned in an effort to re-engage patient;
   a. Patients may be administratively discharged if they do not attend the Program on a regular basis and ~~have failed to~~ **do not** respond to repeated attempts to re-engage; and Program physician may discharge the patient due to lack of follow through with treatment recommendations.
7. All anticipated discharges from the Program will be discussed with the physician and significant others involved in the patient's care, before a discharge decision is made.
8. ~~The focus of discharge planning is to assist patients in achieving and maintaining their goals. This will be provided on a group/individual basis and will be related to the treatment plan. Assessing the potential of each individual, evaluating his/her progress in overcoming deficits, and counseling the patient to develop expectations for him/herself will be an ongoing part of treatment. Planning for a smooth transition from the Program will also be an ongoing part of treatment.~~**Indivdiual and group sessions will be utilized to assist patients in achieving and maintaining treatment goals and planning for a smooth transition from the Program.**

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical Staff
2. Patient progress toward goals and appropriateness for discharge will be discussed in treatment team meetings and the discharge plan will also be reviewed at the treatment team meeting.
3. A plan of transition will be developed, which includes contacting the appropriate referral agency, establishing a time-line for discharge from the program, actively involving the patient in the planning and a subsequent decrease in treatment days.
4. The plan of transition will be developed to limit the potential for separation related stress and/or increased symptomatology. The plan will be discussed with, and agreed upon by the patient.
5. When the transition is complete, with the approval of the treating psychiatrist, patient, and the treatment team, the patient will be discharged from the Program.
6. When discharging a patient:
   a. Complete the discharge checklist on the day of discharge
   b. Complete the **Discharge/**Aftercare plan, to include the discharge medications, discharge instructions, and follow up care. In the case of an unanticipated discharge, mail the patient and caregiver a copy of this Aftercare plan.
   c. Audit the chart and check for:
      i. ~~All pages~~**all downtime and paper forms** labeled/identified with name of patient, date of birth, date of admission, attending physician and Medical Record number;
      ii. All progress notes completed, dated and signed;
      iii. All orders noted and signed;
      iv. physician progress notes and treatment plan reviews are current
   d. The complete discharge summary must be written ~~and signed~~ within 3 days by the ~~physician/Allied Health Professional (AHP) on their next scheduled day~~**therapist**.
7. The medical record may be retained on site for up to ~~ten~~ **seven** days.
8. The discharge audit form is completed by the therapist within five days of discharge. The chart will then be sent to Medical Records to be scanned.

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

~~California Hospital Association (2017). *California Hospital Consent Manual.* Sacramento, CA: California Hospital Association.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Family Involvement

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE**
1. To identify the role of the family in the patient's treatment.

B. **POLICY**
1. When appropriate, the patient's family and or significant others will be involved in the patient's treatment.

C. **PROCEDURE**
1. Who may perform/responsible: Clinical staff
2. At the time of screening, the Community Liaison Coordinator (CLC) will discuss the opportunity for family participation in treatment with the potential patient and the family when appropriate.
3. With the patient's consent, family members will be encouraged to participate in the treatment process by participating in family therapy sessions as ordered by the attending physician.
4. With the patient's consent, the family will also be involved in the discharge planning process.
5. A Release of Information must be signed by the patient before any interaction is initiated with the family or significant other, or before any information is provided to them.

D. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Patient and Family Education

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Laboratory Services

ISSUE DATE: 08/96
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**
1. To provide laboratory services for patients attending the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. OPBHS provides patients access to Tri-City Healthcare District (TCHD) laboratory services as ordered by the attending physician/Allied Health Professional (AHP) or medical consultant.

C. **PROCEDURES:**
1. Who may perform/responsible: Registered Nurse (RN) and Laboratory Staff
2. The RN notes the physician/AHP order for laboratory services and ~~completes the appropriate lab requisition form indicating that results are either to be faxed or printed at the program.~~**coordinates completion of lab services with the patient.**
3. The RN refers to the physician/AHP order and hospital lab for any special provisions or preparations (i.e. fasting; hold a.m. prescription) and instructs patients prior to lab work.
~~4. The RN arranges with the patient the date and time of laboratory procedures.~~
~~5. The RN provides the phlebotomist with the completed laboratory requisition forms and assists in identifying the patients scheduled for laboratory procedures.~~
~~6.~~4. Same sex staff should supervise collection from patients of specimens for drug and alcohol urine screenings.
~~7.~~5. The RN is responsible for correctly labeling the urine specimen and arranging for safe transport to the laboratory.
~~8.~~6. All staff handling urine specimen are to utilize Infection Control: Standard and Transmission-Based Precautions.
~~9. The physician/AHP signs lab results and the labs are filed in the lab section of the medical record.~~
~~10.~~7. In the event of a critical lab value, the RN contacts the physician/AHP immediately, and proceeds with physician/AHP orders.

D. **RELATED DOCUMENT(S):**
1. Infection Control Policy: Standard and Transmission-Based Precautions

~~E. REFERENCE(S):~~
~~1. Joint Commission Safety Manual~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Medical Emergencies**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define appropriate methods of handling emergency medical situations.

B. **POLICY:**
1. Medical emergencies are managed by Outpatient Behavioral Health Services (OPBHS) Registered Nurse (RN). All clinical staff assisting in medical emergencies is required to maintain current Basic Life Support (BLS) Certification.

C. **PROCEDURE:**
1. Who may perform/responsible: Nursing Staff
2. For minor injuries (i.e., superficial cuts and bruises), the patient will be evaluated by the RN on duty. First aid treatment is provided by the RN. The patient is referred to his/her primary care physician for follow-up, as necessary.
3. For acute medical conditions requiring immediate attention, the RN will arrange for the most appropriate type of transportation for the patient, to the nearest Emergency Department.
4. In cases of severe suicide attempts or medical emergency, the RN will initiate lifesaving procedures (i.e., CPR, direct pressure, etc.) and have a staff member immediately dial 911.
5. Any first aid or other medical services provided to the patient must be documented by the RN in the patient's medical record.

D. **RELATED DOCUMENT(S):**
1. Outpatient Infusion Center Policy: Medical Emergencies

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Organizational Structure**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To define lines of responsibility for clinical supervision and administrative supervision.

B. **POLICY:**
1. Outpatient Behavioral Health Services (OPBHS) staff operates using the guidelines of the organizational structure, and obtain both clinical and administrative supervision.

C. **PROCEDURES:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) Administrative Staff, Medical Directors, Operations Manager and Director of Behavioral Health or designee.
2. Clinical Supervision:
   a. All patients must be admitted by a psychiatrist who has the responsibility for supervising and periodically evaluating all treatment services provided to the patient under his/her care. The attending physician/Allied Health Professional (AHP) must also provide supervision and direction to any therapist involved in the client's treatment. The OPBHS Medical Director(s) has responsibility for overseeing and ensuring the quality of care provided to the patients. The Medical Director(s) reports administratively to the Operations Manager. The Medical Director(s) reports in all matters of a clinical nature to the TCHD Psychiatric Committee.
3. Administrative Supervision:
   a. The Operations Manager provides administrative supervision of all OPBHS staff and has administrative responsibility for all aspects of the OPBHS. The Operations Manager reports to the Director of Behavioral Health or CNE.
4. Site Management:
   a. Administrative and financial operation of the OPBHS is the responsibility of TCHD. The Operations Manager has responsibility for day to day operation of the site including staff recruitment, supervision, clinical services, nursing services, environmental maintenance, quality improvement and utilization of reviewed activities. Also included is monitoring of staff and physician documentation compliance and monitoring of compliance to all TCHD rules, policies and procedures.
   b. The Medical Director(s) has responsibility for overseeing the quality of medical care provided at the OPBHSs. The Medical Director(s) must be a Board Certified or Board Eligible Psychiatrist and be a member in good standing of the TCHD medical staff and a member of the appropriate TCHD medical committee. The Medical Director(s) attends weekly treatment planning meetings, clinical problem solving meetings and is available to the Operations Manager and staff to consult on cases, physician issues and clinical

programming. The Operations Manager and Registered Nurses (RNs) provide initial orientation and training of all Medical Director(s). The training includes:

i. responsibilities and duties of the Medical Director(s);
ii. documentation requirements;
iii. policies and procedures; and
iv. clinical program guidelines.

5. Quality Improvement and Utilization Review:
   a. The Operations Manager has responsibility for monitoring and reporting Quality Improvement and UR issues to TCHD Director of Behavioral Health and other medical staff committees. This includes an analysis of trends and a plan of correction when needed. Reports provide statistical analysis and trending of results across programs and recommend changes in programming, policies and procedures based upon an analysis of the results.
6. Personnel:
   a. Clinical and administrative personnel at OPBHS are TCHD employees. All employees must satisfy the personnel requirements set forth by TCHD (which may include) a pre-employment physical with a PPD test or chest x-ray. The operations Manager or designee provides an orientation for all new employees. Staff development is provided on a regular basis to all staff. The Operations Manager is responsible for overseeing compliance with:
      i. TCHD policies;
      ii. The Joint Commission, Medicare, or appropriate standards, and staff development requirements (i.e., TCHD orientation, Basic Life Support, fire/disaster training, etc.);
      iii. state and federal employee regulations; and
      iv. periodic and annual performance evaluations.
7. Community Development and Liaison (CLC):
   a. The CLC is responsible for screening each potential patient to determine clinical appropriateness for admission. The CLC also has responsibility for establishing and maintaining relationships with community agencies, residential care facilities, public and private mental health providers, advocacy groups and others involved in the treatment of the mental health patients in the community. The maintenance of these relationships is critical in providing a continuum of care for patients with psychiatric disabilities. Additionally, the CLC is responsible for developing community education programs for both professionals and non-professionals involved with patients.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Physician Admission Order**

ISSUE DATE: **08/96**
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To clarify what is necessary for admission to Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. Admission to the OPBHS must be upon the order of a program physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Tri-City Healthcare District (TCHD) credentialed physicians.
2. A Physician Admission Order must be received on the day the patient is admitted to the OPBHS.
3. The patient may be admitted with a telephone order but must be seen by the physician within seven days of admission to Intensive Outpatient and within 24 hours of admission to Partial Hospitalization Program.
4. All assessments, OPBHS interventions (group therapy, individual and family therapies) must be ordered by a program physician.
5. On admission, the physician orders the duration of treatment, based on medical need.
6. Admission to OPBHS requires a general health statement by the admitting physician, indicating medical stability.

D. **REFERENCE(S):**
1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Referral and Admission Screening**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. Define the referral and admission screening process.

B. **POLICY:**
1. Referrals for outpatient services are accepted from professional sources, through self-referral, from family members or from residential care providers. It is the responsibility of the Community Liaison Coordinator (CLC) (or his/her designated backup) to determine eligibility for service. All individuals that are in need of service should be evaluated as quickly as possible.
2. Whenever it is determined that a person, who is referred, is not eligible for services, it is the responsibility of the CLC to assure that an appropriate referral for alternative service(s) is made.
3. All persons accepted into the Program must meet admission criteria (see Outpatient Behavioral Health: Admission & Eligibility Criteria Policy).

C. **PROCEDURE:**
1. Who may perform/responsible: CLC or designee
2. At the point of initial referral contact, the CLC makes an initial determination of eligibility and legal status (if on conservatorship, the CLC obtains the conservator's consent to treat by the first day of admission to program). The CLC, along with the prospective patient, establishes a suitable time and location for admission screening. Screening may take place in an inpatient setting, at the patient's home, the program site, or other convenient location.
3. If the patient is referred by a non-psychiatrist, the CLC, after obtaining a release of information, contacts the psychiatrist currently working with the patient to determine if he/she agrees with the recommendation for treatment. The CLC inquiries about whether the community psychiatrist will continue to follow patient during treatment or if a program psychiatrist will follow the patient.
4. The CLC conducts a screening and completes the "Referral and Screening Report" to establish eligibility and appropriateness for admission, to identify any special issues or concerns and to gather all essential background information. The CLC obtains the "Authorization for Release of Information" which can be used to obtain copies of clinical records from previous treatment providers.
5. The CLC will meet with the Operations Manager, Clinical Coordinator, RN or designees to triage the potential admissions or to coordinate the admission process for any new patients.
6. The clinical staff will be briefed on all new admissions in the daily morning meeting. Briefing should include the patient's history and presenting problems.
7. The CLC will contact referral sources and the patient to advise them of specific admission activities, day and time. The CLC is responsible for assuring that arrangements for physician coverage have been finalized.

8. In the case of a program re-admission, if the patient has been discharged from the program for more than 30 days, the CLC will complete the Re-Assessment Screening Form. In the event that a patient is discharged from the program for a period less than 30 days and is referred back to the Program, a new CLC assessment may not be necessary. The physician's Admission assessment, Psychosocial Assessment, and Nursing Assessment will suffice.

D. **CLC REFERRAL AND SCREENING REPORT: OVERVIEW:**

1. This report is used by the CLC for the purpose of evaluating clinical eligibility for admission to the Program. It is an important component to the admission process and should be thoroughly completed. This report is a document included in the medical record (in the admission section), and it should be filled out completely. The medical director and attending physicians should use this report as part of their orientation to any potential admission prior to completion of the Psychiatric Admission Assessment. The final decision whether to admit the patient to program is the psychiatrist's.
2. The report should support medical necessity for this level of intensity of treatment by documented evidence which identifies: recent inpatient hospitalizations; failed efforts to ameliorate symptoms through outpatient services/lower level of care; recent change in acuity of psychiatric symptomatology; a description of decrease in functioning level; and, evidence that the individual meets the diagnostic inclusion criteria and criteria related to type and severity of impairment.
3. The first page of this report is used primarily for billing purposes, transportation, and Therapist orchestration of services. Diagnosis, history of illness and psychiatric treatment, current symptomology, current risk factors, and the clinical admission criteria and summary of impressions are detailed in the screening report.

E. **FORM(S):**

1. Authorization for Release of Information
2. Referral and Screening Report

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

1. Outpatient Behavioral Health Policy: Admission & Eligibility Criteria

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Role of the Therapist**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To delineate the responsibilities of the Therapist in the Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**
1. A therapist is defined as a qualified mental health clinician authorized by the state to provide services, such as a psychologist, licensed clinical social worker, marriage family therapist, licensed professional clinical counselor, or license eligible therapists with California Board of Behavioral health registration.
2. On admission, all patients are assigned a Therapist. The Therapist acts as the primary OPBHS treatment coordinator for the patient, coordinating all treatment services provided to the patient, under the direction of the attending physician.

C. **PROCEDURE:**
1. Who may perform/responsible: Clinical staff
2. Responsibilities of the Therapist:
   a. Care Coordination:
      i. Develops therapeutic relationship with individual patients in caseload. Schedules regular 1:1 interaction to review patient goals and progress;
      ii. For each patient in caseload, the therapist has regular documented contacts with others involved in the patients care (i.e., physician, family members, residential care providers, case managers, conservators, etc.). Acts as liaison, as necessary, for information regarding treatment issues, changes in treatment plan, discharge plan, etc. These contacts may be both by phone and in person;
      iii. Monitors patient attendance at treatment program, following up in a timely manner when attendance problems develop;
      iv. Gathers information, initiates and implements behavioral contracts as needed;
      v. Assists in obtaining insurance authorizations and counseling patient on funding issues, as needed;
      vi. Coordinates with attending physician all treatment plan changes, reviews patient progress and discharge plan; and
      vii. Maintains patient satisfaction with the treatment program.
   b. Treatment and Documentation:
      i. Facilitates group treatment modalities within scope of practice, as assigned by the Operations Manager, using approved curriculum and standard group facilitation techniques.

ii. Conducts initial assessment of new patients within caseload and develops the treatment plan with patient and team collaboration. Develops master treatment plans in a timely manner as prescribed by OPBHS policies and procedures, using data from all assessments and with approval from treatment team.
iii. Reviews and updates treatment plans for patients within caseload, as defined in the OPBHS policies and procedures.
iv. Utilizes treatment planning meetings to review problems, progress and discharge plans for all patients on caseload.
v. Documents progress on a daily basis for all patients in groups facilitated by a Therapist. Progress notes are accurate; refer to problems identified on the treatment plan, and address group focus and patient response as related to treatment goals. All documentation must be legible.
vi. Documents each incident or unusual occurrence at the time it happens.
vii. Monitors medical records, for all patients within caseload, to insure completeness and accuracy. Notifies Operations Manager of any deficiencies and develops a plan of correction.
viii. Completes discharge summaries for all patients on caseload as prescribed by OPBHS policies and procedures.

c. Other Duties:
i. Participates in public relations and educational activities as assigned by the Operations Manager.
ii. Assists in the evaluation of patients referred for admission to OPBHS, as requested by Operations Manager.

D. **REFERENCE(S):**

1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Scope of Services

ISSUE DATE: 08/96

REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 07/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **PURPOSE:**

1. To define the specific plan and staff qualifications necessary to provide treatment in the intensive outpatient and partial hospitalization Program (PHP). Intensive Outpatient Treatment is a level of care that provides treatment for individuals with psychiatric illness who continue to require structured treatment but of lesser intensity than is offered in Inpatient Behavioral Health Treatment. Partial hospitalization is a level of care that is more intensive than IOP, provided for patients exhibiting severe and disabling symptoms.

B. **POLICY:**

1. In providing treatment in the Intensive Outpatient Treatment and partial hospitalization programs, the goal of the Behavioral Health Outpatient Services is to provide psychiatric treatment to individuals with psychiatric illness as defined in the current DSM of the American Psychiatric Association, in a less restrictive setting than an inpatient unit. The benefits of this type of care include: lessening the disruption of social, family and community ties; encouraging the patient to test new skills in a more natural environment than a hospital setting; providing a treatment milieu that fosters independence and self-reliance; soliciting feedback from the home environment thereby involving the patient's family or care providers in the treatment process and providing cost-saving benefits through a shortening of the inpatient stay or preventing the need for full hospitalization.

C. **SERVICES OFFERED:**

1. The Program philosophy of care is based on the belief that individuals with psychiatric symptoms can achieve recovery, maintain stability, and reach their maximum rehabilitation potential through the provision of quality, goal oriented treatment. Outpatient Behavioral Health Services (OPBHS) provides a highly structured treatment environment that is predicated on personal responsibility, individual dignity and respect for self-determination. Individuals served in OPBHS attend groups and activities based on an individualized assessment of their needs. Each patient is encouraged to participate with the staff and physician in planning their treatment, setting realistic, obtainable goals and assessing their progress in the Program.
2. The OPBHS utilizes a blend of psychosocial rehabilitation and the medical model of treatment to help individuals achieve recovery. The Program is continually evaluated, utilizing feedback from physicians, staff, and patients; and evidenced-based information. The Program is responsive to the needs of the patients and the community standard of practice.
3. A highly trained and motivated staff is the key to maintaining a quality clinical Program. Staff development is promoted through a comprehensive orientation Program, ongoing in-service education and continuing educational opportunities. The philosophy revolves around the patient,

his/her unique needs and assisting the patient to cope more effectively with psychiatric symptoms and life stressors. Assessment of a person's needs is based on past history and present level of functioning. Every area is assessed including physical, psychological, social, spiritual and environmental, so that a treatment plan is designed specific to each patient's needs. Through individual and group experiences in the OPBHS, progress will be assessed and the treatment interventions modified, as needed, to accomplish the goals defined by the patient and the treatment team. The OPBHS are designed to provide a series of successful experiences, allowing the patient to utilize skills learned, that result in enhanced symptom management and personal empowerment.

