TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
August 25, 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:

To Listen and Address the Board when called upon:
Dial in: 669-900-6833 Meeting ID: 894-9970-7292 Pass code: 685692

The Board may take action on any of the items listed below, unless the item is specifically labeled "Informational Only"

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Approval of agenda		
3	Roll Call / Pledge of Allegiance	3 min.	Standard
4	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
5.	Introductions a) Henry Showah, Chief of Staff	5 min.	Chair
6	July, 2022 Financial Statement Results	10 min.	CFO
7	Reports – Information Only		
	a) Geriatric Emergency Department Accreditation	10 min.	Dr. Cary Mells
	b) Foundation Report	10 min	Foundation
	c) External Affairs Update	20 min.	Chief External Affairs Officer
	d) Chief Medical Officer Update	10 min.	Dr. Gene Ma

Note: This certifies that a copy of this agenda was posted in the entrance to the Tri-City Medical Center at 4002 Vista Way, Oceanside, CA 92056 at least 72 hours in advance of the meeting. Any writings or documents provided to the Board members of Tri-City Healthcare District regarding any item on this Agenda is available for public inspection in the Administration Department located at the Tri-City Medical Center during normal business hours.

Note: If you have a disability, please notify us at 760-940-3348 at least 48 hours prior to the meeting so that we may provide reasonable accommodations.

	Agenda Item	Time Allotted	Requestor
8	New Business - None	--	--
9	Old Business – None	--	--
10	Chief of Staff – None *(No credentials this month)*	--	--
11	Consideration of Consent Calendar ***Requested items to be pulled <u>require a second</u>*** (1) Approval of Resolution 817, 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 a Medical Staff Leadership agreement for Chief of Staff, Henry Showah, M.D., for a term of 24 months, beginning August 1, 2022 and ending on July 31, 2024, for an annual cost not to exceed $72,000, plus an additional educational allowance for the 24-month term of $10,000, for a total term cost not to exceed $154,000. (3) Approval of an agreement with Chris Guerin, M.D., Coverage Physician for the Diabetes Services/Program for a term of 24 months, beginning July 1, 2022 and ending June 30, 2024, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost of $28,800 and a total cost for the term of $57,600. (4) Approval of the addition of Rod Serry, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 12 months, beginning October 1, 2022 and ending September 30, 2023, at a shared term cost of $365,000. (5) Approval of an agreement with Yuan Hwang Lin, M.D. and Darrell Wu, M.D. as the Emergency Department On-Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning September 1, 2022 and ending August 31, 2024, at an annual cost of $365,000 and a shared total term cost of $731,000. (6) Approval of the addition of Hannah Kirby, M.D. to the ED On-Call Coverage Panel for Orthopedics for a term of 21 months, beginning October 1, 2022 and ending June 30, 2024 at a total term cost of $984,000 for the shared call panel. (7) Approval of an agreement with Coastal Surgeons, A California Medical Corporation, to provide a comprehensive General Surgicalist program for a term of 24 months, beginning July 28, 2022 and ending July 31, 2024, at a daily rate of $2,900, an annual cost of $1,058,500 and a total term cost of $2,131,500. (8) Administrative Committees **A. Policies** **1. Patient Care Services Policies & Procedures** a. Code Maternity Team Mobilization Policy b. Code Pink Response Plan Policy c. Consent for Operative or Other Procedures d. Miscarriages and Stillbirth Identification and Disposition Procedure e. Patient Food Refrigerators/Freezers Procedure	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

f. Privacy Code Policy
g. Staff, Registry-Traveler Usage Policy

2. Administrative 200 District Operations
a. Charity Care, Uncompensated Care, Community Service 285
b. Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions 276

3. Administrative 300 Patient Care
a. Decision Making for Unrepresented Patients 397
b. Non-Beneficial Treatment 399
c. Skilled Nursing Facility (SNF) Refusal to Readmit Policy

4. Cardiac Rehab
a. Fall Risk Assessment
b. Outpatient Medical Records Storage Retention

5. Emergency Department
a. Behavioral Health – Room Safety Check
b. ED Disaster Procedure
c. ED Saturation-Ambulance Diversion Policy
d. Triage of Emergency Department Patients

6. Food & Nutrition
a. Diet Manual Policy
b. Nutrition Assessment and Care for Adult Geriatric Patients Policy

7. Home Care
a. Admission to Service
b. Agency Right of Refusal of Care
c. Aseptic Procedure & Infectious Waste Disposal (DELETE)
d. Assessment
e. Care and Maintenance of Indwelling Pleural Catheter (Pleurx) (DELETE)
f. Care Coordination
g. Communication with the Sensory Impaired
h. Critical Lab Values
i. Culturally and Linguistically Appropriate Services (Hispanic)
j. Discharge
k. Disposal of Needles & Syringes, Hazardous Materials
l. Documentation
m. End of Life Decisions
n. Face to Face Encounter
o. Fall Prevention
p. Hand-off Communication
q. Home Total Parenteral Nutrition TPN
r. Hypoglycemic Management (Symptomatic)
s. Influx of Infectious Patients
t. Infusion Program
u. Interruption of Services
v. Intravenous (IV) Therapy Peripheral Management (DELETE)
w. KCI Wound Vac Therapy Clinical Guidelines
x. Late Entry Documentation