D. **CLINICAL PROGRAM:**

1. The clinical Program is based on the principles of recovery, crisis stabilization, psychiatric rehabilitation and relapse prevention. Programming includes group psychotherapy and individual psychotherapy, focusing on recovery, life management skill building, symptom management, functional skills development, relapse prevention and developing/utilizing a community based support system. Dual Recovery groups are also provided for patients with Co-Occurring Mental Health and Substance Use Disorders.

E. **POPULATION SERVED:**

1. The OPBHS treats persons from the age of 18 and up who have a DSM psychiatric disorder with a primary ~~Axis I~~ diagnosis of Schizophrenia, or other psychotic disorders, Anxiety Disorders, Mood Disorders, Somatoform Disorders, Eating Disorders, Personality Disorders, and other Diagnostic Categories that significantly impact functioning.

F. **ACCESSING SERVICES:**

1. A person may enter the OPBHS in several ways:
2. Referral by a discharge planner as a follow-up to inpatient treatment;
3. Self-referral in coordination with a treating physician/Allied Health Professional (AHP) (If the patient is not currently in treatment with a psychiatrist, one will be assigned from the medical staff);
4. Community referral from a family member, board and care manager, conservator, social worker, or therapist.
5. Physician referral (The primary psychiatrist is encouraged to follow the patient while in treatment and a co-treatment option may be available).

G. **HOURS OF OPERATION:**

1. The OPBHS will provide three to four hours of clinical programming a day, Monday through Friday, except major holidays. Patients in IOP usually receive no more than twelve (12) units of service per week. Patients in the PHP can receive more services, up to four per day, five days per week. Some exceptions can be granted for brief periods if the level of symptoms increase, and the insurance care manager approves.

H. **SCREENING:**

1. When an individual is referred for treatment in the OPBHS, an appointment is set for an initial screening. This is performed by the Community Liaison Coordinator (CLC), but may be done by another health care professional on the staff. The purpose of the initial screening is to determine if the patient meets the clinical admission criteria for OPBHS (Admission & Eligibility Criteria policy). If the results of the initial screening indicate that the patient is not appropriate for this level of care, the referral source is contacted and an appropriate referral is made.

I. **ASSESSMENT AND EVALUATION:**

1. Upon admission to the OPBHS, an initial psychiatric assessment, nursing assessment, psychosocial assessment, suicide risk assessment, and if indicated, a substance abuse assessment will be completed. When a person is evaluated for treatment, the following information is obtained:

a. Past psychiatric history;
b. Current psychiatric/medical diagnosis and any medications being prescribed;
c. Current symptoms;
d. Risk for suicide;
e. Risk for Falls;
f. Substance abuse history;
g. Identification of patient's strengths; and
h. Any special considerations.

J. **METHOD OF SERVICE DELIVERY:**

1. Clinical needs, once identified, will be addressed in group and on an individual basis. Structured psycho-educational and process groups will utilize appropriate materials to enhance learning and address specific issues related to symptom management and functional living skills. The focus is on recovery, medication management, symptom management, community-living skills, crisis management, managing relationships, personal care management, substance abuse recovery and other topics as needed.

K. **THERAPEUTIC PROGRAM:**

1. All services provided are appropriate for the treatment of the patient's identified problems. OPBHS will assist in the improvement of the patient's functional level and reduce the risk for exacerbation of symptoms, relapse on drugs or alcohol and hospitalization. Programming is individualized so that patients may initially attend two to five days per week as needed. As the patient improves, it is anticipated that he/she will move to a lower level of care. This will assist in maintaining stability and preventing psychiatric decompensation.

L. **TREATMENT PLANNING AND REVIEW OF GOALS AND OBJECTIVES:**

1. The treatment planning process involves the establishment of Master Treatment Plan within seven days of admission to the OPBHS. This individualized treatment plan is written based on the patient's identified symptoms, goals, and wishes, and in collaboration with the patient. The plan is written by the Therapist assigned to the patient, and is initiated under the direction of the admitting psychiatrist. Within seven days of treatment, a Master Treatment Plan (MTP) is completed by the Treatment Team, under the direction of the attending physician and/or Medical Director. After the completion of the MTP, the next treatment plan review will occur monthly for IOP or bi-weekly for PHP. The plan is also reviewed if the patient goes into crisis, or if their condition changes, so that treatment provided in the Program accommodates newly identified needs.

M. **DISCHARGE PROCESS:**

1. The patient's discharge needs are identified on admission to the OPBHS. As the patient's needs become more defined, programming and discharge planning for the patient will be modified to meet those needs. As part of the discharge planning process, the Therapist will follow-up with the referral source and those in the community providing support, as well as the patient, to assure a smooth transition back into the community and/or a transition to a lower level of care.

N. **ORGANIZATIONAL RELATIONSHIPS:**

1. The OPBHS staff is accountable to the Operations Manager. Each interdisciplinary treatment team member has input into the Program planning process. Staff meetings are held **bi**-monthly or as necessary to address problems as they relate to patient care.
2. The Operations Manager/designee has the authority to make operational decisions on a day to day basis. The Operations Manager is supervised by the Director of Behavioral Health or Chief Nurse Executive (CNE).

O. **EMERGENCY SERVICES:**

1. If a crisis or emergency psychiatric situation should occur at the site, immediate contact will be made by staff to de-escalate the situation. If attempts by staff at verbal de-escalation fail,

emergency procedures will be initiated (see Psychiatric Emergencies). If a medical emergency occurs, it will be evaluated by the Registered Nurse (RN) and 911 will be called, if necessary (see Outpatient Behavioral Health: Medical Emergencies Policy).

P. **AFTERCARE AND POST-DISCHARGE:**

1. Post discharge planning will be provided by the patient's Therapist in an effort to provide continuity of care. The Clinical Coordinator and CLC will maintain and make available to staff, a current list of community resources. An Aftercare group, facilitated by a program therapist, ~~will~~ **may** be offered one time per week as a free follow-up support service.

Q. **STAFFING QUALIFICATIONS AND PATTERNS:**

1. The OPBHS will provide clinical services delivered by qualified health care professionals to adequately assess and address the identified clinical needs of patients. These services are augmented by administrative and support staff necessary to maintaining a comprehensive and responsive treatment program. Professional staff meets all federal and state requirements for licensing, registration or certification. Clinical staffs providing services are Licensed Clinical Social Workers (LCSW), **Licensed** Marriage and Family Therapists (MFT), **Licensed Professional Clinical Counselors (LPCC),** Psychologists, and Master of Social Work (MSW), ~~and~~ MFT interns **and LPC interns** who are supervised on site by licensed practitioners. There will be availability of professional nursing services to meet the needs of those patients requiring such services. Nursing services are provided by Registered Nurses who provide, supervise and evaluate nursing care.
2. Each therapist working a forty (40) hour week will be responsible for managing an average total of sixteen to ~~twenty~~ **eighteen** patient cases (on their caseload) and facilitating ten groups per week.
3. When appropriate qualified professional staff members are not available or are not needed on a full time basis, arrangements are made to obtain these services on a per diem or part time basis.

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

1. Outpatient Behavioral Health Policy: Medical Emergencies

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

~~1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~
~~2. Joint Commission Safety Provision of Care 2017~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Smoke Free Environment**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	**~~12/16~~08/20**
Division of Psychiatry Approval:	**~~06/17~~03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/17~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~08/17~~ n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To establish a smoke free environment.

B. **POLICY:**
1. It is the responsibility of the Outpatient Behavioral Health Services (OPBHS) to establish and maintain an optimally healthy and safe environment for its patients, employees, medical staff and visitors. Therefore, smoking is prohibited in all areas within the OPBHS.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS staff and patients
2. Tri-City Medical Center (TCMC) is a non-smoking facility.
3. All employees are expected to respect and assist in enforcing this policy. Failure to maintain a smoke free environment is a violation of various local and state ordinances.
4. Outside area of OPBHS is not a TCMC property and patients may choose to smoke outside the building.
5. Patients are encouraged to not smoke in the front of the building.
6. Staff will provide patients with information and referrals for smoking cessation.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: 205 Smoke-Free Environment

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Standards for Clinical and Professional Practice**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**

1. To provide mandatory standards for Clinical and Professional Practice in Outpatient Behavioral Health Services (OPBHS).

B. **POLICY:**

1. All staff members must act in a professional and appropriate manner at all times at the OPBHS and must treat patients of the OPBHS, as well as each other, with respect and consideration. Accordingly, there are specific, clinically accepted and approved operating standards and principles that all staff members must follow, including, but not limited to, the following specific areas:
2. Community Outings and Diversional/Enrichment Activities:
   a. Certain diversional and enrichment activities can assist patients in developing tools to better understand and identify the natural support and opportunities available in the community after discharge from the OPBHS. However, community outings and diversional or enrichment activities are not a billable service and must not be billed for. Most times, outings are properly classed as enrichment or a diversional activity. Recognizing that at times it may be sensible and clinically appropriate to break up continuous treatment with diversional activities, however, the rule is simple—enrichment or diversional activities can occur, but must not be billed.
3. Token Economies, "Bonus" Stores, and Attendance Awards:
   a. Token economies and bonus stores, whether run by staff or patients, as a rule, are not allowed. Only under particular patient circumstances and based upon an individual patient's treatment plan (and appropriate physician order), might it be approved. Further, any incentive that is likely to influence or induce an individual to receive services, or to continue to receive services, is strictly prohibited. There shall be no attendance awards such as, certificates or award ceremonies, which "reward" a patient for perfect attendance.
4. Bribes and Contingencies:
   a. It is unacceptable for any staff member to bribe a patient in any way to improve attendance or participation in programming or for any other reason. It is equally unacceptable for any staff member to withhold from a patient any of the patient's personal possessions or any item to which the patient is entitled in order to improve the patient's attendance or participation in programming.
5. Recording of Services Provided:
   a. Groups are to be scheduled for a minimum of forty-five (45) minutes. To be credited for having provided a group therapy service to a patient, that patient must have participated in the group for a reasonable amount of time. The service is considered billable only if

the patient has participated based on level of symptomatology. These sessions must begin and end on time. There must be absolute integrity and accuracy in the recording of such services.

6. Group Size:
   a. Staffing standards allow for reasonably sized therapy groups. A range of between eight (8) and ten (10) patients per group is optimal for the type of group work being conducted.
7. Use of Stigmatizing Language/Gestures:
   a. It is clear that language not only reflects the nature of thinking, but it also shapes the quality of thinking and actions. It is with conviction that an OPBHS culture is created in which the language staff use is congruent with the view that consumers of OPBHS services are whole, adult people. Programs are designed to instill hope and support recovery.
   b. Accordingly, it is inappropriate for any staff member to use stigmatizing, or otherwise offensive, language or gestures in the treatment of patients at the OPBHS.
8. Professional Boundaries:
   a. All staff members are required to maintain professional boundaries with patients at all times. It is in the best interest of the patient for staff members to avoid a personal relationship of any kind with patients or any family members or significant others of a current patient who participated in the patient's treatment. No staff member shall socialize or fraternize, by phone, social media, in-person or otherwise, at any time with any patients of the OPBHS, or any family member or significant others of patients who participated in the patient's treatment.
   b. If there's an existing relationship between a staff member and a patient/family member prior to the patient beginning treatment, the staff member must maintain professional boundaries and not engage in any discussions regarding the patient outside of the OPBHS. In addition, the staff member must convey to the treatment team the nature of the existing relationship so that adequate precautions are taken to protect patient's confidentiality.

C. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Staff
2. All clinical and administrative staff members must abide by the above standards in the planning or provision of services or in the operation of the OPBHS. Any practice that conflicts with the above standards is prohibited and could result in disciplinary action, up to and including, termination.
3. If an individual case arises where a patient's physician/Allied Health Professional (AHP) and treatment team believe a patient would clinically benefit from a particular incentive or specific behavioral contract (which appears to be contradictory to the above), the Operations Manager must obtain approval from the Director of Behavioral Health.
4. Any staff member who becomes aware of a suspected compliance issue with respect to the above standards and requirements must report it immediately to his/her Supervisor, or Tri-City Healthcare District (TCHD) Values Line.

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

~~1. Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Substance Abuse

ISSUE DATE: 08/96
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **POLICY:**

1. Patients with comorbid substance abuse problems or dual diagnosis may be treated in Outpatient Behavioral Health Services (OPBHS) if they agree to adhere to OPBHS guidelines and if they agree to accept treatment for their substance use problem.
2. Patients are not permitted to attend OPBHS under the influence of alcohol, marijuana or illicit drugs or to bring those substances to OPBHS. Substance abuse is also defined as "misuse of prescribed medications".
    a. An individual under influence can include individuals that use alcohol, marijuana, illicit drugs or misuse prescribed medications the day they are in the program or the night before.
    b. Behaviors that may indicate an individual is under the influence include, someone behaving differently than usual, erratic, with an altered state of consciousness, unpredictable behavior, agitation, excessive sedation, slurred speech, dilated eyes, impaired gait, etc.
3. If the patient's substance use problem becomes so severe that it endangers the patient's safety, interferes with psychiatric treatment, or prevents the patient from benefiting from treatment, a referral to a higher level of care or a substance abuse program may be made.

B. **PROCEDURE:**

1. Who may perform/responsible: OPBHS Clinical and Nursing Staff
2. If substance abuse is detected by OPBHS staff during OPBHS time, the patient will be dismissed for the day. The patient's physician/Allied Health Professional (AHP) will be immediately notified.
3. If the patient may be medically endangered by his substance abuse, the physician/AHP will be notified before the patient is dismissed in order to determine the best approach to take and to assess the need for immediate medical treatment.
4. With collaboration with physicians/Allied Health Professionals, OPBHS staff will determine a safe plan to transport the individual home and to ensure that the individual does not drive under the influence.
5. At the time of dismissal, the patient will be reminded that he/she must meet with the Therapist or treatment team before he/she may continue in the OPBHS. If the patient does not call back within 24 hours, the Therapist will contact the patient to schedule the meeting. The meeting will include consideration of the patient's possible need for substance abuse treatment, within or independent of the OPBHS.
6. If the individual continues in treatment, a contract for continuing participation in the Dual Diagnosis component of the program may be developed. The contract may address various issues, such as substance abuse abstinence, participation in dual diagnosis groups, 12-step

meeting attendance, avoidance of high risk places or things, etc.

7. Repeated violations of OPBHS rules concerning substance abuse may result in the patient's discharge from the OPBHS.
8. The incident is documented in the patient's record along with a description of the action taken.
9. Patients are referred to a higher level of care or substance use treatment if they are determined to meet one or more exclusionary criteria, which include:
    a. Lack of interest in being clean or sober and refusal to reduce substance use
    b. Daily excessive drinking or signs of withdrawal and increased tolerance
    c. More than one occasion of coming to OPBHS under the influence
    d. Multiple relapses and refusal to take steps to improve chance of success
    e. Inability to reduce use
    f. Multiple episodes of dishonesty regarding use
    g. High risk of suicide, violence, medical issues, homicide, or severe exacerbation of symptoms associated with use.
    h. Extent of prescription use leads to high risk of self harm
    i. Refusal to communicate with other prescribing physicians/AHPs, or primary care physician (PCP), or family/caregivers combined with severe risk of self harm
    j. Continued use of multiple pharmacies, Emergency Departments (EDs), and physicians/AHPs and refusal to change this high risk behavior
    k. Poses a risk to milieu by influencing other patient to use substances
    l. The team, including the physician, determines that patient has a current primary issue with substance use and can benefit from substance use treatment.

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: Suicide Assessment

ISSUE DATE: 08/96
REVISION DATE~~(S)~~: 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/07, 06/10, 04/13, 09/17

Department Approval:	~~12/16~~08/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **PURPOSE:**
1. To define the course of action necessary when a patient expresses suicidal ideation.

B. **POLICY:**
1. Acutely suicidal patients are not appropriate for Outpatient Behavioral Health Services (OPBHS) and need to be evaluated for inpatient treatment. If a patient is admitted for inpatient care, OPBHS staff will follow the patient's progress and assist in assessing the patient's readiness to return to OPBHS. Patients reporting suicidal ideation will be assessed for level of risk and appropriate interventions will be conducted accordingly.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS Clinical Staff.
2. All new patients will undergo an evidence-based suicide risk assessment, such as the Columbia-Suicide Severity Rating Scale (C-SSRS). The assessment is completed at intake by the Clinical staff.
3. If a patient is assessed to be at moderate or high risk for suicide, then the staff notifies the physician/Allied Health Professional (AHP) in order to evaluate appropriate level of care needed for the patient.
4. If physician/AHP determines that the patient can safely remain in OPBHS, staff will provide the patient with information on how to access emergency crisis services and will develop a safety plan.
5. The therapist will establish a treatment goal specifically addressing safety for those patients that score moderate to high on the suicide assessment.
6. If, during the course of treatment, the OPBHS staff member becomes aware of a patient's suicidal intentions or actions, he/she becomes responsible for initiating a course of action. That person, or designee, must take necessary precautions to ensure patient's safety.
7. Assessment will be immediately initiated to determine the risk of the suicidal intent or action.
   a. Some of the factors to consider are: whether the patient has a specific plan to make an attempt, whether the patient is now experiencing circumstances that would enhance the likelihood of the attempt, etc.
8. The staff member who discovers the situation will inform the physician, Clinical Coordinator, and the Operations Manager.
9. An action plan is initiated based on the assessment of acuity.
   a. If a suicide attempt has already been made, the patient is to be transferred immediately to Tri-City Healthcare District's (TCHD) emergency room by ambulance. A staff member will be designated to notify the patient's physician/AHP and family member or significant

other.

b. If a suicide attempt has not been made, but the threat is considered to be imminent, the patient's physician/AHP is to be contacted immediately to give direction concerning the patient's disposition. If the patient's attending physician/AHP is not available, the Medical Director will be contacted.

c. Patients that are identified at risk will be closely monitored until they are transported safely for inpatient treatment.

d. Patients that are on close watch will be asked to voluntary give staff their belongings in case they possess any contraband items and to protect their safety.

e. If the threat of suicide is determined not to be imminent, the treatment team will be notified to heighten awareness to possible future suicidal risk and also to plan further treatment interventions. A written safety plan will be developed by the patient and the therapist to help identify warning signs, coping strategies, and emergency resources. If appropriate, the patient's family/support system/Board and Care Manager should be contacted to monitor for safety.

10. Document in the patient's medical record the patient's statements and actions, the assessment process, the disposition of the patient and staff interventions. The patient's Therapist will discuss all verbalizations of suicidal ideation with the patient's attending psychiatrist and the treatment team in order to develop appropriate treatment interventions.

11. The OPBHS staff will contact the inpatient treatment team, should the patient be hospitalized, to insure continuity of care and to conduct hand-off communication.

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

1. Outpatient Behavioral Health: Psychiatric Emergencies

E. **REFERENCES:**

1. The Columbia Suicide Severity Rating Scale (C-SSRS) Supporting Evidence (2017)
2. The Joint Commission Source Newsletter (2016)
3. The Joint Commission National Patient Safety Goals (2017)

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SER

DELETE - using the EMR and will not have paper document

SUBJECT: Summary of Care List

ISSUE DATE: 02/06
REVISION DATE~~(S)~~: 06/07, 06/10, 04/13

Department Approval:	~~12/16~~07/20
Division of Psychiatry Approval:	~~06/17~~03/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

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

~~1. To insure that a complete and current Summary of Care List is included in the patient's medical record that will be available and readily accessible to all staff and caregivers.~~

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

~~1. The Outpatient Behavioral Health Services (OPBHS) Summary of Care list will include the five required elements:~~

~~a. patient name,~~
~~b. diagnosis,~~
~~c. current medications (including initial order date, change order dates, d/c date, dose, frequency, dates reordered),~~
~~d. allergies,~~
~~e. relevant, past operative/invasive procedures.~~
~~f. Additionally, for the purposes of this department, it will include the name of the attending psychiatrist, patient phone number, co-treating psychiatrist (if applicable), the patient's pharmacy and pharmacy phone number.~~

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

~~1. Who may perform/responsible: OPBHS nursing staff~~
~~2. A Summary of Care/Medication List will be completed by a Program Registered Nurse (RN) upon patient admission to OPBHS.~~
~~3. The Summary of Care List will be inserted as the cover document in the Medication section (red tab) of the medical record or in the electronic record.~~
~~4. The Program RN will revise and keep current the List as necessary to include changes in medications, diagnosis, or other relevant data.~~
~~Upon discharge from the Program a copy of medications list is given to the patient.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

SUBJECT: **Treatment Planning**

ISSUE DATE: **08/96**
REVISION DATE(S): 05/98, 08/00, 10/01, 02/02, 02/03, 01/05, 06/06, 06/10, 04/13, 08/17

Department Approval:	~~12/16~~**08/20**
Division of Psychiatry Approval:	~~06/17~~**03/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~07/17~~**04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	~~08/17~~ **n/a**
Board of Directors Approval:	**08/17**

A. **PURPOSE:**
1. To establish the requirements for inter-disciplinary treatment and develop appropriate plan for treatment.

B. **POLICY:**
1. A patient's treatment in the Outpatient Behavioral Health Services (OPBHS) will be guided by a written, individualized, inter-disciplinary, physician approved plan of treatment that abides by all regulatory guidelines. Pursuant to written clinical assessments (see Outpatient Behavioral Health: Clinical Assessment Policy), a master treatment plan (MTP) will be established within seven days of admission. This MTP is reviewed and, as clinically indicated, revised during the course of the patient's participation in OPBHS. It will be developed around medically authorized short-term and long-term treatment goals. These goals will be aimed at enabling the patient to recover and function appropriately at a less intensive level of care in the shortest amount of time possible and will reflect individualized discharge criteria. There is a high value placed upon patient participation in treatment planning and, accordingly, the MTP that is established will reflect a blend of both clinical judgment and patient preference. Psychiatric Diagnoses will be listed on the MTP in accordance with Medicare guidelines. Treatment Plan Reviews will be completed each calendar month thereafter and will incorporate feedback and recommendations provided during treatment planning and review meetings. Partial hospitalization patients will have treatment reviews every two weeks.
2. While the content of the treatment plan is ultimately a medical/clinical responsibility, it is the responsibility of the Operations Manager/designee to manage the treatment planning process and to assure that an up-to-date treatment plan is established and maintained for every patient in the OPBHS throughout the course of his/her treatment.

C. **PROCEDURE:**
1. Who may perform/responsible: OPBHS Clinical Staff
2. The assigned Therapist and the patient meet to begin developing the treatment plan. On the first day of treatment, the problem title is identified by the patient and the therapist. Within the first week of admission, a more comprehensive Master Treatment Plan (MTP) will be developed with input from the clinical team, including the physician, during the treatment team process. The MTP includes:
   a. At least one individual problem title and goal plan that reflects the psychiatric diagnosis, medical necessity for this level of treatment, a list of patient strengths, discharge criteria, and the recommendations of the physician. If the patient also has a diagnosis related to

substance use, a second problem title and goal plan may be completed as well.

b. Each individual problem title and goal plan should include a minimum of one short-term goal that directly correlates with the problem title and diagnosis.

c. If the patient carries a medical/physical diagnosis that is treated by an outside physician and has the potential for being addressed in OPBHS (i.e. diabetes), a separate problem title may be opened and indicated as "active" or "monitored". This determination should be a collaborative effort between clinical and nursing staff.

3. The MTP is presented in treatment team for approval by the seventh calendar day following admission to OPBHS. Patients in the Dual Recovery Treatment Track will have two active problems with ~~two~~ **at least one** goals for each problem. Patient preferences are considered when developing treatment goals. The patient must always be involved in the treatment planning process.

   a. The MTP is developed based on information obtained from a variety of sources. These include past history; current assessments or screenings conducted by the Community Liaison Coordinator, physician/Allied Health Professional (AHP), nurse, and therapist; and information provided by the patient and caregivers. Consistent with the "physician driven treatment" model, the patient's diagnosis is determined by the physician/AHP and the treatment plan must be approved by the physician/AHP.

4. Treatment interventions should be completed and include ~~groups the patient will be attending,~~**the** number of days per week they will be attending~~, and individual therapy interventions.~~**;** ~~a~~Any changes in the interventions and frequency of treatment must be ordered by the physician/AHP.

5. All core clinical assessments and any other assessments ordered on admission will be completed before MTP presentation, within seven calendar days of admission. However if the patient does not attend prior to treatment team presentation, or is too anxious to complete the assessment, staff must make an effort to complete all assessments as soon as possible. The Therapist meets with the patient to conduct assessments, explain the treatment planning process and to determine his/her**/their** preferences concerning possible short and long-term goals and treatment interventions. Discharge planning and discharge criteria will also be discussed as part of the assessment process.

6. An MTP meeting is conducted by the Operations Manager, Clinical Coordinator, or designee, no later than the 7th calendar day following admission for patients in the OPBHS. ~~All s~~**S**taff who have completed assessments will either be present at the meeting or will have submitted written recommendations to the designated Therapist. The Therapist leads an oral case presentation to summarize the reasons for referral to the OPBHS, present a concise clinical formulation and to identify/recommend problems, goals and treatment interventions. The presentation is based on:

   a. The initial CLC Referral and Screening Report;
   b. The physician's admission orders;
   c. All core and special clinical assessments (Physician Admission Assessment, Nursing Assessment, Fall Risk Assessment Biopsychosocial Assessment, Substance Abuse Assessment, ~~and~~ Suicide Risk Assessment **and clinical screening questionnaires, such as the PHQ-9, PCL-5, BPRS and GAD-7**);
   d. The patient's stated treatment preferences;
   e. Problem Title and Short Term Goals that are measurable, specific and descriptive of the patient's behavior and what they will do~~, followed by a baseline statement to use as a benchmark for measurement.~~**.**
   f. Clinical impressions of the patient's initial response to treatment; and
   g. Other available clinical history/collateral information

7. The presentation of the patient is to include:

   a. Physical description;
   b. Diagnosis;
   ~~b.~~**c. Strengths**
   ~~c.~~**d.** Brief history of psychiatric illness;
   ~~d.~~**e.** Current medications;

~~e.~~**f.** Previous psychiatric hospitalizations (total number and most current);
~~f.~~**g.** Specifically what triggered this admission, including any psychosocial stressors;
~~g.~~**h.** Summary of recommendations from clinical assessments; and
~~h.~~**i.** Problem title and goals.
~~i.~~**j.** The treatment team is responsible for finalizing a MTP for each patient. The MTP is to be completed by the therapist and is reviewed in treatment team and approved by the OPBHS psychiatrist.

8. Patients' active participation in treatment planning is vital. The Therapist meets with the patient to review the MTP and obtain the patient's approval.
9. Routinely, at the prescribed treatment plan review intervals, the Therapist meets with the patient to assess his/her perspective on treatment progress and to review goal status, making goal and treatment modifications as necessary.
10. A review of each patient's treatment plan is conducted monthly for intensive outpatient and bi-weekly for partial hospitalization patients (depending on FI guidelines) at which time the Therapist once again leads a case presentation. This presentation will be preceded by the Therapist's review of all progress notes since the last MTP meeting. The purpose of the presentation is to summarize progress and to determine the need for any changes to identified problems, goals, treatment interventions or discharge criteria.
11. The Therapist completes any agreed upon treatment plan revisions **with patient input** and obtains approval from the patient and the treatment team.
12. To promote successful completion of treatment goals and positive outcomes, the patient's primary therapist will maintain contacts with patient's family members and outside providers as warranted. In addition, the therapist or the OPBHS Service Coordinator may assist patient with coordinating any outside services needed.

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

1. CLC Referral and Screening Report
2. Outpatient Behavioral Health Policy: Clinical Assessment

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

~~1.~~3. ~~Local Coverage Determination for Outpatient Hospital Based Psychiatric and Psychology Services (L27587)~~

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

ISSUE DATE: 10/09 **SUBJECT: Utilization Review Process**

REVISION DATE~~(S)~~: 04/10, 02/12, 02/13, 02/16, 01/19

Case Management Department Approval:	**~~10/18~~10/21**
Utilization Review Committee Approval:	**~~11/18~~10/21**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Staff Department or Division Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/18~~02/22**
Administration Approval:	**~~01/19~~05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/19**

A. **PURPOSE:**
1. To establish criteria for utilization review process.

B. **POLICY:**
1. Case Management staff will utilize hospital approved (InterQual®) Severity of Illness/Intensity of Service (SI/IS) guidelines to perform and document admission reviews, observation status and continued stay reviews, discharge disposition review and retroactive review for all patients as stated in this procedure.
2. Case Management staff will identify appropriateness of level of care (i.e. ICU/CCU, DOU/Telemetry, Acute Care, Monitored Med/Surg, NICU, and Women's Care Services).
3. Case Management staff shall review admission criteria for Observation vs. Inpatient.
4. Every reasonable effort shall be made for appropriate admission criteria to be documented within 24 business hours of admission.

C. **PROCEDURE:**
1. Admission Review
   a. All new Tri-City Medical Center (TCMC) Admissions (Inpatient & Observation Service) and transfers to TCMC shall have an initial InterQual® review performed no later than 24 business hours following admission to TCMC to determine appropriateness of an admission to a Level of Care.
      i. Priority of Initial Review:
         1) Medicare
         2) Medi-Cal & Cash
         3) Commercial Insurance
      ii. Every reasonable effort shall be made to complete Initial CM Reviews within 24 calendar hours of admission to TCMC
      iii. EXCEPTIONS: Routine postpartum, newborn care.
         1) Vaginal Delivery – provide review 48 hours following delivery
         2) Cesarean Section Delivery – provide review 96 hours following delivery
   b. Admission Review shall include a "Patient Status Reconciliation" – the physician order must match the correct level of care- Inpatient vs Outpatient / Observation,
      i. Case manager shall contact the admitting physician to discuss any discrepancy and clarify the physician's intent. The Case Manager shall contact the Physician Advisor as needed.
   c. Clinical review findings shall be documented in **the electronic health record (EHR)**~~Cerner~~ within 24 business hours of admission.

i. The following medical groups' Utilization Management staff will perform utilization review for their capitated patients per contractual agreement.
   1) PCAMG (Primary Care Associates Medical Group)
   2) GTCIPA (Greater Tri-City Independent Physician Association)
   3) Graybill Medical Group (except CHG)

ii. TCMC Case Management staff and the medical groups' utilization management staff will have ongoing communication regarding cases, issues, problems, on an as-needed basis.

2. California Children's Services (CCS)
   a. Identify all patients under the age of 21 and screen for potential CCS eligible diagnosis (refer to CCS approved diagnoses).
   b. Review all patients under 21 for changes in clinical condition representing a potential California Children's Services (CCS) -eligible condition. If the patient appears to meet the eligibility criteria, a referral is made to the Social Worker and communication is made to the Business Office to generate a referral to CCS.
3. California Department of Correction (CDCR):
   a. Clinical updates shall be provided daily Monday through Friday via pre-scheduled conference call
4. Continued Stay Review
   a. All inpatients will be reviewed for Continued Stay, Monday – Friday, utilizing InterQual® guidelines' Intensity of Service (IS) and appropriateness of level of care and medical necessity (unless Payor has been granted electronic health record (EHR) Access by TCMC for the purposes of performing their own clinical reviews).
   b. If Continued Stay criteria are not met or the current level of care is no longer appropriate, case is discussed with the attending/treating physician.
      i. NOTE: If attempts to contact/discuss the case with the attending/treating physician are unsuccessful, refer case to the Physician Advisor.
   c. InterQual® reviews shall be provided to the payer / review organization via **EHR~~Cerner~~** or in manner requested by the payer.
      i. The payer information (including authorization number and days authorized) will be documented in **EHR~~Cerner~~**.
   d. When a patient is transferred to another area of the hospital, the transferring case manager / social worker is responsible for:
      i. Hand-Off Communication to accepting Case Manager / Social Worker utilizing SBAR format as adopted by TCMC~~, and documented in Allscripts~~.
      ii. Completing all electronic medical record documentation.

D. **REFERENCE(S):**
1. InterQual Level of Care Criteria, Acute Care - Adult (Annual Edition as appropriate & updated)

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 01/99

SUBJECT: Automatic I.V. to Oral Conversion

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

~~POLICY NUMBER: 8390-6012~~

Department Approval:	**~~03/18~~12/21**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **PURPOSE:**

1. To provide a process for changing select parenteral medications to the oral or enteral route when medically appropriate in order to reduce cost, hospital length of stay, and associated risks with continued intravenous therapy while maintaining equivalent clinical outcomes

B. **POLICY**:

1. The clinical pharmacist will review patient profiles, current progress notes, pertinent labs, and discuss patient status with the patient's nurse or physician to determine eligibility for IV to PO conversion. If the patient meets approved criteria, the clinical pharmacist will transition the patient to oral therapy upon authority of the Pharmacy and Therapeutics (P&T) Committee
2. Such therapeutic conversions will be reviewed and revised at least annually
3. A complete list of approved IV to PO conversions shall be available on the Tri-City Medical Center intranet (see attachment)

C. **PROCEDURE**:

1. IV to PO conversion may be executed by pharmacists after prescribers have been advised of the policy set forth by the Pharmacy and Therapeutics Committee. Such medication conversions will be automatic and notification to each individual prescriber will be communicated via a comment placed in the replacement order and/or a progress note entered in the patient's medical record.
2. Only medications with prior P&T approval may be automatically converted by pharmacists
3. Pharmacists will evaluate all adult patients for potential IV to PO conversion after receiving at least one dose of intravenous therapy and have been hospitalized for at least 24 hours
    a. Exception: Orders for IV levothyroxine will be held for up to 5 days since the last known dose in patients that were confirmed to be compliant with oral therapy prior to admission unless specifically ordered by physician not to hold IV levothyroxine, endocrinology is consulting on the patient, or patient has been diagnosed with myxedema coma. The pharmacist will discontinue the original IV levothyroxine order and enter a "Levothyroxine Consult" order as a placeholder. During the 5 day hold period, the patient may be converted to oral levothyroxine if eligible per policy. If 5 days have lapsed since the patient's last known oral dose and the patient remains ineligible for oral conversion, IV levothyroxine will be initiated as per the original order
4. If the patient is being considered for an IV to PO conversion, the clinical pharmacist will examine the route of therapy and determine if it is clinically appropriate to perform a parental to oral therapy switch

5. If the patient meets the approved criteria and none of the exclusion criteria for transition to oral therapy, the clinical pharmacist will enter a new order via CPOE using the same physician name as the original order and will include the drug name, dose, route, and frequency. Any special instructions and "per Pharmacy IV to PO Protocol" will be entered in the order comments. The order shall be electronically signed by the pharmacist, "Per Pharmacy Protocol." The pharmacist shall discontinue the intravenous medication ordered by the physician to prevent duplication in therapy
6. The new order stop date will be changed by the pharmacist to reflect that of the original order
7. If a drug-food interaction exists that can alter absorption of the medication (i.e levofloxacin and iron, antacids, calcium, sucralfate), the pharmacist will change administration times of the drug to avoid such interaction
8. In the event the physician wishes to opt out of automatic IV to PO conversion, the physician shall write in the order comments of the IV order "No IV to PO conversion." The physician may also order an Rx Note stating "No IV to PO conversion" to cover all medications. Such instructions should also be documented in the latest progress note.
9. Any orders that are changed back to the IV form by the physician following conversion by a pharmacist to oral therapy will be referred for clinical review and discussion with the prescribing physician
10. Prior to writing an order to change the medication to the oral (or enteral) route, all of the following criteria must be verified:
    a. Inclusion Criteria:
        i. Patient is improving clinically
        ii. Tolerating food or enteral feeding for at least 24 hours (may be NPO if cleared for, and tolerating other oral medications)
        iii. Able to adequately absorb oral medications via the oral, gastric tube, or nasogastric tube route
        iv. Has not received anti-emetics within the last 24 hours
        v. Patient adherence to oral therapy is anticipated
        vi. Does not display signs of shock; not on vasopressor blood pressure support
        vii. Taking other medications via the oral, gastric tube, or nasogastric tube route
        viii. Does not have any contraindications to oral or enteral medication administration
        ix. Additional requirements for antimicrobials:
            1) Blood cultures negative at 72 hours
            2) Afebrile for at least 24 hours (T <100.4F or 38C)
            3) Heart rate ≤ 90 BPM
            4) Systolic blood pressure ≥ 90 mmHg (without vasopressor drugs)
            5) RR ≤ 20 BPM
            6) Signs and symptoms of infection have improved or abated
                a) Improving or normalized WBC and differential counts
                b) Clinical improvement at site of infection
                c) Hemodynamically stable
                d) Patient is not septic
    c. Exclusion Criteria:
        i. Persistent nausea, vomiting and/or diarrhea
        ii. Difficulty swallowing, refuses oral medication, or is strict NPO for a procedure
        iii. Altered mental status or aspiration risk and no NG access
        iv. Experienced severe trauma within last 72 hours
        v. Patient with the following GI conditions:
            1) Known or suspected ileus with no active bowel sounds
            2) Known or suspected malabsorption syndrome, motility disorder, short bowel syndrome, partial or total removal of the stomach
            3) Known or suspected gastrointestinal obstruction