	Agenda Item	Time Allotted	Requestor
	y. Pain Symptom Management z. Patient Information Flow Process (DELETE) aa. Patient Safety bb. Physician Orders cc. Plan of Care dd. Procedure for Use of Home Care Nursing Bag ee. Restraints (DELETE) ff. Resumption of Care gg. Significant Change in Condition (SCIC) hh. Subcutaneous Catheter (DELETE) ii. Transfer jj. Unna Boot Application kk. Wound Assessment **8. Rehabilitation** a. Computer Downtime/Printer Malfunction b. Mission Statement Goals and Objectives Policy – 100 c. Rehabilitation Dress and Appearance Policy – 1710 d. Service Locations e. Staff Rotations – 615 Policy f. Statement of Accountability Policy – 102 **9. Women & Newborn Services** a. Elective Delivery Under 39 Weeks b. Infant Transport – Intrafacility c. Standards of Care: Intrapartum d. Standards of Care: Postpartum e. Vibroacoustic Stimulation (9) Minutes a) May 26, 2022, Regular Meeting b) June 10, 2022, Special Meeting c) June 29, 2022, Special Meeting d) June 30, 2022, Regular Meeting (10) Meetings and Conferences – None (11) Dues and Memberships - None (12) Reports (a) Dashboard – Included (b) Lease Report – (July, 2022) (c) Reimbursement Disclosure Report – (July, 2022)		
12	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
13	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
14	Comments by Chief Executive Officer	5 min.	Standard
15	Board Communications (three minutes per Board member)	18 min.	Standard
16	Report from Chairperson	3 min.	Standard
17	Total Time Budgeted for Open Session	2 hours	
18	Adjournment		

RESOLUTION NO. 817

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 August 25, 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

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: AUGUST 25, 2022
Medical Staff Leadership Agreement – CHIEF OF STAFF

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

Physician's Name: Henry Showah, M.D.

Area of Service: Medical Staff Leadership: Chief of Staff

Term of Agreement: 24 months, Beginning, August 1, 2022 – Ending, July 31, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
New agreement with new COS, Same rate as prior contract for position

Rate/Hr.	Hrs. per Month Not to Exceed	Max Monthly Cost Not to Exceed	Max Annual Cost Not to Exceed	Education Expense for Term	Total Term Cost Not to Exceed
$150	40 Hrs.	$6,000	$72,000	$10,000	$154,000

Position Responsibilities:

- Perform the duties of the Chief of Staff as set forth in the Tri-City Healthcare District Medical Staff Bylaws
- Attend meetings of the Board of Directors and such Board Committees as per District and Medical Staff bylaws
- Liaise with hospital Administration including reporting on the status of activities of the Medical Staff

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: Jonathan Gonzalez, Director, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize the Medical Staff Leadership agreement for Chief of Staff, with Henry Showah, M.D., for a term of 24 months beginning August 1, 2022, and ending on July 31, 2024, for an annual cost not to exceed $72,000, plus an additional educational allowance for the 24-month term of $10,000, for a total term cost not to exceed $154,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 25, 2022
Medical Director Agreement for Diabetes Services Program

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

Physician's Name: Chris Guerin, M.D.

Area of Service: Diabetic Services Program

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

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

Rate/Hour	Hours per Month	Hours per Year	Monthly Cost	Annual Cost	26 Month (Term) Cost
$150	16	192	$2,400	$28,800	$57,600

Position Responsibilities:

- Functions as the Medical Director for TCMC's Diabetes Program
- Develops, implements and monitors Diabetic planning to ensure patient care quality and regulatory compliance.
- TCMC's Diabetic Program has achieved certification from TJC. As a requirement to maintain accreditation the program must have physician oversight (i.e. Medical Directorship).

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: Christina Krasowski, Director-Emergency Department & Intensive Care / Candice Parras, Chief Patient Care Services Officer

Motion:
I move that the TCHD Board of Directors authorize Chris Guerin, M.D. as the Medical Director for the Diabetic Services Program for a term of 24 months beginning July 1, 2022 and ending June 30, 2024, not to exceed an average of 16 hours per month or 192 hours annually, at an hourly rate of $150 for an annual cost of $28,800, and a total cost for the term of $57,600.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 25, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: Cardiology, STEMI

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

Physician's Name: Rod Serry, M.D.

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

Term of Agreement: 12 months, Beginning, October 1, 2022 – Ending, September 30, 2023

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

Rate / Day	Panel Total Term Cost
$1,000 - STEMI	$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: Jonathan Gonzalez, Director, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the addition of Rod Serry, M.D. to the currently existing ED On-Call Coverage Panel for Cardiology-STEMI for a term of 12 months, beginning October 1, 2022 and ending, September 30, 2023, at a shared total term cost of $365,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: August 25, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: Cardio-Thoracic Surgery

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

Physician's Name: Yuan Hwang Lin, M.D. & Darrell Wu, M.D.

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

Term of Agreement: 24 months, Beginning, September 1, 2022 – Ending, August 31, 2024

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

Rate/Day	Panel Annual Cost	Panel Total Term Cost
$1,000	$365,000	$731,000

Description of Services/Supplies:

- Provide 24/7 patient coverage for all Cardio-Thoracic 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: Jonathan Gonzalez, Director, Medical Staff / Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize Yuan Hwang Lin, M.D. and Darrell Wu, M.D., as the ED On-Call Coverage Panel for Cardiothoracic Surgery for a term of 24 months, beginning September 1, 2022 and ending, August 31, 2024, at an annual cost of $365,000 and a shared total term cost of $731,000.

Tri-City Medical Center

TCHD Board of Directors
DATE OF MEETING: August 25, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – Orthopedics

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

Physician's Names: Hannah Kirby, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 21 months, Beginning, October 1, 2022 – Ending June 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call agreement with Entire ED call panel for Orthopedic Surgery
No additional cost based on previously approved call panel agreement

Rate/Day	Panel Days during Term	Panel Annual Cost
Monday-Friday: $1,500	456 days	$684,000
Saturday-Sunday: $1,650	182 days	$300,300
	Total Term Cost:	**$984,300**

Position Responsibilities:

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

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

Person responsible for oversight of agreement: Jonathan Gonzalez, Director, Medical Staff Services / Gene Ma, Chief Medical Officer

Motion: I move that the TCHD Board of Directors approve the addition of Hannah Kirby, M.D. to the ED On-Call Coverage Panel for Orthopedics for a term of 21 months, beginning October 1, 2022 and ending June 30, 2024, at a total term cost of $984,000 for the shared call panel.

Tri-City Medical Center

TCHD Board of Directors
DATE OF MEETING: August 25, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE – General Surgicalist

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

Physician's Names: Coastal Surgeons

Area of Service: Surgical Hospitalist for all Acute Care Service Units

Term of Agreement: 24 months, Beginning, July 28, 2022 – Ending July 31, 2024

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

Rate/Day	Annual Cost	Total Term Cost
$2900	$1,058,500	$2,131,500

Position Responsibilities:

- Provide 24/7 patient coverage for a hospital-based, Surgical Hospitalist program otherwise referred to as a General Surgicalist to consult, manage, and treat all general surgical needs, including but not limited to primary management of soft tissue and deep space infections requiring surgical evaluation
- Provide both inpatient and outpatient follow-up of all general surgical cases managed at Tri-City by the General Surgicalist program
- Coordinate surgical care across all specialties including Emergency medicine, Hospital medicine, and subspecialty care
- Dedicate a Medical Director to oversee the success of the program, integration into hospital services, and to coordinate quality of care initiatives with the Hospital quality department to achieve benchmarked quality outcomes

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: Gene Ma, M.D., Chief Medical Officer

Motion: I move that the TCHD Board of Directors authorize an agreement with Coastal Surgeons, A California Medical Corporation, to provide a comprehensive General Surgicalist program for a term of 24 months, beginning July 28, 2022 and ending July 31, 2024, at a daily rate of $2900, an annual cost of $1,058,500 and a total term cost of $2,131,500.

ADMINISTRATION CONSENT AGENDA
August 16th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Code Maternity Team Mobilization Policy	3 year review, practice change	Forward To BOD For Approval
2. Code Pink Response Plan Policy	3 year review, practice change	Forward To BOD For Approval
3. Consent for Operative or Other Procedures 359	3 year review, practice change	Forward To BOD For Approval
4. Miscarriages and Stillbirth Identification and Disposition Procedure	3 year review, practice change	Forward To BOD For Approval
5. Patient Food Refrigerators/ Freezers Procedure	Practice change	Forward To BOD For Approval
6. Privacy Code Policy	3 year review, practice change	Forward To BOD For Approval
7. Staffing, Registry-Traveler Usage Policy	3 year review, practice change	Forward To BOD For Approval
Administrative 200 District Operations		
1. Charity Care, Uncompensated Care, Community Service 285	Practice change	Forward To BOD For Approval
2. Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions 276	3 year review, practice change	Forward To BOD For Approval
Administrative 300 Patient Care		
1. Decision Making for Unrepresented Patients 397	3 year review	Forward To BOD For Approval
2. Non-Beneficial Treatment 399	3 year review	Forward To BOD For Approval
3. Skilled Nursing Facility (SNF) Refusal to Readmit Policy	3 year review	Forward To BOD For Approval
Cardiac Rehab		
1. Fall Risk Assessment	3 year review	Forward To BOD For Approval
2. Outpatient Medical Records Storage Retention	3 year review, practice change	Forward To BOD For Approval
Emergency Department		
1. Behavioral Health - Room Safety Check	NEW	Forward To BOD For Approval
2. ED Disaster Procedure	NEW	Forward To BOD For Approval
3. ED Saturation-Ambulance Diversion-Policy	3 year review, practice change	Forward To BOD For Approval
4. ED Scope of Practice Definition Policy	3 year review, practice change	Forward To BOD For Approval
5. Triage of Emergency Department Patients	3 year review, practice change	Forward To BOD For Approval
Food & Nutrition		
1. Diet Manual Policy	3 year review	Forward To BOD For Approval
2. Nutrition Assessment and Care for Adult Geriatric Patients Policy	3 year review, practice change	Forward To BOD For Approval
Home Care		
1. Admission to Service	1 year review, practice change	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
August 16th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
2. Agency Right of Refusal of Care	1 year review, practice change	Forward To BOD For Approval
3. Aseptic Procedure & Infectious Waste Disposal	DELETE	Forward To BOD For Approval
4. Assessment	1 year review, practice change	Forward To BOD For Approval
5. Care and Maintenance of Indwelling Pleural Catheter (Pleurx)	DELETE	Forward To BOD For Approval
6. Care Coordination	1 year review, practice change	Forward To BOD For Approval
7. Communication with the Sensory Impaired	1 year review, practice change	Forward To BOD For Approval
8. Critical Lab Values	1 year review	Forward To BOD For Approval
9. Culturally and Linguistically Appropriate Services (Hispanic)	1 year review, practice change	Forward To BOD For Approval
10. Discharge	1 year review, practice change	Forward To BOD For Approval
11. Disposal of Needles & Syringes, Hazardous Materials	1 year review, practice change	Forward To BOD For Approval
12. Documentation	1 year review, practice change	Forward To BOD For Approval
13. End of Life Decisions	1 year review, practice change	Forward To BOD For Approval
14. Face to Face Encounter	1 year review, practice change	Forward To BOD For Approval
15. Fall Prevention	1 year review, practice change	Forward To BOD For Approval
16. Hand Off Communication	1 year review, practice change	Forward To BOD For Approval
17. Home Total Parenteral Nutrition TPN	1 year review, practice change	Forward To BOD For Approval
18. Hypoglycemic Management (Symptomatic)	1 year review, practice change	Forward To BOD For Approval
19. Influx of Infectious Patients	1 year review, practice change	Forward To BOD For Approval
20. Infusion Program	1 year review, practice change	Forward To BOD For Approval
21. Interruption of Services	1 year review, practice change	Forward To BOD For Approval
22. Intravenous (IV) Therapy Peripheral Management	DELETE	Forward To BOD For Approval
23. KCI Wound VAC Therapy Clinical Guidelines	1 year review, practice change	Forward To BOD For Approval
24. Late Entry Documentation	1 year review, practice change	Forward To BOD For Approval
25. Pain Symptom Management	1 year review	Forward To BOD For Approval
26. Patient Information Flow Process	DELETE	Forward To BOD For Approval
27. Patient Safety	1 year review, practice change	Forward To BOD For Approval
28. Physician Orders	1 year review,	Forward To BOD For Approval