4) High nasogastric output (greater than 500ml/day) or requiring continuous GI suction
5) Continuous tube feedings that cannot be interrupted and patient requires a medication known to bind to enteral nutrition formulas (levothyroxine)
6) Active GI bleed
7) Receiving neuromuscular blocking agents

vi. Cystic Fibrosis exacerbation
vii. Patients with Grade III or IV mucositis
viii. Wernicke's encephalopathy (Utilizing high dose thiamine 500 mg IV q8h x 48 hours then 500 mg IV daily x 5 days. May switch to thiamine 100 mg po daily indefinitely once tx course complete)
ix. Hx of heavy ETOH use (Must receive 100 mg IV daily for at 3-5 days prior to thiamine interchange)
x. Myxedema coma or if endocrine consulting (for IV levothyroxine)
xi. Actively seizing or at high risk for recurrent seizures or if neurology consulting (for levetiracetam)
xii. Patient's condition is rapidly changing such that their ability to tolerate oral medication may be compromised within the next 24 hours
xiii. Any situation in which the patient is currently receiving other oral medication and/or food but the pharmacist or other healthcare provider questions the current suitability of this route
xiv. Additional requirements for antimicrobials
1) Patient has a serious or life threatening infection which include but not limited to: Meningitis, endocarditis, endovascular infections, inadequately drained abscess or empyema, necrotizing fasciitis, osteomyelitis, septic arthritis, bacteremia, legionella pneumonia, invasive candidiasis
2) Immunocompromised (i.e on concomitant immunosuppressive, recent chemotherapy, chronic steroid use, HIV infection)
3) WBC less than (<) 4 or greater than (>) 12 or ANC < 500
4) Temp ≥ 100.4F or 38C or Temp ≤ 98.6F or 36C
5) HR> 90 BPM or SBP< 90 mmHg
6) RR greater than (>) 20 BPM or PaCO2 greater than (>) 32 mmHg
7) Candidemia or bacteremia treated less than 7 days
8) Other infections which require extended intravenous therapy
9) Severe C.dif requiring IV metronidazole and oral vancomycin where switching to oral metronidazole offers no benefit

D. **RELATED DOCUMENT(S):**
1. Automatic I.V. to Oral Conversion Medication Tables

Automatic I.V. to Oral Conversion Medication Tables

Table 1: GI drugs Eligible for IV to PO Conversion			
Dosing Suggestions			
Indication	**IV Regimen**	**PO Regimen**	**Enteral Feeding tubes**
SRMD Prophylaxis	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po BIDAC	Famotidine 20mg DHT/NG/OG/PEG q12h
***NSAID-induced ulcer prophylaxis**	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	Famotidine 20mg DHT/NG/OG/PEG q12h
***Symptomatic GERD**	Pantoprazole 40mg IV q24h Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 20mg po BIDAC	Famotidine 20mg DHT/NG/OG/PEG q12h
***Erosive esophagitis**	Pantoprazole 40mg IV q24h Famotidine 20-40mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 20-40mg po BIDAC	Famotidine 20-40mg DHT/NG/OG/PEG q12h
***Hypersecretory Disorders**	Pantoprazole 80mg IVP BID Famotidine 20mg IV q6h	Pantoprazole 40mg PO AC-BFK Famotidine 20mg po q6h	Famotidine 20mg DHT/NG/OG/PEG q6h
***Active duodenal ulcer**	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 20mg PO AC-BFK Famotidine 40mg po QHS or 20mg BIDAC	Famotidine 40mg DHT/NG/OG/PEG q24h or 20mg q12h
***Active gastric ulcer**	Pantoprazole 40mg IVP BID Famotidine 20mg IV q12h	Pantoprazole 40mg PO AC-BFK Famotidine 40mg po QHS	Famotidine 40mg DHT/NG/OG/PEG q24h

Automatic I.V. to Oral Conversion Medication Tables

Table 2: Antimicrobials Eligible for IV to PO conversion		
IV Drug Regimen:		**Convert to:**
Drug	**IV Dose**	**Oral Conversion**
Azithromycin	250mg IV q24h 500mg IV q24h	250mg po q24h 500mg po q24h
Ciprofloxacin	400mg IV q24h 400mg IV q12h 400mg IV q8h	500mg po q24h or 250mg po q12h 500mg po q12h 750mg po q12h
Doxycycline	100mg IV q12h	100mg po q12h
Fluconazole	100mg-400mg IV q24h	100mg-400mg po q24h
Levofloxacin	250mg-750mg IV q24h-q48h	250mg-750mg po q24h-q48h
Linezolid	600mg IV q12h	600mg po q12h
Metronidazole	250mg IV q6h or q8h 500mg IV q6h or q8h	250mg po q6h-q8h 500mg po q6h-q8h
Sulfamethoxazole/trimethoprim (Bactrim or Septra)	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses	5-10mg/kg/day TMP in divided doses 15-20mg/kg/day TMP in divided doses

Table 3: All Other Medications Eligible for IV To PO Conversion		
IV Drug Regimen:		**Convert to:**
Drug	**IV Dose**	**Oral/Enteral Feeding tube Conversion**
Acetaminophen	1000 mg IV Q6H	1000 mg PO Q6H
Levothyroxine	12.5mcg-100mcg IV daily	2 x IV dose (25mcg-200mcg po AC-BFK)
Levetiracetam	250-1500mg IV q12h-q24h	250-1500mg po q12h-q24h (same dose regimen)
Thiamine	100mg IV q24h	100mg po q24h (same dose regimen)
Folate	0.5-1mg IV q24h	0.5-1mg po q24h (same dose regimen)

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/91

SUBJECT: Drug Samples

~~**POLICY NUMBER: 8390-2009**~~

REVISION DATE(S): 12/91, 01/97, 07/00, 02/03, 06/04, 04/05, 06/05, 07/06, 07/09, 10/10, 02/12, 01/14, 06/14, 07/18

Department Approval:	~~04/18~~12/21
~~**Medical Staff Department/Division Approval:**~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~03/22
Medical Executive Committee Approval:	~~06/18~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. **DEFINITIONS:**

1. Drug Samples are prescription medications packaged as one or more dosage units by a manufacturer or distributer in accordance with Federal and State statues. Drug samples are provided by a pharmaceutical company to a licensed practitioner free of charge. A drug sample is not intended to be sold and is intended to promote the eventual sale of the drug. A drug sample may be a packet, card, blister pack, bottle, container, or other single package that is provided to a patient in an unbroken or unopened condition. Drug samples include dose titration packages and starter kits.

B. **POLICY:**

1. The use of drug samples is not permitted for inpatients or outpatients within this hospital.

C. **EXCEPTION:**

1. The Behavioral Health Unit (BHU) may request samples be provided directly from the drug company representative to the pharmacy department pursuant to a written request from the prescribing practioner for certain non-formulary medications in the event that no other source of supply is available to the pharmacy. The pharmacy will store these samples in a locked area apart from other hospital stock, and ensure sample drugs are not expired prior to dispensing to the BHU. These samples will be used for inpatient administration only and will not be dispensed for outpatient use.
2. Patient-Own-Med: Will be considered on a case by case basis in the event that no other source of supply is available to the pharmacy. Approval required by Clinical Manager.

D. **PROCEDURE:**

1. General use:
   a. Drug samples shall be provided only by licensed practioners in accordance with state laws and regulations
   b. A written request for drug samples shall be made on a form which contains the practitioner's name, address, and professional designation, the identity of the drug sample requested, the quantity of drug samples requested, the name of the manufacturer or distributor of the drug sample, the date of the request and signature of the practitioner making the request.
   c. The pharmacy must keep copies of a practitioner's written request for drug samples for at least 3 years

d. Drug samples shall not be given for long-term use or maintenance therapy, unless they are part of a program that includes pharmacy dispensing and traditional safety checks that are provided by a pharmacist
e. The pharmacy is responsible for the procurement, distribution, and control of all drugs, including drug samples used in the institution

2. Prescribing, packaging, labeling, dispensing
   a. Drug samples must be dispensed in the original packaging and at a minimum will include the following:
      i. Drug name and drug strength
      ii. Lot number and expiration date
      iii. Only one dosage unit per blister, when blister packaging is used
      iv. Manufacturer-provided information as required by the FDA (i.e. medication guide)
   b. Multiple doses may be packaged in a manner that preserves labeling for each dose (i.e., the label of each dose will contain the drug's name, strength of medication, lot number, and expiration date)
   c. An order will be entered via CPOE and verified by the pharmacist as TNF-MED "DRUG SAMPLE - Name of Drug."
   d. An NDC number shall be assigned to each drug sample to facilitate electronic documentation and tracing of drug samples
   e. A BCMA label with the patient name and specific instructions for use will be affixed to the container dispensed
   f. Prior to dispensing of drug samples, the pharmacist shall check the expiration date and visually examine the product's integrity
3. Storage and handling
   a. Drug samples shall be safely stored and in accordance with the manufacturer's labeling.
   b. All expired, damaged, or deteriorated drug samples shall be immediately removed and disposed of properly
   c. Once appropriately labeled, the drug sample will be loaded for patient-specific use and stored in the BHU/inpatient unit Pyxis.
   d. Upon discontinuation of the drug or patient discharge, the pharmacy will be notified by nursing so that the drug sample can be unloaded from the Pyxis and returned to pharmacy or to the patient (if Patient Own Med).
4. Monitoring and record keeping
5. Patient-specific information (i.e. medical record) shall be readily available to the pharmacist at the time that sample medications are provided to patients for the purpose of checking for interactions/contraindications
6. Patients taking drug samples shall be monitored for therapeutic effect and adverse events.
7. Prescribers shall document in the patient's medical record drug samples given to patients as they would any other medication
8. Drug samples shall be included in any list of medications that is communicated to another provider or care setting.

E. **REFERENCE(S):**

1. Federal Food, Drug, and Cosmetic Act (FD&C Act). Prescription Drug Marketing Act of 1987. Section 5: Distribution of Drug Samples.
2. NCC MERP. Recommendations for Avoiding Medication Errors with Drug Samples. http://www.nccmerp.org/council/council2008-01.html
3. ASHP. Drug Distribution and Control: Distribution–*Technical Assistance Bulletins.* http://www.ashp.org/DocLibrary/BestPractices/DistribTABHosp.asp

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 12/13 **SUBJECT: Employee Theft or Impairment**

REVISION DATE: 12/13, 07/18

Department Approval:	**~~04/18~~12/21**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **PURPOSE:**
1. To set the expectation for individuals employed with in the pharmacy department if suspected of chemical, mental or physical impairment, theft, or drug diversion.

B. **DEFINITIONS**:
1. Impairment: a symptom of reduced quality or strength
2. Theft: the wrongful taking and carrying away of the personal goods or property of another.
3. Drug Diversion: any criminal act or deviation that removes a prescription drug from its intended path from the manufacturer to the patient or return/waste.

C. **POLICY**:
1. If an employee is suspected of impairment, theft or drug diversion it shall be brought to the attention of the employee's direct supervisor and the Pharmacist in Charge (PIC) immediately.
    a. The supervisor or PIC will evaluate to determine the need for immediate intervention in compliance with existing hospital policies (Alcohol and Drug Testing Guidelines for Employees Policy 429, Coaching and counseling for Work Performance Policy# 8610-424, Locker Entry by Force, Security Department SDPPM #206)
        i. Immediate intervention can include drug or alcohol testing (in compliance with Health and Safety Policy 429)
        ii. If immediate intervention is not deemed necessary, a formal investigation will be launched.
            1) Based on the results of the investigation, further action taken may be up to and including termination.
            2) The seriousness of the violation, the position or responsibility held by the employee, and past record of employment are all things that will be considered in determining whether to suspend, transfer, terminate, or take other actions against the employee.
            3) The pharmacy shall report to the Board of Pharmacy within 14 days of the receipt or development thereof the following information with regard to any licensed individual employed with the pharmacy:
                a) Any admission by a licensed individual of chemical, mental, or physical impairment affecting his/her ability to practice.
                b) Any admission by a licensed individual of theft, diversion, or self-use of dangerous drugs.
                c) Any video or documentary evidence demonstrating chemical, mental, or physical impairment of a licensed individual to the extent it affects his/her ability to practice.

d) Any video or documentary evidence demonstrating theft, diversion, or self-use of dangerous drugs by a licensed individual.
e) Any termination based on chemical, mental, or physical impairment of a licensed individual to the extent it affects his/her ability to practice.
f) Any termination of a licensed individual based on theft, diversion, or self-use of dangerous drugs.

4) A copy of the report to the Board of Pharmacy will be kept in the pharmacy and readily retrievable for three (3) years.
5) The CEO of Tri-City Medical Center will be notified immediately if an employee is terminated for any of the above reasons.

2. According to the Drug Enforcement Agency (DEA), theft of a controlled substance from a pharmacy is a criminal act and a source of diversion that requires notification to DEA.
   a. A designated person within the pharmacy department must notify in writing the local DEA Diversion Field Office within one business day of discovery of a theft of controlled substance.
   b. The designated person must also complete a DEA Form 106 (Report of Theft or Loss of Controlled Substances) which can be found online at http://www.deadiversion.usdoj.gov/ under the Quick Links section.
   c. If, after initial notification to DEA, the investigation of the theft determines no such theft, a DEA Form 106 does not need to be filed. However, the registrant must notify DEA in writing of this fact in order to resolve the initial report and explain why no DEA Form 106 was filed regarding the incident.
   d. A copy of the DEA Form 106 shall be printed, kept in the pharmacy and readily retrievable for three (3) years.
3. The pharmacy may also choose to notify local law enforcement depending on the severity of the violation.
4. An employee who has knowledge of drug diversion by a fellow employee has an obligation to report such information to their supervisor or PIC. Failure to report will result in action up to and including termination of employment.

D. **RELATED DOCUMENT(S):**
1. Administrative Policy: Alcohol and Drug Testing Guidelines for Employees - 429
2. Administrative Policy: Coaching and counseling for Work Performance Policy - 424
3. Security Policy: Locker Entry by Force - 206

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 05/94

SUBJECT: Labeling Standards

REVISION DATE: 10/96, 02/97, 08/00, 02/03, 06/05, 03/06, 04/09, 07/09, 01/12, 09/15 07/18

Department Approval:	**~~02/18~~03/22**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **POLICY**:

1. All medications shall be clearly labeled in a consistent and legible manner, in compliance with state and federal requirements, professional standards, and regulations.
2. There shall be a standard method for appropriately and safely labeling medications dispensed to both inpatients and outpatients.
3. Any medication or medication container (i.e. syringe, bag, bottle, tube, jar) that is prepared but not immediately administered must be labeled in accordance with this policy.
   a. Note: The Joint Commission defines immediately administered as; "An immediately administered medication is one that is prepared or obtained, taken directly to a patient, and administered to that patient by an authorized staff member, without any break in process."
4. When preparing individualized medications for multiple patients or when the person preparing a medication is not the person administering the medication, the label must also include the patient's name and the patient's location
5. For labeling of medications dispensed to a sterile field see Patient Care Services Policy Labeling Medications/Solutions On and Off a Sterile Field

B. **PROCEDURE:**

1. Labels prepared by the pharmacy are typed or printed from a computer.
2. To the extent feasible, labels are affixed directly to the immediate container and not to an overwrap such as a box, foil wrap, or plastic bag. In cases where the physical characteristics of the immediate container of the medication do not permit full labeling, a partial label containing, at a minimum, the patient name and location may be placed on the container and the complete labeling applied to an appropriate outer container.
3. All medications dispensed from the pharmacy, including compounded IV admixtures and parenteral nutrition, contain, at a minimum, the following information on the label:
   a. The patient's name and location
   b. The proprietary and/or nonproprietary name of the medication
   c. Medication strength or concentration
   d. Dose
   e. Dosage form, including any pertinent statements bearing on special characteristics of the dosage form (i.e. sustained release, enteric coated, sublingual, chewable, solution, elixir, suspension, etc)
   f. Bar-code

g. Manufacturer or distributor (if not evident from a proprietary name or from pharmacy prepackaging records
h. Expiration date or beyond use date
i. Expiration time, when it occurs in less than 24 hours
j. Date prepared and ingredients including diluents on all compounded IV admixtures and parenteral nutrition
k. Quantity dispensed
l. Infusion rate, if IV and if applicable
m. Directions for use and any applicable storage, handling, or cautionary statements (e.g., refrigerate, shake well, not to be chewed, "Caution: Chemotherapy", "Not to be given IV, For Irrigation Only")

4. Medication bar-codes are scanned and verified to assure they read and are linked in the computer system(s) to the right medication, right strength and right dosage form
5. Medications that are mislabeled (i.e., labels are illegible, incomplete, incorrect, etc.) are segregated from the active inventory and are not used
6. Source or bulk containers prepared for use during compounding will be labeled pursuant to Pharmacy Policy Sterile Product Preparation
7. Chemotherapy will be labeled pursuant to Pharmacy Policy Chemotherapy Prescribing, Processing, and Preparation
8. Prescriptions intended for use outside of the hospital shall be labeled to ensure complete understanding and compliance by the patient/family and shall include at a minimum:
   a. Patient's name
   b. Prescriber's name
   c. Date the prescription is issued
   d. Prescription number or other means of identifying the prescription
   e. Generic drug name and manufacturer's name (manufacturer's name not required if Brand name is used)
   f. Strength of the drug
   g. Directions for use
   h. Physical description of the dispensed medication including its color, shape, and any identification code that appears on the tablets or capsules (unless exempted per Board of Pharmacy)
   i. The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription
   j. Quantity of the drug dispensed
   k. Expiration date of the drug dispensed
   l. Name and address of the pharmacy

C. **RELATED DOCUMENT(S):**
1. Patient Care Services Policy: Labeling Medications/Solutions On and Off a Sterile Field
2. Pharmacy Policy: Sterile Product Preparation
3. Pharmacy Policy: Chemotherapy Prescribing, Processing, and Preparation

D. **REFERENCE(S):**
1. The Joint Commission Standards MM.05.01.09; MM.03.01.01 EP:7 (2017)
2. Centers for Medicare and Medicaid Services (CMS) 482.25(b)
3. California Code of Regulations, Title 16, Section 4076 and 4128
4. American Society of Hospital Pharmacists. ASHP technical assistance bulletin on single unit and unit dose packages of drugs. Am J Hosp Pharm.1985; 42:378–9.

Tri-City Medical Center
Oceanside, California

PHARMACY MANUAL

ISSUE DATE: 02/03 **SUBJECT: Medication Recall**

REVISION DATE: 06/03, 08/05, 01/06, 03/08, 02/09
07/11, 11/14, 04/17, 05/18

Pharmacy ~~Patient Care Services~~ Content Expert~~Department~~ Approval:	**~~01/18~~12/21**
~~Clinical Policies & Procedures Committee Approval:~~	**~~02/18~~02/22**
~~Nurse Executive Council Approval:~~	**~~03/18~~03/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Committee Approval:	**~~03/18~~03/22**
Medical Executive Committee Approval:	**~~04/18~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~05/18~~ n/a**
Board of Directors Approval:	**05/18**

A. **POLICY:**

1. The Pharmacy Department shall maintain a system whereby drugs subject to recall are immediately identified, removed from active inventory, and sequestered.
2. The Pharmacy Department is notified of manufacturer's or Food and Drug Administration (FDA's) recall or medication discontinuation proceedings through direct mail, wholesaler's notification, written or electronic FDA Safety Alert or Recall Notification.
   a. Chronological files of such notifications, alerts, and recall notices shall be maintained for at least one (1) year.

B. **PROCEDURE:**

1. When the Pharmacy Department receives information about a medication recall or discontinuation by the manufacturer or the FDA for safety reasons, affected providers and/or patients will be notified of the recall or discontinuation if required by law or regulation.
2. The pharmaceutical buyer or designee shall remove all lots of a recalled drug if found in inventory. Recalled medications are replaced with an unaffected lot number of the same medications or generic equivalent, when available.
   a. A record of actions taken shall be written on the recall notice; including none found in inventory and the date the action was taken.
   b. If affected lots of recalled drugs were identified in inventory, the Pharmacy Director or designee will be notified of all actions taken by the buyer or designee.
3. All drug storage areas of the hospital shall be inspected, including satellite pharmacies, surgery and other floor stock areas if applicable.
4. Recalled medications are quarantined in a designated area separate from active stock. This area is clearly identified.
5. Recalled medications are returned in accordance with manufacturers/recall notice specifications.
6. Medications recalled for safety reasons are reported to the Pharmacy and Therapeutics Committee.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 10/10 **SUBJECT: Restricted Antimicrobials**

REVISION DATE~~(S)~~: 07/15, 01/19

Pharmacy Department Approval:	~~09/18~~03/22
~~**Medical Staff Department or Division Approval:**~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~09/18~~03/22
Medical Executive Committee Approval:	~~11/18~~04/22
Administration Approval:	~~01/19~~05/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **PURPOSE:**
1. To provide a list of restricted antimicrobials where prescribing of such medications is limited to specific indications or medical specialty in order to improve clinical outcomes, reduce rates of emerging resistance, and reduce the incidence of adverse events.
2. To provide restriction criteria and outline requirements for prescribing and dispensing of restricted antimicrobials
3. To provide a process that streamlines the approval of restricted antimicrobials

B. **POLICY:**
1. Restriction criteria shall be reviewed and revised at least annually by Pharmacy and the Infectious Disease (ID) Physician based on usage patterns, microbiology data, and cost-effective analyses.
2. Restriction Criteria shall be approved by the Pharmacy & Therapeutics (P&T) committee.
   a. Use of antimicrobials that do not meet criteria shall require ID approval.
   b. The Infectious Disease Physician shall collaborate with those who fail to comply with the restriction guidelines set forth by P&T.
3. All restrictions apply to inpatient and emergency room patients with the exception of patients enrolled in investigational antibiotic drug studies.

C. **PROCEDURE:**
1. The clinical pharmacist and/or Pharmacy Clinical Manager shall review all requests for restricted antimicrobials.
2. If the patient meets criteria for use of the agent (see Antimicrobial Agents Requiring Approval: Criteria For Use), the clinical pharmacist will approve the request.
3. If the patient fails to meet criteria, the prescriber will be notified that continued use of restricted antimicrobials requires approval by the Infectious Disease Physician, and/or Intensivist as indicated by criteria use guidelines
4. If the prescriber insists on using a restricted antimicrobial, the patient will be provided with enough doses (i.e. up to 24 hours, or through the weekend) to allow enough time for the prescribing physician to contact the Infectious Disease Physician and obtain approval. The prescriber will be notified of how many doses will be dispensed pending approval.
5. The Infectious Disease Physician will determine if the antimicrobial is indicated and provide approval if continued use of restricted antimicrobial is deemed appropriate.
6. It is the ordering physician's responsibility to follow-up with a maintenance order for the antimicrobial after approval from the Infectious Disease Physician has been obtained

7. In addition to Infectious Disease Physician approval, all non-formulary agents require approval from the Clinical Pharmacy Manager **or ID Pharmacist**

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

1. Antimicrobial Agents Requiring Approval: Criteria For Use

ANTIMICROBIAL AGENTS REQUIRING APPROVAL: CRITERIA FOR USE

ANTIBIOTICS:

1. Amikacin
   a. All use restricted to Infectious Diseases Physicians
2. Aztreonam (Azactam)
   a. Treatment of documented aerobic gram-negative bacilli infections in which beta-lactams are contraindicated due to a true anaphylactic penicillin or cephalosporin allergy (any prescriber)
      i. Monotherapy should be used only when cultures and sensitivities have been reported
   b. Empiric therapy is restricted to Intensivists or Infectious Diseases Physicians
~~3. Cefepime (Maxipime)~~
   ~~a. For treatment of documented *Pseudomonas aeruginosa* (any prescriber)~~
   ~~b. For empiric treatment of febrile neutropenia (any prescriber)~~
   ~~c. Other empiric therapy restricted to Oncologists, Intensivists, or Infectious Disease Physicians~~
~~4.~~3. Ceftaroline (Teflaro)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
~~5.~~4. Ceftolozane-tazobactam (Zerbaxa)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
~~6.~~5. Ceftazidime (Fortaz)
   a. For treatment of documented *Pseudomonas aeruginosa* (any prescriber)
   b. Empiric therapy restricted to Oncologists, Intensivists, Infectious Diseases Physicians, or Nephrologists
~~7.~~6. Ceftazidime-avibactam (Avycaz)
   a. ~~Non-formulary agent~~**All use**-restricted to Infectious Diseases Physicians
~~8.~~7. Colistin/colistimethate
   a. Non-formulary agent restricted to Infectious Diseases Physicians
~~9.~~8. Dalbavancin (Dalvance) & oritavancin (Orbactiv)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
   b. Should not be dispensed unless ordered by Infectious Diseases Physician and approved by pharmacy Clinical Manager
~~10.~~9. Daptomycin (Cubicin)
   a. For treatment of serious infections (except involving the urinary tract or lungs) with confirmed vancomycin resistant *Enterococcus ~~faecalis/faecium~~***species**-(any prescriber)
   b. Empiric therapy or UTI is restricted to Intensivists or Infectious Diseases Physicians
10. Eravacycline (Xerava)
~~b.~~**11. a. All use restricted to Infectious Diseases Physicians**
~~11.~~**12.** Ertapenem (Invanz)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
~~12.~~**13.** Fidaxomicin (Dificid)
   a. ~~Non-f~~**F**ormulary agent restricted to Infectious Diseases Physicians
~~13.~~**14.** Linezolid (Zyvox)
   a. For treatment of serious infections (except involving the urinary tract) with confirmed vancomycin resistant *Enterococcus ~~faecalis/faecium~~***species** (any prescriber)
   b. Empiric therapy or UTI is restricted to Intensivists, or Infectious Diseases Physicians
~~14.~~**15.** Fosfomycin (Monurol)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
~~15.~~**16.** Meropenem (Merrem)
   a. For treatment of serious infections due to documented multi-drug resistant gram negative bacilli that are only sensitive to the carbapenem class of antibiotics (any prescriber)
   b. For treatment of extended-spectrum beta-lactamase (ESBL) producing Enterobacteriaceae.

c. Empiric therapy restricted to Oncologists, Intensivists, or Infectious Diseases Physicians

~~16.~~**17.** Meropenem/vaborbactam
   a. Non-formulary agent restricted to Infectious Diseases Physicians

~~17.~~**18.** Quinupristin/dalfopristin (Synercid)
   a. Non-formulary agent restricted to Infectious Diseases Physicians

~~18.~~**19.** Tigecycline (Tygacil)
   a. Non-formulary agent restricted to Infectious Diseases Physicians

ANTIFUNGALS:

1. Amphotericin B liposomal (Ambisome)
   a. All use restricted to Oncologists, Intensivists, or Infectious Diseases Physicians
2. **Flucytosine (Ancobon)**
   a. **All use restricted to Infectious Diseases**

~~2.~~**3.** Micafungin (Mycamine)
   a. For treatment of documented invasive candidiasis (not urin**arye,** ~~or~~ respiratory**, ocular, or intra-cranial**), pending species identification (any prescriber)
   b. Empiric therapy is restricted to Oncologists, Intensivists, or Infectious Diseases Physicians
3. Posaconazole (Noxafil)
   a. IV formulation: All use restricted to Infectious Diseases Physicians
   b. PO formulation: All use restricted to Oncologists or Infectious Diseases Physicians
4. Isavuconazonium (Cresemba)
   a. Non-formulary agent restricted to Infectious Diseases Physicians
5. Voriconazole (Vfend)
   a. For treatment of documented invasive aspergillus infections (any prescriber)
   b. Empiric therapy or other fungal infections restricted to Oncologists, Intensivists, or Infectious Diseases Physicians

ANTIVIRALS:

1. **Ganciclovir**
   a. **All use restricted to Infectious Diseases Physicians**
2. **Valganciclovir**
   a. **All use restricted to Infectious Diseases Physicians**

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 07/11

SUBJECT: Risk Evaluation and Mitigation Strategies (REMS)

REVISION DATE: 12/15, 01/18

Department Approval:	~~10/17~~12/21
Pharmacy and Therapeutics Approval:	~~11/17~~03/22
Medical Executive Committee Approval:	~~11/17~~04/22
Administration Approval:	05/22
Professional Affairs Committee Approval:	~~01/18~~ n/a
Board of Directors Approval:	01/18

A. **PURPOSE:**

1. To define a process for managing medications with FDA Risk Evaluation and Mitigation Strategies (REMS).
2. A Risk Evaluation and Mitigation Strategy (REMS) is a strategy to manage a known or potential serious risk associated with a drug or biological product. A REMS will be required if the Food and Drug Administration (FDA) determines that a REMS is necessary to ensure the benefits of the drug or biological product outweigh its risks. A REMS can include a Medication Guide, Patient Package Insert, a communication plan, elements to assure safe use, and an implementation system.

B. **DEFINITION(S):**

1. Medication Guide/Patient Package Insert (PPI) – The FDA official Medication Guide is written information used to provide patient education. The guide is written using non-technical language and a standardized format.
2. Communication Plan – A communication plan is developed by the drug's sponsor to support implementation of an element of the REMS, and can inform key audiences (health care providers) about the risks of the drug. A communication plan educates, informs and raises awareness about the risks. Examples include letters to healthcare providers, communications to professional societies and/or professional education.
3. Elements to Assure Safe Use (ETASU) – ETASU are required medical interventions or other actions healthcare professionals need to execute prior to prescribing or dispensing the drug to the patient. These special requirements or restrictions are to optimize safe use of a drug. ETASU include a wide range of measures such as; special training for prescribers and/or dispensers, enrollment in a special registry, specialized distribution systems with select distributors or specialty pharmacies, patient monitoring requirements and more.
4. Implementation System – The drug's sponsor may be required to monitor, evaluate, and make efforts to improve the ETASU program.
5. Timetable for Assessment – Timetable for assessments must be at least by 18 months, 3 years, and in the 7th year after the REMS is approved. Assessment results may be used to modify the REMS, or even eliminate it after 3 years, if the assessment shows changes are needed or that the REMS has met its goal.

C. **POLICY:**

1. Tri City Healthcare District (TCHD) will comply with all REMs required by the FDA as they pertain to the inpatient hospital setting.

a. Formulary medications with REMS are identified as part of the formulary review process. Drugs with active REMS are evaluated for applicable required elements to assure safe use
b. Non-formulary medications with REMS requirements are identified during order entry and/or review by the pharmacist prior to dispensing. A copy of the REMS communication plan and any other REMS requirements are communicated to other healthcare providers as applicable
c. Patient own medications with REMS requirements brought into the facility and authorized for inpatient use are assessed and identified by the pharmacist during order review. Per the REMS, applicable requirements are verified and when necessary, communicated to other healthcare providers.

2. A list of drugs/biological products on the inpatient formulary that require REMs will be maintained on the Tri-City Intranet.
3. As other formulary drugs and/or biological products are identified by the FDA requiring REMS in the inpatient hospital setting, TCHD will update the relevant REMS references on the Intranet.

D. **REFERENCE(S):**

1. The Food and Drug Administration Amendments Act of 2007 (FDAAA)
2. The Joint Commission Standard MM.01.01.03; MM.02.01.01; MM.05.01.01; MM.05.01.11; MM.06.01.01
3. Centers for Medicare and Medicaid Services (CMS) CoP §482.25 (a)
4. Healthcare Facilities Accreditation Program (HFAP) 25.01.20
5. DNV National Integrated Accreditation for Healthcare Organizations (NIAHO –DNV) MM.1, MM.2
6. ASHP REMS Database and Resources https://www.ashp.org/REMS (Accessed July 2017)
7. FDA Medication Guides http://www.fda.gov/Drugs/DrugSafety/UCM085729 (Accessed July 2017)
8. FDA REMS e-mail alerts (Accessed July 2017) https://public.govdelivery.com/accounts/USFDA/subscriber/new?topic_id=USFDA_340

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 10/07

SUBJECT: Technician Checking Technician Program

REVISION DATE: 10/07, 07/09, 01/12, 07/15, 07/18

Department Approval:	**~~04/18~~03/22**
~~Medical Staff Department/Division Approval:~~	**~~n/a~~**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~03/22**
Medical Executive Committee Approval:	**~~06/18~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~07/18~~ n/a**
Board of Directors Approval:	**07/18**

A. **POLICY**:

1. A general acute care hospital, as defined in Health and Safety code 1250(a), that has an ongoing clinical pharmacy program may allow pharmacy technicians to check the work of other pharmacy technicians in connection with the filling of floor and ward stock and unit dose distribution systems for patients admitted to the hospital whose orders have previously been reviewed and approved by a licensed pharmacist.
2. Only inpatient hospital pharmacies as defined in 4029(a) that maintain a clinical pharmacy services program as described in 4052 may have a technician checking technician program as described. The pharmacy shall have on file a description of the clinical pharmacy program prior to initiating a technician checking technician program. The overall operation of the program shall be the responsibility of the pharmacist-in-charge.
3. This section shall only apply to acute care inpatient hospital pharmacy settings.
4. Hospital pharmacies that have a technician checking technician program shall deploy pharmacists to the inpatient care setting to provide clinical services.
5. The Technician Check Technician (TCT) program shall include only refills to the Automated Dispensing Machines (ADM).
6. Compounded and repackaged products must be checked by a pharmacist prior to the medication being used under the TCT for refill into the ADM.
7. The pharmacist(s) on duty will be responsible for answering any questions or handling any issues a technician may have with regards to TCT program.
8. Every technician will have their work checked by another technician when refilling any medication for distribution to an ADM.
9. Quality Assurance audits will be conducted at random and unannounced times. If more than one mistake is found during the audit, education will be given and the audit will be repeated at a random time within the next 30 days. If more than one error is found on the repeat audit, the technician will undergo further training and shall not be permitted to act as a Technician Checker until 3 consecutive audits result in no more than a single error.
10. All technicians will be given a written test (Pharmacy Tech Competency Test) on an annual, ongoing basis. A supervisor will re-educate as needed when 100% score is not achieved on the annual written test.

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION SERVICES

ISSUE DATE: 10/88 **SUBJECT:** Disaster Plan

REVISION DATE: 9/93, 3/97, 6/00, 3/03, 12/12

Department Approval:	**02/20**
Division of Pulmonary Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure efficient Pulmonary Rehabilitation Center Services and to maintain adequate availability of personnel in the event of disaster, to establish, supervise, and maintain safety of the patients we serve.

B. **INTRODUCTION:**

1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located on the TCMC intranet.

C. **NOTIFICATION:**

1. The Pulmonary Rehabilitation Center shall be notified of the Disaster Plan Activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page.
2. Charge Responsibilities
   a. Read the Unit Leader Responsibilities found in the Department Disaster packet (This is kept in the Safety and Disaster Manual). Charge duty shall transfer to the Manager/Director after one arrives.
   b. Complete and send one employee with the Personnel Inventory Form to the Incident Command Center.
      i. Personnel Inventory Forms are found on the TCMC intranet. The Incident Command Center is located in the French Rooms. If the Incident Command Center is not set up, contact the Emergency Department.
   c. Recall staff from breaks for standby to report to disaster priority areas.
      i. Staff shall return immediately if they hear the overhead page activating the disaster plan.
   d. Contact Manager/Director and begin call-in procedure. Relay as much information as you can to the Incident Command Center.
   e. Upon direction of Incident Commander or Department Director, begin call-in procedure.
   f. Every hour, or more frequently as directed, send status reports to Incident Command Center.

D. **STAFF RESPONSIBILITIES:**

1. Assist in evacuating patients from the Pulmonary Rehabilitation Center to their private vehicles, ensuring safety of patients at all times. Patients shall be sent to their homes via private transportation.
2. Facilitate flow of patients out of unit.

3. Facilitate the call-in procedure.
4. Man the telephones for incoming requests
5. Assists in preparing the Pulmonary Rehabilitation Center for use by other department's personnel as necessary.

E. **EVACUATION OF UNIT:**

1. The decision to evacuate the Pulmonary Rehabilitation Center rests with the Incident Commander after an evaluation by Facilities Management.
2. Complete Evacuation:
   a. All patients shall be evacuated to their private homes unless situation prohibits them from leaving hospital premises.
   b. Patients shall be assisted to their private vehicles via ambulation; wheelchair assistance or other appropriate "carries" as necessary.
3. All staff shall report to Command Center to assist hospital in appropriate capacity.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 02/94~~February 17, 1994~~ **SUBJECT: Closed Circuit Surveillance System**

REVIEWED DATE(~~S~~): 1/97, 5/03, 11/06, 03/09,0 6/11 **POLICY NUMBER: 512**
REVISION DATE(~~S~~): 07/03, 10/11, 12/15, 12/15, 09/19

Department Approval:	~~04/19~~03/22
Environmental Health and Safety Committee Approval:	~~06/19~~03/22
Administration Approval:	~~09/19~~05/22
Professional Affairs Committee Approval ~~Date(s)~~:	n/a
Board of Directors Approval ~~Date(s)~~:	09/19

A. **PURPOSE:**

1. To ensure the safe and appropriate management of the Closed Circuit Surveillance System (CCSS) in accordance with ~~L~~local, ~~S~~state and federal laws. The CCSS system is for the prevention or detection and investigation of a crime or disorder, apprehension and prosecution of offenders (including use of images in criminal proceedings) in the interest of public and employee ~~H~~health and ~~S~~safety, protection of Tri-City Healthcare District (TCHD) property and assets.