ADMINISTRATION CONSENT AGENDA
August 16th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
	practice change	
29. Plan of Care	1 year review, practice change	Forward To BOD For Approval
30. Procedure for Use of Home Care Nursing Bag	1 year review, practice change	Forward To BOD For Approval
31. Restraints	DELETE	Forward To BOD For Approval
32. Resumption of Care	1 year review, practice change	Forward To BOD For Approval
33. Significant Change in Condition (SCIC)	1 year review, practice change	Forward To BOD For Approval
34. Subcutaneous Catheter	DELETE	Forward To BOD For Approval
35. Transfer	1 year review, practice change	Forward To BOD For Approval
36. Unna Boot Application	1 year review, practice change	Forward To BOD For Approval
37. Wound Assessment	1 year review, practice change	Forward To BOD For Approval
Rehabilitation		
1. Computer Downtime/ Printer Malfunction	3 year review	Forward To BOD For Approval
2. Mission Statement Goals and Objectives Policy - 100	3 year review	Forward To BOD For Approval
3. Rehabilitation Dress and Appearance Policy - 1710	3 year review	Forward To BOD For Approval
4. Service Locations	3 year review, practice change	Forward To BOD For Approval
5. Staff Rotations - 615 Policy	3 year review	Forward To BOD For Approval
6. Statement of Accountability Policy - 102	3 year review	Forward To BOD For Approval
Women & Newborn Services		
1. Elective Delivery Under 39 Weeks	3 year review, practice change	Forward To BOD For Approval
2. Infant Transport- Intrafacility	3 year review, practice change	Forward To BOD For Approval
3. Standards of Care: Intrapartum	3 year review, practice change	Forward To BOD For Approval
4. Standards of Care: Postpartum	3 year review, practice change	Forward To BOD For Approval
5. Vibroacoustic Stimulation (VAS)	3 year review, practice change	Forward To BOD For Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 7/12	**SUBJECT: Code Maternity Team Mobilization**
REVISION DATE: 02/16	**~~POLICY NUMBER: IV.AAA~~**

Patient Care Services Content Expert Approval:	**01/22**
Clinical Policies & Procedures Committee Approval:	**~~07/15~~02/22**
Nursing Leadership~~Executive Council~~ Approval:	**~~07/15~~03/22**
Department of OB/GYN Committee Approval:	**~~12/15~~06/22**
Medical Executive Committee:	**~~01/16~~06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~02/16~~ n/a**
Board of Directors Approval:	**02/16**

A. **PURPOSE:**

1. To delineate a systematic method for **notification of the** responding **team** to an intrapartum/postpartum hemorrhage emergency that may require surgical and/or massive transfusion interventions.~~, placental previas, placental acretas, uterine rupture, intrapartum and postpartum hemorrhage.~~