B. **POLICY:**

1. TCHD~~C~~ utilizes the CCSS system to maintain optimum levels of ~~S~~safety and ~~S~~security for patients, staff, visitors and the general public. TCHD is conscious that it must not breach issues affecting a person's civil liberties and matters of privacy. These images may be required for investigations related to harassment, workman's compensation, or in relation to a criminal incident. The monitoring and any subsequent viewing of the images must take place in a secure environment to which only authorized personnel have access. Authorized personnel may include: Safety/Security Manager or **their**~~his~~ design**ee**~~ate~~, Security Supervisor/Officers, Legal, Risk Management and Human Resources. Law Enforcement Agencies and personnel directly involved in a specific investigation may also be included.

C. **PROCEDURE:**

1. To enable TCHD to deal promptly with a request for access, **authorized TCMC personnel as notated in Section B of this policy may provide the reason for request of CCSS material and images along with dates, times and locations and do not have to complete an Image Request Form**~~staff or~~**. However,** Authorities Having Jurisdiction (AHJ) **or Law Enforcement agencies**, will be instructed to complete the Access to CCSS Image Request Form giving information such as, dates, times, locations and reasoning to assist in identifying the personnel data requested.
2. The Safety/Security Manager or Security Supervisor will review all requests for approval.
3. Any CCSS images that are requested to be removed from TCHD:
   a. Must be approved by Safety/Security Manager, Security Supervisor or Risk Management.
   b. Copies are to be handled, **provided by electronic means or** ~~and~~ printed by the Security Department **Director, Manager, Supervisor.**
   c. When CCSS images are required for evidential use in legal actions, **a digital disc recording is made by the Security Director, Manager or Supervisor, placed in a sealed envelope, signed and dated and will remain secured until the**

investigation has been completed. When CCSS material or images are required for TCHD disciplinary proceedings, the Security Director, Manager or Supervisor will transfer the CCSS material or images through approved electronic means as notated in Section C Procedure d of this policy ~~or TCHD disciplinary proceedings, a digital disc recording is made by the Security Supervisor, placed in a sealed envelope, signed and dated, and will remain secured until the investigation has been completed.~~.

d. All requests received from Legal, HR and Risk will have that requested data downloaded onto their secured, pass code generated file, designated specifically for their department within the Security **shared**~~hard~~-drive.

4. Viewing of images within the security office **or any location** is controlled by the Security Supervisor or designee.

~~4.~~5. **At no time will anyone outside of the people or agencies that follow be authorized to view CCSS material or images: Security Dept. officers, authorized personnel as per the Security Dept. Director, Manager or Supervisor, AHJ, HR, Legal or Risk Depts. Any non-adherence to this policy and its procedures could lead to discipline up to termination as well as an investigation and thorough follow-up if done by an outside agency.**

D. **PROCEDURE FOR SECURITY OFFICERS:**

1. All Security Officers will be trained on the CCSS system and will be able to demonstrate working proficiency with the CCSS system prior to end of their probationary status.
2. All Security Department personnel~~, while assigned to the Emergency Department,~~ will be responsible to use and operate the CCSS system in a confidential and approved manner. Any misuse, unauthorized operation, or allowing others to view without expressed permission **from the Security Department Director, Manager or Supervisor** will result in disciplinary action up to and including termination.
3. All Security computers when not in use or manned, are to be turned off or locked down prior to leaving the area.
4. The Security Supervisor will be immediately notified of any detected condition or operational failure which requires the immediate attention or repair of the CCSS system.

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

1. Access to CCSS Image Request Form
2. CCSS Locations List

Tri-City Medical Center
Oceanside, California

DELETE: No longer required

SECURITY
SECURITY ADMINITRATION

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: October 01, 1993~~ ~~Reviewed: 10/97, 5/03, 11/06, 3/09, 6/11~~ ~~Revision: 7/03~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Guidelines for Nuclear Medicine Department~~ ~~Page 1 of 1~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department SDPPM # 515~~

SUBJECT: Security Department Guidelines for Nuclear Medicine Department

ISSUE DATE: October 01, 1993
REVIEWED DATE(S): 10/97, 5/03, 11/06, 3/09, 6/11
REVISION DATE(S): 7/03

Department Approval Date(s): **05/20**
Environmental Health and Safety Committee Approval Date (s): **08/20**
Administration Approval: **05/22**
Professional Affairs Committee Approval Date(s): **n/a**
Board of Directors Approval Date(s):

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

~~1. To establish guidelines for Security Department personnel to utilize while providing services for the Nuclear Medicine Department.~~

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

~~1. It is the policy of the Security Department that all Security Department personnel follow the procedures for providing services to the Nuclear Medicine Department.~~

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

1. ~~See Attached Policy~~

Tri-City Medical Center
Oceanside, California

~~SURGICAL SERVICES~~
~~SURGERY~~
PATIENT CARE SERVICES

ISSUE DATE: 04/94

SUBJECT: ~~Sanitation:~~ Perioperative/Procedural Environmental Cleaning

REVISION DATE(S): 02/05; 01/06; 06/09; 11/09; 01/10; 10/12, 01/13

Patient Care Services Content Expert Approval:	**~~02/20~~12/21**
Clinical Policies and Procedures Committee Approval:	**12/21**
Nursing Leadership Approval:	**03/22**
~~**Department of Anesthesiology Approval:**~~	~~**n/a**~~
~~**Operating Room Committee Approval:**~~	~~**n/a**~~
Infection Control Committee Approval:	**~~03/20~~04/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~04/20~~05/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **PURPOSE:**

1. **To provide evidence-based guidelines for thorough and consistent cleaning practices of routine preliminary (i.e., damp dusting before first procedure), intraoperative, end of procedure, terminal, and scheduled cleaning of the oOperating rRoom (OR) ~~environment~~and invasive procedure areas.**
2. **To foster an environment of teamwork and collaboration within the OR/invasive procedure ~~operating room~~areas.**
3. **To provide a clean environment to patients and minimize exposure risk to ~~Operating Room~~ (OR) and invasive procedure area personnel and patients.**~~control and reduce the possibility of cross-contamination of the surgical patient and personnel in the surgical suite, cleaning will be comprehensive enough to provide a bacteriologically safe environment regardless of the procedure being performed or the condition of the patient.~~

B. **DEFINITION(S):**

1. Cleaning: The **physical removal of foreign material, e.g.** ~~absence of visible~~ dust, soil, **and organic material such as blood and debris, secretions, excretions and microorganisms.** ~~debris, or blood.~~ **Cleaning physically removes rather than kills microorganisms. It is accomplished with water, detergents and mechanical action.**
2. Contact time: The specific length of time a disinfectant **is exposed to surfaces in order to achieve the appropriate level of disinfection.**~~must remain in contact with a microorganism to achieve disinfection.~~
3. Disinfection: A process that kills pathogenic and other microorganisms by physical or chemical means. **Medical equipment must be cleaned properly before effective disinfection can take place.**
4. Scheduled cleaning: Periodic cleaning (i.e., weekly, monthly) of areas and equipment that are not cleaned daily or after every use.
5. **Room turnover: Between case cleaning performed by:**
   a. **Perioperative aides in the OR**

b. **Perioperative aides in Interventional Radiology (IR), and Cardiac Catheterization Lab (CCL) during normal business hours, and Environmental Services (EVS) personnel after hours**

~~4.~~**c. EVS in Labor and Delivery Operating Rooms (OB-OR)**

6. Terminal cleaning: Thorough environmental cleaning that is performed at the end of each day the room or area is used **and is performed by:**~~.~~

a. Perioperative aides in the OR

~~5.~~**b. EVS in IR, CCL, OB-OR, Pulmonary clinical areas (i.e., Bronch Room, Pulmonary Function Testing (PFT) room, and Pulmonary bronchoscope storage room).**

C. POLICY:

1. Recommended equipment (~~Dedicate to OR and/or SPD~~shall be dedicated equipment to each area):

a. Properly stocked cleaning cart
b. Goggles or safety glasses
c. Step stool
d. Microfiber cleaning cloths or disposable wipes
e. Bucket for cleaning solution
f. Small nylon ~~broom~~sweep set/dust pan (for larger debris)
g. Microfiber flat mop system or a microfiber bucket mop system
h. Microfiber high dusting tool and replacement pads
i. Disposable personal protective equipment (PPE) -(gloves, masks)
j. Trash liners
~~a.~~k. Wet floor sign

~~6.~~2. Chemicals

~~C. POLICY:~~

a. EPA registered hospital grade disinfectant~~Cleaning chemicals used in Surgical Services must be~~ approved by Infection Prevention.

~~1.~~

b. Cleaner/disinfectants
c. Ammonia free glass cleaner
d. Iodine remover and tape/adhesive remover as needed

3. Safety

a. Follow Standard Precautions.

~~a.~~**i.** ~~Personal protective equipment (~~PPE~~)~~ must be worn during handling of contaminated items or cleaning of contaminated surfaces, to reduce the risk of exposure to blood, body fluids, and other potentially infectious materials.

~~b.~~**ii.** Gloves must be worn when it is reasonably anticipated that there may be contact with blood, body fluids, or other potentially infectious materials during handling or touching of contaminated items or surfaces.

~~c.~~**iii.** Masks, eye protection, and face shields must be worn whenever contact with splashes, spray, splatter, or droplets ~~or~~**of** blood, body fluids, or other potentially infectious materials is anticipated.

~~d.~~**iv.** Wear respiratory protection (i.e., N95 or powered air-purifying respirator [PAPR]) if cleaning procedures are expected to generate infectious aerosols.

~~e.~~**b.** Perform hand hygiene after PPE is removed and as soon as possible after hands are soiled.

c. Be alert for sharps and sharp objects.
d. Wear ~~scrubs~~ surgical attire and proper PPE as needed.
e. Always display wet floor or caution signs when cleaning floors.
~~2.~~f. Use chemicals ~~Cleaning chemicals are prepared, handled, used, stored, and disposed of~~ aaccording to manufacturer's instructions for use (IFU).

g. Ensure proper labeling of all chemical containers (e.g. when~~I~~f a cleaning chemical is dispensed or removed from the original container), **including mop buckets. These must**

~~be the secondary container must~~ immediately ~~be~~ labeled with the chemical name, concentration, and expiration date.

h. **Do not mix or combine chemicals.**

i. **For environmental and worker safety, apply chemicals using pour spouts NOT spray bottles.**

j. **-If using a cleaning cloth and bucket system, never re-immerse cloths into the bucket. Change cloths.**

k. **If using pop up disposable wipes:**
   i. **Use properly by changing frequently to ensure proper application.**
   ii. **Be sure they disperse sufficient amount of disinfectant for the appropriate contact time.**

l. **If a bucket and disposable wipe system is used, ensure wipes are properly saturated (follow directions on label) and close lid of container properly between use and when storing.**

m. **Review the Safety Data Sheets (SDS) and/or labels of selected cleaning chemicals.**

n. **OR staff: Assure functionality of electrical equipment and scan for electrical cord damage before using or cleaning.**

4. **General Infection Prevention Procedures**

a. **Follow protocol for hand hygiene and alcohol based hand rubs.**

b. **Perform hand hygiene and don PPE.**

c. **Leave the cleaning cart in the hall near the door but do not obstruct passage. Carry supplies and equipment into the room as needed.**

d. **Work methodically through the room in an organized pattern through the room, starting from the ceiling down and clean to dirty.**

e. **DO NOT use spray bottles. Rather use a small bucket system with microfiber cloths or disposable wipes. Microfiber cloths should not be stored in the buckets but dipped into the cleaning solution just prior to use.**

f. **Frequently change to a fresh cleaning cloth or saturated wipe when needed (see zone map), never re-dip or re-use cloths.**

~~3.~~g. Brooms with bristles may not be used to sweep the floor in the semi-restricted and restricted areas.

~~a.~~h. **Horizontal surfaces should be damp dusted before the first case of the day.** A clean, low-linting cloth moistened with disinfectant (i.e., Sanicloth AF3 ready-to-use wipes) is used to damp dust.

i. **Every operating room and procedure room should be terminally cleaned when the scheduled procedures are complete for the day or once during each 24 hour period during regular hours of operation.**

j. Before storage and re-use, cleaning equipment must be disassembled, cleaned, disinfected, and dried, per manufacturer's IFU.

k. **Consider the floors in the perioperative practice setting to be contaminated.**

l. **Consider items that contact the floor for any amount of time to be contaminated.**

m. **Clean and disinfect noncritical items (i.e., positioning devices) per the manufacturer's IFU after the items contact the floor.**

n. **Mop floors with damp or wet mops. Do not dry mop in semi-restricted or restricted areas.**

o. **After each patient use, clean and disinfect reusable noncritical, nonporous surfaces (e.g., mattress covers, positioning devices) and equipment per manufacturer's IFU.**

p. **Before cleaning, inspect mattresses and padded positioning devices (e.g., OR beds, arm boards, gurneys) for any moisture, stains, or damage.**

q. **Remove and replace damaged or worn mattress coverings according to manufacturer's IFU.**

r. **Discard single-use items after each patient use.**

s. **Clean and disinfect equipment that is stored outside the surgical suite before bringing it into the semi-restricted area.**

~~a.~~

~~5. Before applying a disinfectant, remove visible soil (e.g., dust, debris) from the surface.~~

~~6. Spray bottles may not be used to apply disinfectants to environmental surfaces in the perioperative setting. Poured solutions or ready-to-use wipes shall be used.~~

~~7. Apply disinfectants for the contact time required per manufacturer's IFU. Reapply the disinfectant as needed to ensure the surface remains wet for the duration of the contact time.~~

~~8. Cleaning materials (i.e., microfiber mop heads, cloths and ready-to-use wipes) shall be disposable and low linting.~~

~~9.~~ Brooms with bristles may not be used to sweep the floor in the semi-restricted and restricted areas.

~~10. Cleaning materials, tools and equipment (i.e., cleaning carts, floor scrubber) are dedicated for use in specified areas and may not be taken out of dedicated areas or to other areas of the hospital (i.e., OR dedicated equipment, SPD dedicated equipment).~~

~~11.~~ Before storage and re-use, cleaning equipment must be disassembled, cleaned, disinfected, and dried, per manufacturer's IFU.

~~12. High touch objects and surfaces in the OR must be cleaned and disinfected after each procedure. High touch areas are, including but not limited to:~~

~~a. OR table: controller, side rails, mattress, base~~
~~b. Light switch and surgical light switches~~
~~c. Front door handles and side door push plates~~
~~d. Anesthesia machine and Pyxis~~
~~e. IV poles~~
~~f. Prep stands~~
~~g. Handles on warmers~~
~~h. Surgical lights~~
~~i. Phones~~
~~j. Trash hamper lids~~
~~k. Neptune~~
~~l. Bovie~~

~~13. Clean in a methodical pattern to limit the transmission of microorganisms.~~

~~a. Use a new ready to use wipe to clean each area/equipment.~~
~~b. When cleaning with the same cleaning material (i.e., mop head), progress from clean to dirty areas.~~
~~c. Clean from top to bottom.~~

~~14. Do not return used cleaning materials (i.e., mop heads) to the cleaning solution container.~~

~~15. Discard disposable cleaning materials after each use, according to manufacturer's IFU.~~

~~16. Consider the floors in the perioperative practice setting to be contaminated.~~

~~a. Consider items that contact the floor for any amount of time to be contaminated.~~
~~b. Clean and disinfect noncritical items (i.e., positioning devices) per the manufacturer's IFU after the items contact the floor.~~

~~17. Mop floors with damp or wet mops. Do not dry mop in semi restricted or restricted areas.~~

~~18. After each patient use, clean and disinfect reusable noncritical, nonporous surfaces (e.g., mattress covers, positioning devices) and equipment per manufacturer's IFU.~~

~~a. Before cleaning, inspect mattresses and padded positioning devices (e.g., OR beds, arm boards, gurneys) for any moisture, stains, or damage.~~
~~b. Remove and replace damaged or worn mattress coverings according to manufacturer's IFU.~~

~~19. Discard single use items after each patient use.~~

~~20. Clean and disinfect equipment that is stored outside the surgical suite before bringing it into the semi restricted area.~~

~~21. Standard precautions must be followed when cleaning to prevent contact with blood, body fluids, or other potentially infectious materials.~~

~~a.~~ Personal protective equipment (PPE) must be worn during handling of contaminated items or cleaning of contaminated surfaces, to reduce the risk of exposure to blood, body fluids, and other potentially infectious materials.

~~b.~~ Gloves must be worn when it is reasonably anticipated that there may be contact with blood, body fluids, or other potentially infectious materials during handling or touching of contaminated items or surfaces.

~~c.~~ Masks, eye protection, and face shields must be worn whenever contact with splashes, spray, splatter, or droplets or blood, body fluids, or other potentially infectious materials is anticipated.

~~d.~~ Wear respiratory protection (i.e., N95 or powered air-purifying respirator [PAPR]) if cleaning procedures are expected to generate infectious aerosols.

~~e.~~ Perform hand hygiene after PPE is removed and as soon as possible after hands are soiled.

~~22.~~t. When visible soiling by blood, body fluids, or other potentially infectious materials appears on surfaces or equipment, the area must be cleaned and disinfected immediately or as soon as feasible.

~~23.~~u. Clean spills of blood or body fluids in the following manner, to minimize risk to personnel during cleanup:

~~a.~~i. Apply an EPA-registered disinfectant that is effective against bloodborne pathogens to the spill.

~~b.~~ii. Soak up the spill with an absorbent material and discard.

~~c.~~iii. Clean and disinfect the surface.

~~24.~~v. Items that are saturated with blood, body fluids, or other potentially infectious materials (i.e., would release the fluids in a liquid or semi-liquid state if compressed), and items caked with dried blood, body fluids, or other potentially infectious materials must be placed in a red bag labeled biohazardous waste.

~~25.~~w. Contaminated liquid waste may be suctioned into Neptune or solidified in a canister using solidifying powder.

~~26.~~x. Immediately or as soon as possible after use, contaminated sharps (e.g., needles, blades) must be discarded in a puncture-resistant red sharps container.

~~a.~~y. Contaminated single-use instruments must be discarded in the puncture-resistant recycle collection bins.

~~b.~~z. Bins must not be overfilled.

~~27.~~aa. Laundry contaminated with blood, body fluids, or other potentially infectious materials must be handled as little as possible. Contaminated laundry is placed in blue bags.