B. **DEFINITIONS:**

1. Code Maternity: An overhead page and/or calls that may be initiated when a patient ~~in the Women and Newborn Services (WNS) departments: Labor and Delivery (L&D) or Mother/Baby unit,~~ experiences an obstetrical (OB) related emergency resulting in hemorrhage.
2. Postpartum hemorrhage: When a **cumulative blood loss**~~n estimated blood loss (EBL)~~ of greater than 500 mL occurs in a vaginal delivery~~ and the patient is hypotensive~~ **or**~~. When~~ a **cumulative** blood loss of greater than 1000 mL occurs for a Cesarean-section (C-section) **with continued bleeding or if there is a greater than 15 percent change in vital signs (VS) or heart rate (HR) greater than or equal to 110 beats per minute, blood pressure (BP) less than or equal to 85mmHg/45mmHg , oxygen saturation (O2 sat) less than 95 percent or increased bleeding during recovery or postpartum.**~~and the patient is hypotensive. shows signs of hypovolemia.~~
3. ~~The Code Maternity **paging tree will go to** team consists of:~~
   - ~~a. Any Obstetrician/ OB Allied Health Practitioner IN HOUSE~~
   - ~~b. OB-1 Anesthesiologist~~
   - ~~c. Anesthesia Technician (if in house)~~
   - ~~WNS Assistant **Clinical** Nurse Manager/~~
   - ~~**L&D** Charge Nurse~~
   - ~~d. **Mother/Baby Charge Nurse**~~
   - ~~e. WNS Primary RN~~
   - ~~f. WNS Secondary RN~~
   - ~~g. WNS Third RN~~
   - ~~h. WNS Secretary~~
   - ~~i. OB Surgical Technician~~
   - ~~j. Phlebotomist Support~~
   - ~~k. Blood Bank~~
   - ~~l. Nursery **Transition** RN~~
   - ~~Security~~
   - ~~**Admin Coordinator/Nurse Supervisor**~~
   - ~~m. **Respiratory Therapist**~~

~~Ad hoc members may be called at the discretion of the team leader and/or charge RN and can include: Neonatal Intensive Care Unit (NICU) team, Intensive Care Unit (ICU) RN, Main Operating Room (OR) RN, Mother/Baby Unit Assistant Care Technician (ACT), Interventional Radiology (IR) Sterile Processing Department Representative, Pharmacy, and Social Services.~~

~~4. **You MUST call blood bank separately, they are not part of the paging tree system**~~

C. **POLICY:**

~~1. A Code Maternity shall be called for an intrapartum/postpartum patient who has uncontrolled bleeding and/or is evidencing signs of hemorrhagic shock.~~

~~2. The Code Maternity may be activated by the following personnel:~~

~~a. Physician/Allied Health Professional~~

~~b. WNS Charge Nurse/Assistant Nurse Manager (ANM)~~

~~c. Nurses~~

~~d. Unit Secretary when directed from any of the above members~~

~~3.~~**1.** A Code Maternity is initiated by dialing the operator at extension "66" on **a hospital** ~~the~~ telephone and informing the operator to initiate **a** Code Maternity **and location/room number.** ~~, emergency page. Tell the operator the location of the emergency (i.e., "Code OB, 2nd floor Labor and Delivery, OR room #" or "Code Maternity, 2nd floor, PP room #).~~

a. The operator shall announce "Code Maternity" and the **location** ~~LOCATION~~ over the Private Branch Exchange (PBX) system three times, twice.

b. The text/paging tree includes by not limited to ~~will go to the following~~**:**

a. Admin Coordinator/Nurse Supervisor
b. L&D Charge RN
c. L&D Educator
d. L&D Manager
e. Mother Baby Charge RN
f. Anesthesia Tech
g. Anesthesiologist on call cell phone and pager
h. OB Tech
i. Phlebotomy Coord 1 and 2
j. Pulmonary Lead
k. Pulmonary assigned to the NICU
l. OB Hospitalist

~~a.~~**c. Primary provider notified by designee**

~~D. **RESPONSE PLAN WITHIN THE HOSPITAL:**~~

~~1. When a Code Maternity is requested and announced, the members of the health care team responsible for responding are to report to the location identified and provide assistance as indicated by their role.~~

~~2. The First Responder at the emergent event notifies the charge nurse or designee of the emergency need.~~

~~3. The Charge Nurse:~~

~~a. Obtains a history of the situation and may initiate or designate someone to initiate a Code Maternity by dialing "66" and informing the operator.~~

~~b. Directs personnel, make reassignments as necessary and clears the room of extra traffic in response to the code.~~

~~c. Retrieves OB hemorrhage medication kit **and other medications as needed** from the Pyxis refrigerator.~~

~~d. Assigns a recorder to complete the CODE Maternity report (see Attachment A).~~

~~e. Serves as main liaison with the Blood Bank during massive hemorrhage. Initiates transfusion protocol via the red phone **(if in the OR)** and blood transfusion request form based on provider direction.~~

~~f. Communicates with the laboratory hematologist monitoring critical lab values such as complete blood count (CBC), platelets and/or coagulation panels, as ordered by the provider.~~

g. Makes arrangements for transfer and provides additional help if necessary.

The Primary RN: **acts as the team leader until relieved by the obstetrical provider, anesthesiologist, or charge RN. The Primary RN and the 2nd/3rd RN may:**

4.

a. Acts as the team leader until relieved by the obstetrical provider, anesthesiologist, or charge RN.

b. Starts 2nd IV line

c. Inserts a Foley

d. Administers medications per physician/provider.

Prepares patient for possible transport to the OB OR **either from the Labor and Delivery or Mother/Baby units.** if the event occurs while on an intrapartum status. If the patient is postpartum, preparing to transfer to the OB Post Anesthesia Care Unit (PACU) should be anticipated.

e. **Assist with recording duties.**

5. The Secondary/Third RN:

a. Supports the care and intervention needs for the patient as directed

b. Starts 2nd IV line

c. Inserts a Foley

d. Administers medications per physician/provider.

e. Assist with recording duties.

f. Assist patient move to the OR, and/or assume circulation duties if the patient is on postpartum.

6. The Obstetrical Physician/Allied Health Professional**Provider** evaluates the patient's condition, **and** directs the resuscitation as the team leader.

a. Makes the determination to move the patient to the OB OR and/or PACU post assessment.