D. **OR AND INVASIVE PROCEDURE ROOM TURNOVER (BETWEEN CASE CLEANING) ~~AND~~ PROCEDURES ~~ROOM CLEANING~~:**

1. All horizontal surfaces (e.g., furniture, surgical lights, booms, equipment) must be damp dusted before the first scheduled surgical or other invasive procedure of the day.
   a. Damp dusting is performed before case carts, supplies, and equipment are brought into the room.
   ~~b.~~ A clean, low-linting cloth moistened with disinfectant (i.e., Sanicloth AF3 ready-to-use wipes) is used to damp dust.
2. **Room turnover process (including trash and contaminated laundry removal) may ~~(not)~~** ~~Operating and procedure rooms must be cleaned and disinfected after each patient procedure.~~

~~a.~~3. ~~Do not~~ begin ~~environmental cleaning, including trash and contaminated laundry removal,~~ until the patient has left the OR or procedure room.
   a. Clean from top to bottom and front to back following cleaning checklist.
   b. Remove instruments, basins and trays to appropriate locations for reprocessing. Place all sharps in appropriate containers.
   c. ~~Remove trash and used linen from the room~~**All linen is considered contaminated, remove all soiled linen including gowns, towels and washcloths. Handle soiled linen carefully, being alert for sharps and other objects. Do not carry or hold linens near the body.**
      i. Roll the linen into a bundle for easy handling. Avoid excessive handling or shaking of the linen.

ii. **Used disposable drapes, gloves, gowns, and PPE that do not contain blood or body matter are not necessarily infectious waste.**

d. **Remove trash and infectious waste (This could include sharps containers in the rooms.):**

i. **Leave plastic trash can liner in container, close, twist and tie knot in the top of bag.**

ii. **Use caution and look for protruding objects in the waste bag or container. Never reach into or push on the bag to compress the trash.**

iii. **Lift the liner carefully and place the trash and infectious waste bags into the designated containers. Never carry waste bags against the body.**

iv. **Wipe all surfaces of the waste containers with cleaning solution and allow to air-dry. Insert new waste liner.**

4. **Any area visibly soiled with small amounts of blood, tissue or body fluids should be spot cleaned with a cleaner disinfectant and allowed to air dry.**

~~3.~~**5.** The OR/**procedure** bed/lights is considered the dirtiest part of the OR/**procedure room** after the procedure and should either be cleaned last, or be cleaned as a separate area. ~~(i.e., remove gloves and perform hand hygiene after cleaning this area; don clean gloves before proceeding with cleaning the rest of the OR).~~

a. **Unlock the OR table and completely break down so all surfaces can be cleaned with a cleaner disinfectant.**

b. **Wipe the joints, table attachments, frame, legs, and rails.**

c. **Turn down the mattress and wipe the table bed frame and back of the mattress working from the top and repeat at the bottom.**

d. **Wipe sides of the mattress and change wipe or cloth as needed. Be sure to wipe both sides of coated pillows and allow all elements to air dry.**

e. **Move the lights down from over the operating table and wipe with cleaner disinfectant, wiping all areas of the top of the light including the extender arms.**

f. **Wipe light reflectors**

~~a.~~**g.** **Remove gloves and perform hand hygiene after cleaning this area; don clean gloves before proceeding with cleaning the rest of the OR/procedure room.**

~~4.~~**6.** Clean and disinfect all **high touch areas, furniture and equipment**~~high-touch areas and items~~ used during patient care ~~according to manufacturer's IFU,~~ including, but not limited to:

a. Anesthesia carts, including the top and drawer handles

~~i.~~**b.** Anesthesia equipment (e.g., IV poles, IV pumps)

~~ii.~~**c.** Anesthesia machines, including dials, knobs, and valves

~~iii.~~**d.** Patient monitors, including cables

~~iv.~~**e.** OR bed ~~s and~~ attachments (e.g., arm boards, stirrups, head rests)

~~v.~~**f.** Reusable table straps

~~vi.~~**g.** Positioning devices (e.g., chest rolls, axillary rolls, bed clamps)

~~vii.~~**h.** Patient transfer devices (e.g., roller board)

~~viii. Overhead procedure lights~~

~~ix.~~**i.** Tables and Mayo stands

~~x.~~**j.** Mobile and fixed equipment (e.g., sitting stools, standing stools, tourniquets, bovie, microscope, robot)

~~xi.~~**k.** Light switches

~~xii.~~**l.** Door handles and push plates

~~xiii.~~**m.** Telephones

~~xiv.~~**n.** Computer accessories (i.e., keyboard, mouse)

~~xv.~~**o.** Chairs, stools, and step stools

~~xvi. Trash and linen receptacle lids~~

~~b.~~ The OR bed/lights is considered the dirtiest part of the OR after the procedure and should either be cleaned last, or be cleaned as a separate area (i.e., remove gloves and perform hand hygiene after cleaning this area; don clean gloves before proceeding with cleaning the rest of the OR).

7. **Assure functionality of electrical equipment and scan for electrical cord damage before using or cleaning.**
~~6.~~8. Clean -and disinfect the floor with a mop after each surgical or invasive procedure when visibly soiled or potentially soiled by blood or body fluids (i.e., splash, splatter, dropped item).
~~5.~~9. Spot clean and disinfect the walls and ceiling after each surgical or invasive procedure when visibly soiled.

E. **TERMINAL ROOM CLEANING PROCEDURES:**
1. Terminally clean operating and procedure rooms each day the rooms are used.
2. **Wear appropriate attire for surgical services and don PPE as appropriate.**
3. **The scrub room, halls and utility room, store rooms and instrument processing areas are part of the sterile operating room area, and should be included in all cleaning and disinfecting procedures.**
   a. **Wipe sink shelves and surrounding surfaces with a clean cloth and cleaner disinfectant. Thoroughly clean the scrub sink area, including the counter, faucet, handles, sink basin, under the sink, and all pipes where condensation can harbor germs. Clean the spout of the faucet by putting the cloth in the opening and wipe. Replace soap and waterless hand sanitizer as needed.**
   b. **Pay special attention to corners, the soap dispenser and rim of the sink drain.**
   ~~a.~~c. **Remove gloves, perform hand hygiene and enter the OR suite to be cleaned.**
~~6.~~4. **OR -Suite/Invasive Procedure Room**
   a. **Clean from top to bottom and front to back following cleaning checklist.**
   b. **Remove instruments, basins and trays to appropriate locations for reprocessing. Place all sharps in appropriate containers.**
   c. **All linen is considered contaminated, remove all soiled linen including gowns, towels and washcloths. Handle soiled linen carefully, being alert for sharps and other objects. Do not carry or hold linens near the body.**
      i. **Roll the linen into a bundle for easy handling. Avoid excessive handling or shaking of the linen.**
      ii. **Used disposable drapes, gloves, gowns, and PPE that do not contain blood or body matter are not necessarily infectious waste.**
   d. **Remove trash and infectious waste (This could include sharps containers in the rooms~~.~~):**
      i. **Leave plastic trash can liner in container, close, twist and tie knot in the top of bag.**
      ii. **Use caution and look for protruding objects in the waste bag or container. Never reach into or push on the bag to compress the trash.**
      iii. **Lift the liner carefully and place the trash and infectious waste bags into the designated containers. Never carry waste bags against the body.**
      iv. **Wipe all surfaces of the waste containers with cleaning solution and allow to air-dry. Insert new waste liner.**
   e. **Any area visibly soiled with small amounts of blood, tissue or body fluids should be spot cleaned with a cleaner disinfectant and allowed to air dry.**
   f. **Move all mobile equipment to the side nearest the hall door.**
   g. ~~**The OR bed/lights is considered the dirtiest part of the OR after the procedure and should either be cleaned last, or be cleaned as a separate area**~~**Clean the OR/procedural bed/lights~~.~~:**
      i. **Unlock the ~~OR~~ bed/table and completely break down so all surfaces can be cleaned with a cleaner disinfectant.**
      ii. **Wipe the joints, table attachments, frame, legs, and rails.**
      iii. **Turn down the mattress and wipe the table bed frame and back of the mattress working from the top and repeat at the bottom.**
      iv. **Wipe sides of the mattress and change wipe or cloth as needed. Be sure to wipe both sides of coated pillows and allow all elements to air dry.**

v. **Move the lights down from over the operating table and wipe with cleaner disinfectant, wiping all areas of the top of the light including the extender arms.**

vi. **Wipe light reflectors**

~~i.~~vii. **Remove gloves and perform hand hygiene after cleaning this area; don clean gloves before proceeding with cleaning the rest of the OR/procedure room.**

~~b.~~h. **Use a damp high dusting tool with cleaner disinfectant solution, and a ladder as necessary, to clean fixed and ceiling-mounted equipment, as well as external tracks. Pay special attention to air exhaust and intake vents, and remove any lint or dust.**

~~c.~~i. **Wipe walls, ledges, and spot clean other surface areas such as ceilings, cabinet and closet doors and handles with a cleaner disinfectant.**

~~d.~~j. **Clean and disinfect all high touch surfaces, furniture and fixed equipment (including wheels and casters) used during patient care according to manufacturer's instructions for use, including, but not limited to**~~Clean and disinfect the exposed surfaces, including wheels and casters, of all items, including~~:

i. Anesthesia carts, including the top and drawer handles
ii. Anesthesia equipment (e.g., IV poles, IV pumps)
iii. Anesthesia machines, including dials, knobs and valves
iv. Patient monitors, including cables
v. OR beds~~ and~~ -attachments (e.g., arm boards, stirrups, head rests)
vi. Reusable table straps
vii. Positioning devices (e.g., chest rolls, axillary rolls, bed clamps)
viii. Patient transfer devices (e.g., roller board)
~~ix. Overhead procedure lights~~
~~x.~~ix. Tables and Mayo stands
~~xi.~~x. Mobile and fixed equipment (e.g., sitting stools, standing stools, tourniquets, bovie, microscope, robot)
~~xii.~~xi. Storage cabinets, supply carts, and furniture
~~xiii.~~xii. Light switches
~~xiv.~~xiii. Door handles and push plates
~~xv.~~xiv. Telephones
~~xvi.~~xv. Computer accessories (i.e., keyboard, mouse)
xvi. Chairs, stools, and step stools
~~xvii.~~
~~xviii. Trash and linen receptacles~~

k. Clean and disinfect the entire floor, including areas under the bed and mobile equipment. **Do not walk onto the section just cleaned. Continue in four-foot sections.**

l. **Move cleaned mobile patient equipment to the clean side of the room through the disinfectant on floor.**

m. **Clean the second half of the ~~OR~~ room following the same top to bottom and back to front process as described above. Clean the second half of the floor ending at the door.**

n. **Remove PPE after leaving OR suite/procedure room and perform hand hygiene.**

~~7.~~5. **Don new gloves and with a clean cloth or wipe, clean mop handles and cleaning equipment.**

~~a. Spot clean and disinfect the walls and ceilings.~~

~~8. Terminally clean unused rooms weekly.~~

~~9.~~6. Terminally clean the Endoscope Storage Room and Endoscope Processing Room daily **when used**.

~~E.~~F. PRE-OPERATIVE HOLD (POH), POST ANESTHESIA CARE UNIT (PACU), AND PHASE II:

1. Preoperative and postoperative patient care areas must be cleaned after each patient has left the area.

a. Clean and disinfect equipment that is used during patient care according to manufacturer's IFU, including, but not limited to:
   i. Patient monitors, including cables
   ii. IV pumps and IV poles
   iii. Patients beds/gurneys
   iv. Over-bed tables
   v. Bedside tables and drawer handles
   vi. Call lights
   vii. Suction regulators
   viii. Medical gas regulators
   ix. Warming equipment
b. Clean and disinfect the floor with a mop when visibly soiled or potentially soiled by blood or body fluids (e.g., splash, splatter, dropped item).
c. Spot clean and disinfect the walls when visibly soiled.

2. Terminally clean the preoperative and postoperative patient care areas each day the areas are used.
   a. Clean and disinfect the exposed surfaces, including wheel and casters, of all items in the area, including:
      i. Patient monitors
      ii. Patients beds/gurneys
      iii. Over-bed tables
      iv. Call lights
      v. Mobile and fixed equipment (e.g., suction regulators, medical gas regulators, warming equipment)
      vi. Storage cabinets, supply carts and furniture
      vii. Light switches
      viii. Door handles and push plates
      ix. Telephones
      x. Computer accessories (e.g., keyboard, mouse)
      xi. Chairs, stools and step stools
      xii. Trash and linen receptacles
   b. Clean and disinfect the entire floor, including areas under mobile equipment, using a mop.

~~F.~~G. **STERILE PROCESSING DEPARTMENT (SPD):**

1. Damp dust all horizontal surfaces in the sterilization packaging area (e.g., countertops, workstation) at least daily. Use a clean, low-linting cloth moistened with disinfectant, or ready-to-use disinfectant wipe, to damp dust.
2. Terminally clean sterile processing areas each day the areas are used.
   a. Receiving Room
   b. Equipment Room
   c. GUS Room
   d. Sterrad/V-Pro Room
   e. Sterilizing Room
   f. Prep and Pack
   g. Sterile Instrument Storage
   h. Bundle Room
   i. Dirty Utility
   j. Decontamination Room
   k. Clean Storage near Decontamination Room
3. Clean and disinfect the clean work areas, such as the packaging area and sterile storage area, before the dirty work areas, such as the decontamination area, to reduce the possibility of contaminating the clean areas.
4. When feasible, avoid terminal cleaning when personnel are actively decontaminating instruments.
5. Clean and disinfect all work surfaces and high touch objects in the clean work areas and decontamination areas using a clean, low-linting cloth or ready-to-use disinfectant wipe.

6. Remove trash from receptacles in sterile processing areas at least daily and when they are full.
7. Clean and disinfect all floors in sterile processing areas each day the areas are used.

H. OTHER AREAS:

1. Other areas to be cleaned include the Bronch Room, PFT Room and Pulmonary Bronchoscope Storage Room.

2. Clean (i.e., turnover) patient care areas after the patient has left the area:

a. Clean and disinfect equipment that is used during patient care according to manufacturer's IFU.

b. Clean and disinfect the floor with a mop when visibly soiled or potentially soiled by blood or body fluids (e.g., splash, splatter, dropped item).

c. Spot clean and disinfect the walls when visibly soiled.

3. Terminally clean the procedure rooms each day the areas are used:

a. Clean and disinfect the exposed surfaces, including wheel and casters, of all items in the area, including but not limited to:

i. Patient monitors
ii. Patients beds/gurneys
iii. Over-bed tables
iv. Call lights
v. Mobile and fixed equipment (e.g., suction regulators, medical gas regulators, warming equipment)
vi. Storage cabinets, supply carts and furniture
vii. Light switches
viii. Door handles and push plates
ix. Telephones
x. Computer accessories (e.g., keyboard, mouse)
xi. Chairs, stools and step stools
xii. Trash and linen receptacles

b. Clean and disinfect the entire floor, including areas under mobile equipment, using a mop.

4. Terminally clean the Pulmonary Bronchoscope Storage Room daily when used.

~~G.~~**I. SCHEDULED CLEANING:**

1. Cleaning schedule for areas of Surgical Services that are not terminally cleaned:
   a. The following areas shall be cleaned daily **by perioperative aides**~~?~~:
      i. OR hallways
      ii. All substeriles
      iii. Clean Core
      iv. Specimen Room
      v. Elevators
      vi. OR Dirty Utility Room
      vii. POH waiting room
      viii. Patient restroom in PACU
      ix. Patient restroom in Phase II
      x. Patient restroom in POH
      xi. Anesthesia lounge/sleep rooms/restroom
      xii. Physician lounge
      xiii. Staff lounges
      xiv. Female staff restrooms
      xv. Male staff restrooms
      xvi. Male physician restroom
   b. The following areas shall be cleaned weekly **by perioperative aides:**
      i. OR Vents, ~~Walls~~ **walls** and ~~C~~ceilings
      ii. Anesthesia Workroom
      iii. Pump Room

iv. EVS Closets in Surgery, PACU, and SPD
~~v. Specimen room~~
~~vi.~~v. Women's locker room
~~vii.~~vi. Male staff locker room
~~viii.~~vii. Male physician locker room

c. The following areas shall be cleaned monthly **by perioperative aides**:
   i. Storage rooms, including Equipment Room, Storage Room 1, Storage Room 2, and Storage Room Between OR's 3 and 4
   ii. Stairs and stairwells
   iii. Shelving, drawers, and storage bins in OR's and storage areas shall be cleaned in conjunction with monthly outdates.

~~H.~~J. SPECIAL CONSIDERATIONS:

1. Following the care of a patient diagnosed with or suspected of infection with C. Difficile, use a bleach-based disinfectant product (i.e., Dispatch) to clean.
2. Cleaning and disinfection procedures shall be implemented after construction, renovation, repair, demolition, and disaster remediation.
3. Preventative measures shall be taken to prevent pest infestation in the perioperative environment, including removing food, containing biological waste, and keeping windows and doors closed.
   a. If preventative measures fail to eliminate the cause of a pest infestation, a pest control specialist shall be consulted.
   b. Terminally clean affected areas after the pest infestation is resolved.

~~I.~~K. EDUCATION AND TRAINING:

1. Personnel responsible for perioperative sanitation shall be provided education upon hire and annually. Perioperative sanitation competency shall be verified upon hire and annually.

~~J.~~L. QUALITY ASSURANCE:

1. Cleaning practices shall be monitored through audits using fluorescent marking.

~~K.~~M. DOCUMENTATION:

1. Terminal and scheduled cleaning shall be documented in appropriate logs.

~~L.~~N. REFERENCE(S):

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

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 10/94 **SUBJECT: Scheduling Process for Procedures**

REVISION DATE: 1/00, 6/03, 8/09, 06/13, 01/17

Department Approval:	**~~06/16~~10/21**
Department of OB/GYN Approval:	**~~08/16~~12/21**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~01/16~~04/22**
Administration Approval:	**05/22**
Professional Affairs Committee Approval:	**~~01/17~~ n/a**
Board of Directors Approval:	**01/17**

A. **CESAREAN SECTIONS:**

1. Scheduling:
   - **a.** Obstetricians' (OB) offices will call Tri-City Medical Center (TCMC) **Labor and Delivery Unit (L&D)**~~main surgery scheduling at 760-940-7382~~ to schedule surgical procedures in **L&D** ~~Labor and Delivery (L&D)~~ Operating Room (OR).
     - ~~a.~~**i.** **Scheduling hours are Monday through Friday, 0800 to 1800, through the L&D unit secretary.**
     - **ii.** Only **two**~~three~~ cases are to be scheduled each day
       - ~~i.~~1) **If more than two cases are scheduled on a day, the L&D Manager will give approval.**
     - ~~ii.~~**iii.** **Elective surgeries will not be scheduled on the weekends without prior approval from the L&D Manager.**~~No elective surgeries are scheduled on the weekends, if avoidable.~~
   - b. Add-on cases for maternal or fetal medical indications or elective bilateral tubal-ligations (for sterilization), may be scheduled through the **Charge RN** ~~Assistant Nurse Manager (ANM)~~ or designee.
   - c. ~~Required i~~**I**nformation at the time of scheduling shall include:
     - i. Primary Surgeon and Assist
     - ~~1)~~**ii.** Name of the ~~-~~indicated procedure
     - ~~2)~~**iii.** Patient name, Age, Estimated Gestational Age (EGA) in weeks
       - ~~a)~~**1)** ~~If~~**F** under 39 **0/7** weeks EGA at the time of the scheduled procedure, there must be a valid medical indication. See Elective Delivery under 39 **0/7** weeks unit specific policy
     - ~~3)~~**iv.** Patient's Gravida~~-~~ and Para
     - ~~4)~~**v.** Reason for procedure/**Pre-op diagnosis**
     - **vi.** Significant medical problems/history, e.g. Hypertension, Low Amniotic Fluid Index (oligo), Diabetes, known fetal problems or anomalies
     - **vii.** **Indicate if the Cell Saver will be utilized**
       - 1) **The secretary will notify the perfusionist of the scheduled case to confirm availability.**
     - **viii.** **Insurance**
     - **ix.** **The clinic/office will fax prenatal records and consents to L&D**
     - ~~5)~~**x.** **The OB will enter orders for Pre-op and Surgery in the patients Electronic Health Record (EHR).**
   - d. The **Charge RN** ~~ANM/ designee~~**or designee** shall review the OR schedule in Cerner to ensure accuracy~~ and check the delivery log~~ for those patients who have already delivered **and**~~to~~ update **the** schedule as indicated.