7. The Anesthesiologist acts/assists the team leader, provides airway management and directs blood administration management.

a. Makes the determination to move the patient to the OB OR and/or PACU post assessment.

8. The Anesthesia Technician receives direction from the anesthesiologist.

9. The Unit Secretary for L&D receives direction from the team leader.

a. Reports to the area where the emergency is taking place.

b. Pages the primary OB provider to the patient's bedside for evaluation.

c. Helps direct response team members to the correct room/location.

d. Prepares charting paperwork for surgery if indicated..

e. May contact the phlebotomist for repeat blood draws as needed (760-802-9893).

The OB Surgical Technician brings the emergency cart(s) to the scene (OB hemorrhage cart, crash cart, and anesthesia cart).

10. **The surgical tech also prepares the OB OR as directed**

11. The Peri-Operative Aide **Acute Care Technician** receives direction from the team leader/ charge nurse.

a. Acts as lift team member and helps transport the patient, as indicated

b. Prepares the OB OR as directed for potential operative procedure.

12. The Nursery**Transition** RN calls the NICU team **a TEAM NICU** if the maternal hemorrhage occurs during the intrapartum period.

a. Transfers the baby and takes the banded individual to the nursery if event occurs during the postpartum time period.

13. The Blood Bank works with the unit charge nurse during massive transfusion protocol initiation as consultant.

a. The blood bank receives report on the patient and verifies orders for transfusion needs (refer to WNS procedure: Obstetrical Hemorrhage).

b. A hematologist on standby monitors lab values (CBC, platelets, coagulative panel, etc.).

c. The blood bank medical director is available for consult on 24/7 basis (ext. 7924 or via mobile phone at 504-236-1855).

14. The Phlebotomy Team will dispatch a phlebotomist to designated location of patient.

~~a. Assist with blood draws as needed.~~
~~b. If additional draws are needed to be performed, call the phlebotomy coordinator at (760-802-9893) and ask for a phlebotomist to be dispatched to the location for Code Maternity for blood draws only.~~

~~15. Security directs waiting area traffic and monitors the security system doors to allow Code Maternity responders departmental access as needed.~~

~~E.~~**D. REFERENCES:**

1. California Maternal Quality Care Collaborative (CMQCC). (2015~~0~~). Obstetric Hemorrhage Version 2.0 Toolkit.~~ Retrieved on 3/24/2015.~~
~~2. Callaghan W.M., Kuklina EV, & Burg C.J. (2012) Trends in Postpartum Hemorrhage: United States, 1994-2006. American Journal of Obstetrics and Gynecology Apr; 2002 (4):353 E 1-6.~~
~~3. ACOG. (2014) ACOG Committee Opinion No. 590. Preparing for clinical emergencies in obstetrics and gynecology. Obstetrics and Gynecology. 123 (3): 722-725.~~
~~4. Shields, L., Smalarz, K., Reffigee, L., Mugg, S., Burdumy, T., and Propst, M (2011). Comprehensive maternal hemorrhage protocols improve patient safety and reduce utilization of blood products. American Journal of Obstetrics and Gynecology, 205(4): 361-368.~~
~~5. ACOG (2012). ACOG Committee Opinion No 526. Standardization of practice to improve outcomes. Obstetrics and Gynecology, 119 (5):1081-1082.~~
~~6.~~**2.** Simpson, K. & Creehan, P. (20**21**~~14~~) Perinatal Nursing **5**~~4~~th Edition. Philadelphia, PA.

~~F. RELATED DOCUMENTS~~
~~1. Code Maternity Report - Sample~~

SAMPLE CODE MATERNITY REPORT

INITIATE AT HEMORRHAGE STAGE 2:
Blood loss greater than 500 mL vaginal, 1000 mL cesarean OR HR ≥ 110, B/P ≤ 85/45, O2 Sat < 95% OR Increased bleeding during recovery postpartum

MD Team Names:	Notified Time	Arrival Time	Date	Unit (circle one): L&D or MB
Obstetrician #1:			History:	
Anesthes				
Obstetric				
Anesthes				
Others (I applicab				
Vital Sig				ime IR- lin)
HR				
BP				
RR				
O2 sat				
EBL				
LOC				
Urine Ou				
Pain				
Medicat				ime IR- lin)
Metherg				
Hemaba				
Misopro				
Pain me				
Other:				
IV & Bl Product				ime IR- lin)
LR				
NS				
Oxytoci				
RBCs				
PLTS				
CRYO				
LABS (u drawn & resulted				ime IR- lin)
Hct/Hgb				
Platelets				
PT/PTT				
Fibrinog				
ABG				
Procedu				ime IR- lin)
Uterine emboliz etc.				
Primary Nurse	R.N.		Other nurses	
Team Leader (MD) Note:				
MD Signature				

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 12/02	**SUBJECT: Code Pink Response Plan**
REVISION DATE: 11/02; 3/03; 5/05, 5/06, 11/07; 1/08; 1/09; 2/10; 5/11	~~**POLICY NUMBER: IV.T**~~

Patient Care Services Content Expert:	**02/20**
Clinical Policies & Procedures Committee Approval:	~~**12/14**~~**04/20**
Nursing Leadership~~Executive Council~~ Approval:	~~**12/14**~~**05/20**
Perinatal Collaborative Practice Approval:	**09/20**
Department of Emergency Medicine Approval:	~~**01/16**~~**04/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	~~**02/16**~~**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**03/16**
Board of Directors Approval:	**03/16**

A. **PURPOSE:**

1. To provide a systematic method for responding to a cardiopulmonary emergency on children **ages**~~greater than~~ 30 days ~~old~~ through ~~age of~~ 13 **years** within the hospital and outside of the facility on hospital property.

B. **DEFINITIONS:**

1. Child: pediatric patient ~~greater than~~ 30 days old through 13 years. Pediatric Advanced Life Support (PALS) guidelines shall be used to direct resuscitative efforts.
2. Code Pink Response Areas:
   a. Patient Care Areas – areas in the main building with crash carts and AED/debrillators ~~readily~~ available (for example Cardiac Rehabilitation building and Magnetic Resonance Imaging **[**~~(~~MRI~~)~~**]** building).
   b. Non-patient Care Areas: areas on the main campus where crash cart and AED/debrillators not ~~readily~~ available (for example the Business Administration Management **[**~~(~~BAM~~)~~**]** building, registration and parking area).

C. **POLICY:**

1. A Code Pink shall be called on any apneic and/or pulseless child.
2. Any person may initiate a ~~Code Blue or~~ Code Pink by dialing "66" on the telephone. The operator shall announce "Code Pink" and the location over the P.A. system ~~.~~ three times, twice.
3. Response to the Code shall occur according to the following response plan.

D. **RESPONSE PLAN WITHIN PATIENT CARE AREAS:**

1. Code Pink initiation
   a. Staff shall initiate Basic Life Support (BLS) measures until Code Pink Response Team arrives.
2. Code Pink response team:
   a. ~~Emergency Department Code Pink Nurse :~~ **Emergency Department (ED) Registered Nurse (RN).**
      ~~1) Brings cardiac monitor/defibrillator and emergency Rapid Sequence Intubation (RSI) intubation drugs.~~

~~2.~~**i.** Initiates Standardized Procedure for Code Pink Resuscitation until the physician arrives.

~~3.~~**ii.** Remain with patient until transport team arrives or nurse transports patient to appropriate area as ordered by physician.

~~4.~~**iii.** ~~The Code Pink Nurse~~ **Ensures** ~~ensures~~ paperwork and documentation on the Cardiopulmonary Arrest Record and the Emergency Event form in the patient's electronic health (EHR) record is completed.

b. ED Physician:
   i. Responds when available and leads the resuscitative efforts.

c. Respiratory Care Practitioner (RCP):
   ~~1.~~**i.** Brings the pediatric **and neonatal** airway bag**s** to the scene.
   ~~2.~~**ii.** Ventilates patient.
   ~~3.~~**iii.** Assists with airway management.
   ~~4.~~**iv.** Obtains arterial blood gases and "Code Blue lab panel" as ordered.

d. Emergency Medical Technicians (EMTs):
   i. Brings an oxygen tank, airway bag, ~~ambu-bag,~~ **and** gurney ~~and backboard~~ to the scene.
   ii. Assists with CPR.
   iii. Acts as a runner to the ED.
   iv. Transports patient to receiving unit.

e. ~~Assistant Nurse Manager/Relief Charge Nurse (ED only):~~ **ED Shift Coordinator or Charge Nurse:**
   ~~i. Assigns a recorder if not already done~~
   ~~ii. Ensures appropriate paperwork and documentation on the Cardiopulmonary Arrest Record and the Emergency Event Form in the patient's electronic health record (EHR) are completed.~~
   ~~iii. Ensures post code, the "medication tray" inside the crash cart is re-locked with a secure tie (located in the crash cart) for containment at end of code.~~
   ~~iv.~~**i.** Ensure, post code, the "opened" crash cart is locked with the plastic key lock externally, is placed in a secured area, and the Sterile Processing Department (SPD) notified to pick up the used cart.

f. Primary Nurse:
   i. Remains in room to assure responders have current patient information.
   ii. Accesses patient's record and assures responders have information requested (i.e., lab, x-ray, reports).
   iii. Documents in the EHR:
      1) Pre-code assessment findings.
      2) Interventions implemented prior to Code Blue team arrival.

g. Unit Secretary:
   i. ~~Assures patient's chart is in room, phone is available in room, and places~~**Places** call to primary physician as directed.

h. Security Personnel:
   ~~1.~~**i.** Maintains scene safety and keeps area clear of congestion.

i. Sterile Processing Department:
   i. **Brings a pediatric crash cart to the code if the code does not initiate in the Emergency Department.**
   ~~i.~~**ii.** Sends another pediatric crash cart and two infusion pumps to the area.
   ~~ii.~~**iii.** Retrieves used crash cart and intubation tray post code.

E. **RESPONSE PLAN FOR CODE PINK IN NON-PATIENT CARE AREAS:**

1. Staff shall initiate BLS measures until Code Pink Response Team arrives.
2. Code Pink Response Team:
   a. ~~Emergency Department Code Pink~~ **ED RN**~~**Registered nurse**~~:

i. Ensures BLS measures have been implemented and facilitates transport the patient to the ED.

a. ED Physician:
   i. Responds when available and leads the resuscitative efforts.
b. Respiratory Care Practitioner (RCP):
   i. Brings the pediatric **and neonatal** airway bag**s** to the scene.
   ii. Assists with airway management.
   iii. Ventilates patient.
c. -EMT/ ED Personnel :
   i. Brings an oxygen tank, airway bag, ~~ambu bag,~~ **and** gurney ~~and backboard~~ to the scene.
   ii. Assists with CPR.
   iii. Acts as a runner to the ED.
   iv. Transports patient to receiving unit
d. Security Personnel:
   i. Maintains scene safety and keeps area clear of congestion