2. Elective Cases:

a. Known candidates for cesarean sections will have their surgeries scheduled in advance. The most common examples include, but are not limited to:
   i. Progression of pregnancy related hypertension/preeclampsia with changes in baseline labs
   ii. Uncontrolled diabetes
   iii. Known placenta previa
   iv. Previous classic uterine incision
   v. Known fetal anomalies where cesarean section may improve later motor or mechanical function
   vi. Maternal/fetal indication with associated oligohydramnios not conducive to the labor process
   vii. Maternal or fetal condition requiring intervention per perinatal or neonatal consultation

b. The OB physician/Allied Health Professional (AHP) and/or a representative from the physician/AHP's office will contact the **L&D unit** ~~surgery scheduling office~~ at TCMC.
   i. If another procedure will occur with the cesarean section, (e.g. tubal ligation), this needs to be indicated in the scheduling calendar.
   ii. The patient will also be scheduled for pre-op teaching.

c. Scheduled cases are ~~usually~~ limited to **two**~~three~~ per day at 0730~~, 0900,~~ and 1200**(Monday, Tuesday, Wednesday and Friday), 0830 and 1200 on Thursday.**
   ~~c.~~**i. For any alteration in the schedule needs prior approval from the L&D Manger.**

d. Cases are scheduled on a first-come, first-served basis.

e. If a patient scheduled for a cesarean section delivers prior to her scheduled surgery date, it is the responsibility of the Clinic/ Physician/AHP's office to notify the **L&D unit** ~~OR Surgery scheduling center~~ to have her name removed, when possible. This will allow the schedule to be updated and the scheduled slot opened for other requests.~~.~~

3. Pre-op Visit:

a. **Will be scheduled for two days prior to the scheduled procedure date, to allow for processing of pre-op labs/diagnostic tests.**~~Shall be scheduled according to unit policy to allow for processing of pre-op labs/diagnostic tests~~

b. Pre-op teaching will be completed by the L&D nursing staff **and will include the following items documented in the patient's electronic medical record (EMR):**
   i. Opening current pregnancy and updating the pregnancy summary
   ii. Verify or add the patients preferred pharmacy
   iii. Document home medications, including dose, frequency and last date and time taken
   iv. Documenting Height/Weight/Allergies form
   v. Pre-admission assessment form.
   vi. Complete the Cesarean Section Pre-Admission Instructions handout
      ~~b.~~**1) The patient is to sign the handout and a copy will be placed in the patients MR**

B. **INDUCTIONS:**

1. Elective Inductions:

a. Selected patients may be scheduled by their OB physician/AHP for an induction of labor when greater than 39 **0/7** weeks of gestational age

b. The OB physician/AHP and/or representative from the physician's office will contact the L&D **Charge RN**~~ANM~~ or designee to add the patient to the department's schedule.
   i. The patient information should include the patient's:
      1) Name
      2) Patient birthdate
      3) Estimated Due Date/ EGA
      4) Reason for induction
      ~~4~~**5) Bishop Score**
      ~~5~~**6)** Physician/AHP
      ~~6~~**7)** Patient's phone number

ii. The Office will fax the patient's prenatal record to L&D.

c. ~~Generally, p~~Patients should be instructed to call L&D **at the time of** ~~one-two hours before~~ their scheduled induction to ensure room and staff availability to safely proceed with the induction. ~~This will also decrease the number of patients sitting in the waiting area for prolonged periods of time and improve patient satisfaction.~~

d. If a scheduled induction patient fails to **call or show**~~keep appointment~~, it should be determined if the patient has already delivered and attempts made to contact the patient.

i. If there is no indication that the patient has delivered and the patient cannot be contacted, the OB physician/AHP shall be notified.

2. Medically Indicated Inductions:

a. Unscheduled inductions may occur due to newly acquired medical indications.

i. These patient admissions are coordinated directly with the L&D **Charge RN** ~~ANM/~~ designee on an as needed basis by the OB physician/AHP.~~.~~

ii. Medical indications are not elective procedures, but are considered necessary for maternal or fetal concerns requiring intervention by the OB physician/AHP or as a result of a perinatal/neonatal consult.

iii. Staffing availability will need to be allocated to support these admissions and some elective inductions may need to be delayed depending on unit census and nursing ratio requirements.

C. **POSTPARTUM TUBAL LIGATIONS:**

1. Elective tubal ligation after a vaginal delivery will be scheduled by the OB physician/AHP.~~.~~

a. Elective tubal ligations will be added to the department procedure calendar at a proposed time around the scheduled procedures, to ensure L&D staffing is available to support the case in the L&D OR.~~.~~

~~b. Elective tubal ligations that cannot be scheduled during the patient's stay may be scheduled as an outpatient procedure during her postpartum visit.~~

D. **OUTPATIENT PROCEDURES:**

1. Certain patients may be scheduled to come to L&D for a variety of outpatient procedures. These procedures include but are limited to:

a. Antenatal testing
b. Amniocentesis
c. External cephalic version
d. Laminaria insertion

2. The OB physician/AHP and/or a representative from the clinic will contact the L&D **Charge RN or** ~~ANM/~~designee.

a. The information will be entered into the scheduled procedures calendar.
b. In addition to the patient's name, the procedure, the date and time, and a phone number for the patient will also be entered in the calendar.
c. Patient will be instructed to call the L&D unit one-two hours prior to procedure time to ensure a room and nurse are available.

E. **OUTPATIENT REGISTRATION:**

1. Patients coming to TCMC for procedures on the L&D unit will be instructed to check in with the ~~admitting clerk or~~ unit secretary at the front reception desk in WNS.

a. The **unit secretary** ~~admitting clerk~~ will **open and complete the WH Quick Registration for**~~register~~ the patient in the hospital information system

b. A message will then be sent to registration to complete the full registration of the patient.

~~a.~~**i. A copy of the patient's photo ID and insurance card will be sent to registration if available**

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

April 28, 2022 – 2:30 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:00 p.m. on April 28, 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 Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez

Absent was Director Tracy Younger

Also present via teleconference were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Gene Ma, M.D., Chief Medical Officer
Jeremy Raimo, SVP, Business Development
Eva England, Cardiovascular Service Line Director
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Jeremy Raimo, SVP, Business Development
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. via teleconference with attendance as listed above.

2. Approval of agenda

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

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

   Board Counsel Jeff Scott made an oral announcement of the item listed on the April 28, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included one Report Involving Trade Secrets with a disclosure date of May 1, 2022.

5. Motion to go into Closed Session

It was moved by Director Coulter and seconded by Director Sanchez to go into Closed Session at 3:05 p.m. The motion passed (5-0-0-1) with Director Younger absent.

6. At 3:19 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 heard a report involving a trade secret and took no action.

8. Open Session

Consideration to approve an MRI Project Agreement with DEB Construction, LLC for construction of the 3.0T MRI project.

It was moved by Director Chaya to approve the MRI construction project agreement between DEB Construction, LLC and Tri-City Healthcare District at a base cost of $2,963,623.78 and bid alternates as necessary not to exceed $544,461 for a total projected construction cost not to exceed $3,508,084.78. Director Coulter seconded the motion.

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

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

8. Adjournment

It was moved by Director Chaya and seconded by Director Coulter to adjourn the meeting at 3:23 p.m. The motion passed (5-0-0-1) with Director Younger absent.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
April 28, 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 3:30 p.m. on April 28, 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 Gigi Gleason
Director Marvin Mizell
Director Tracy M. Younger

Absent was Director Sanchez

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
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
Dr. Jamie Johnson, Chief of Staff
Jeffrey Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky J. Chavez, called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Mizell to approve the agenda as presented. Director Chaya seconded the motion. The motion passed (6-0-0-1) with Director Sanchez 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 April 28, 2022 Regular Board of Directors Meeting Agenda.

Director Sanchez joined the meeting at 3:37 p.m.

5. March, 2022 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 – $258,599
- Operating Expense - $275,256
- EBITDA - $1,134
- EROE ($8,525)

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

- Average Daily Census – 163
- Adjusted Patient Days – 85,096
- Surgery Cases – 4,918
- ED Visits – 37,383

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

- Net Operating Revenue – $29,893
- Operating Expense - $33,654
- EBITDA – ($1,264)
- EROE – ($2,318)

Mr. Rivas provided information on items that impacted this month's financials, resulting in a $1.6 million hit to our bottom line.

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

- Average Daily Census – 177
- Adjusted Patient Days – 10,244
- Surgery Cases – 612
- ED Visits – 4,342

Mr. Rivas explained ortho and spine cases increased this month, along with additional Kaiser surgeries. Mr. Dietlin noted patients who had put off surgeries during the pandemic are now scheduling their procedures and there have been less cancellation of surgeries due to positive COVID tests.

Director Younger requested the Board receive the daily Flash Report once the Community Works conversion is complete.

Chairperson Chavez requested that going forward Mr. Rivas provide the Board with additional detail and education on the financials so that Board members have a thorough understanding.

6. New Business

a) Consideration to approve Resolution No. 813, 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

Mr. Rivas explained in February the Board approved the first of two Resolutions that will enable the hospital to receive funds sooner under the QIP Program which is the successor to the Prime program. QIP is a program that is based on improving outcomes for patients particularly in the MediCal population. Today's Resolution is a bridge loan for $2,346,338.70 which accounts for approximately 50% of the expected outcome for calendar year 2021.

It was moved by Director Sanchez to approve Resolution No. 813, a Resolution of the 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. Director Coulter seconded the motion.

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

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

b) Consideration to certify SEIU-UHW as the exclusive bargaining representative for the following groups:

1) Psychiatric Liaisons in the Emergency Department
2) Medical Assistant, Clinical Research Coordinator, Medical Laboratory Assistant, Front Desk Reception and Medical Biller in the Oncology Clinic
3) Medical Assistant, Medical Receptionist and Authorization/Referral Coordinator in the Infusion Center

Anna Aguilar, VP of Human Resources reported on March 22, 2022 Tri-City received a petition from SEIU-UHW to include employees from the classifications referenced above be represented by SEIU-UHW and to accrete these classifications into the existing SEIU-UHW contract. On April 13, 2022, it was determined by a neutral third party that the card count exceeded the majority vote.

It was moved by Director Coulter that the TCHD Board of Directors certify the results of the card count, determined by neutral third party to be a majority of employees within the following classifications to be represented by SEIU-UHW and to accrete these into the existing SEIU-UHW contract:

1. **Psychiatric Liaisons in the Emergency Department;**
2. **Medical Assistant, Clinical Research Coordinator, Medical Laboratory Assistant, Front Desk Reception and Medical Biller in the Oncology Clinic;**

3. **Medical Assistant, Medical Receptionist and Authorization/Referral Coordinator in the Infusion Center.**

Director Mizell seconded the motion.

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

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

7. Old Business - None

8. Chief of Staff

a) Consideration of the April 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 25, 2022.

Dr. Johnson presented the Medical Staff Credentials which included nine Initial Appointments, which include a Kaiser and UCSD physician; 20 Reappointments, one Change of Status, one Update to Previous Reappointment; one Automatic Resignation; two Voluntary Resignations and 11 Proctoring Recommendations.

Dr. Johnson presented the Allied Health Professional Credentials which included one Initial Appointment, five Biennial Reappraisals, two Voluntary Resignations and two Proctoring Recommendations.

It was moved by Director Younger to approve the April 2022 Credentialing Actions Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 25, 2022. Director Coulter seconded the motion.

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

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

9. Consideration of Consent Calendar

Director Mizell requested the following items be pulled from the Consent Calendar:

1) Medical Directorship for Opioid Stewardship Program and
2) Discharge Planning, Homeless Patient Policy

It was moved by Director Mizell to approve the Consent Calendar minus the items pulled. Director Younger seconded the motion.

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

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

10. Discussion of items pulled from Consent Calendar

Dr. Gene Ma provided a brief overview of the Medical Directorship for the Opioid Stewardship Program. The purpose of the program is to drive down the prescribing of opioids and give patients the resources they need to return to a normal life.

It was moved by Director Mizell to approve the establishment of the Medical Directorship for Opioid Stewardship Program with services provided by Ole Snyder, MD for a term of 12 months beginning May 1, 2022 through April 30, 2023, with an annual and total term cost not to exceed $18,000. Director Younger seconded the motion.

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

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

Candice Parras, Chief Patient Care officer provided information on the Discharge Planning, Homeless Policy in which legislation requires the hospital to provide transportation, appropriate clothing, foot coverings, a packed meal and appropriate referral to housing source to homeless patients upon discharge. Ms. Parras explained the policy was updated to include additional language to ensure these patients are treated appropriately.

It was moved by Director Mizell to approve Discharge Planning, Homeless Patient Policy as presented. Director Sanchez seconded the motion.

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

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

11. Comments by Members of the Public

There were no comments by members of the public.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO provided a brief COVID-19 update. He reported Tri-City Medical Center's inpatient positive COVID-19 numbers are in the single digits and countywide numbers are hovering around 100. This is good news for the community.

Mr. Dietlin reported on April 18, 2022 Tri-City Medical Center celebrated Donate Life Month with a flag raising ceremony with staff, representatives from Life Sharing and family members who were recipients of donated organs. Just this year alone, Tri-City's partnership with *Donate Life* and *Life Sha*ring has saved the lives of 23 people thanks to the selfless gifts of nine organ donors at TCMC. Today we celebrate the people who give the ultimate gift of life to others. Mr. Dietlin also encouraged everyone to consider being a donor.

Mr. Dietlin commented on the Auxiliary Scholarship Awards event held recently for the first time since the COVID pandemic. He stated it was an inspiring night and wonderful to see the investment in tomorrow's healthcare leadership today. Mr. Dietlin also thanked the Board for participating in the event.

Mr. Dietlin reported May is National Mental Health Awareness month. He commented on Tri-City's partnership with the county to build a 16-bed inpatient stand-alone inpatient psych facility. A meeting is scheduled with the Oceanside Planning Commission in June and we look forward to breaking ground in the near future.

Mr. Dietlin reported earlier today the board approved the 3.T MRI construction project agreement and will enable us to provide state of the art MRI images.

Mr. Dietlin reported Tri-City will be recognizing our nurses and all hospital staff during the upcoming Nurse's Week and Hospital Week. He expressed his appreciation to the thousands of people that work tirelessly to make Tri-City a great hospital that is owned, managed and governed by our community.

13. Board Communications

Director Chaya stated she is very excited to hear all about the positive initiatives moving forward. She thanked Director Mizell for bringing the Opioid Stewardship program to the Board's attention as it is an important effort between the nurses and physicians and surgeons to get patients through their procedures and surgeries without narcotics. Dr. Chaya stated the community will benefit from this program.

Director Sanchez stated that she appreciated the great updates from staff and Mr. Dietlin.

Director Gleason congratulated Dr. Gene Ma, Chief Medical Officer and Tara Eagle, Clinical Lab Manager who were recently named *2022 Live Well San Diego Public Health Champions* for their work on the Local Laboratory Testing Taskforce.

Director Coulter echoed Director Gleason's comments related to our health champions, Dr. Ma and Tara Eagle.

Director Coulter also commented that he was pleased to see COVID-19 numbers going down and looks forward the board meeting in person in the not so distant future.

14. Report from Chairperson

Chairperson Chavez thanked Director Mizell for highlighting the Opioid Stewardship program that was listed on today's Consent agenda and the Discharge of Homeless patients' policy as it provided excellent information to the public.

Chairperson Chavez commented on the Auxiliary Scholarship awards event and the steps taken to keep in line with CDPH and COVID-19 requirements.

Chairperson Chavez stated he would like to reconvene Board Committee meetings in the near future and requested Board members let him know what committees Board members are interested in serving on.

Lastly, Chairperson Chavez commented that the annual Foundation Gala is around the corner and he will poll the Board's support for sponsorship at next month's meeting. Chairperson Chavez encouraged Board members to attend events as they come up as it is a great opportunity to meet the public and see how impactful Tri-City Medical Center really is.

15. Move to adjourn

It was moved by Director Sanchez and seconded by Director Younger to adjourn the meeting. The motion passed unanimously (7-0).

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

_____
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	73.6	71.7	69.5			68.1	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	52.1	

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	92.3	90.2	87.3			94.5	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	98.6	

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)	$275	($2,318)	($2,149)			($10,674)	($908)
FY21	($1,489)	($923)	($930)	$508	($175)	($881)	$1,109	($245)	$210	($554)	$4,682	$4,774	($3,371)	

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%	0.95%	-7.66%	-7.51%			-3.71%	-0.32%
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%	-1.25%	

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)	$1,343	($1,264)	($1,085)			$49	$10,863
FY21	($191)	$291	$302	$1,738	$879	$332	$2,344	$935	$1,383	$422	$5,782	$5,855	$8,436	

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%	4.63%	-4.18%	-3.79%			0.02%	3.87%
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%	3.12%	

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	4.54	4.72	5.09			5.10	5.27
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	5.63	

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	$58.6	$49.2	$49.3			
FY21	$59.5	$57.4	$83.5	$76.9	$71.3	$68.5	$71.4	$75.4	$83.2	$67.3	$59.6	$86.8	

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending April 30, 2022

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term 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)	32,820.75	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	03/31/23	**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)	15,031.39	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)	32,687.41	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	04/30/22	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**230,398.51**				

(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 April 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
7010	FHM COURSE	30922 EDU	125.00	84072	BRITTNEY M BRAKER
7420	ONS/ONCC	31122 EDU	458.00	84073	ASTRID WARNER
8740	ONS ONCC	40722EDU	103.00	82087	SCHWARZEL, DIVINA
8740	RN TO BSN	40722EDU	2,500.00	82702	ORENCIA, RIZALINA
8740	LABOR AND DELIVER BECOMES ABNO	40722EDU	200.00	83489	SIERAS, GWYNETH

**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.