F. **RESPONSE PLAN AT AFFLIATED CENTERS:**

1. Examples including but not limited to:
   a. Outpatient Service Center
   b. Home Care
   c. Hospice
   d. Outpatient Behavioral Health Services
   e. Outpatient Rehabilitation Service Center
   f. Outpatient Nuclear Medicine
   g. Outpatient Imaging
   h. Open MRI
   i. Vista Palomar Park Clinic
   j. Wound Care Center
   k. Tri-City Wellness Center: Cardiac Rehab & Outpatient Rehab
2. The staff of the above mentioned areas is to initiate BLS measures and call 911 to facilitate management and transport of the patient to the Emergency Department.
3. The staff in Home Care~~, Partial Hospitalization,~~ and Outpatient Rehabilitation Services must clearly indicate the facilities are located in Vista to ensure the appropriate authorities respond.

G. **REFERENCES:**

1. American Heart Association. (201~~5~~~~0~~). BLS for healthcare providers: *Professional Student Manual*.
2. American Heart Association (AHA) (201~~5~~~~0~~). Highlights of 2010 aha guidelines for CPR
3. American Heart Association (AHA) (201~~5~~~~0~~). Handbook of emergency cardiovascular care for healthcare providers. .
4. Pediatric advanced life support. (201~~5~~~~0~~). American Heart Association (AHA).

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**11/94**	**SUBJECT:**	**Consent for Operative or Other Procedures**
REVISION DATE:	**09/95, 11/96, 10/97, 07/99, 06/03, 01/06, 02/06, 02/07, 04/09, 12/10, 01/16**	**~~POLICY NUMBER: 8610-359~~**	

Patient Care Services Content Expert~~Department~~ Approval:	**~~10/17~~06/20**
Clinical Policies and Procedures Approval:	**~~08/15~~08/16~~10/17~~02/22**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~09/15~~09/16~~10/17~~03/22**
Operating Room Committee Approval:	**~~11/16~~12/17~~04/22~~**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/15~~01/17~~01/18~~07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~01/16~~ n/a**
Board of Directors Approval:	**01/16**

A. **PURPOSE:**

1. To comply with legal and regulatory standards by defining Tri-City Healthcare District's (TCHD) process to obtain a valid consent, **from an adult patient** prior to diagnostic or therapeutic invasive procedures.

B. **DEFINITION(S):**

1. Adult:

~~1.~~**a.** An individual who has reached the age of **eighteen** (18) years, or a minor who has entered a valid marriage (whether or not the marriage was terminated by dissolution), who is on active duty with the armed forces of the United States of America, or who has been declared emancipated pursuant to Family Code §~~section~~ 7122 et. seq. (Family Code, § ~~section~~7002), or self-sufficient minor (**fifteen** [15] years or older, living apart from his/her parents, and manages his/her own financial affairs) pursuant to Family Code §~~section~~ 6922. **An emancipated minor may consent to medical, surgical, psychiatric, or hospital care without parental consent or knowledge. [Family Code §7050 (e)(1)]**

2. Consent Form:

a. A document that verifies a patient has been informed of a pending diagnostic or therapeutic invasive procedure; understands the information and has given consent to the physician/Allied Health Professional **(AHP)**.

b. Informed consent should be obtained prior to the consent form being signed.

~~2.~~**c. The signed consent form is to be obtained and kept in the patient's record.**

~~1.~~**3.** Informed Consent:

a. Voluntary consent given by a person or a responsible proxy (e.g., legal guardian, responsible party) for invasive diagnostic or therapeutic procedure after being informed of:

i. The purpose, methods, benefits, and risks.
ii. The likelihood of the patient achieving their goals.
iii. Any potential problems that might occur during recuperation.
iv. Reasonable alternatives to the patient's proposed care, treatment, and services.
v. Side effects related to alternatives.

vi. Risks related to not receiving the proposed care, treatment or services.

b. **It is the responsibility of a physician to determine what information a reasonable person in the patient~~client~~'s condition and circumstances would consider material to a decision to accept or refuse a proposed treatment or procedure. The disclosure of any material information and obtaining informed consent shall be the responsibility of the ~~a~~ physician.**

c. **Informed consent must include a verbal explanation by a physician of the patient~~client~~'s right to refuse or accept medical treatment. ~~It must include a written consent form signed by the client indicating the above information has been given. The signed consent form is to be obtained and kept in the client's record as specified in Sections 851 and 852.~~**

d. **(No medical treatment may be administered to a patient~~client~~ without informed consent except in an emergency situation ~~as defined by Section 853~~ or circumstances otherwise authorized by law.**

~~i.~~e. **The patient~~client~~ has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time. Licensed mental health professionals or licensed nursing staff shall verify that the patient~~client~~'s health record contains documentation that the patient~~client~~ has given informed consent to the proposed treatment or procedure.** ~~*9 CCR § 784.29*~~

~~b.~~**f.** The essential criteria of informed consent are:

i. The subject has both knowledge and comprehension.

ii. Consent is freely given without duress or undue influence.

iii. The right of withdrawal at any time is clearly communicated to the subject and documented by the physician/~~Allied Health Professional~~**AHP** in the patient's medical record.

4. Emergency:

~~3.~~**a.** A situation in which immediate services are required for alleviation of severe pain, or immediate diagnosis and treatment of unforeseeable medical conditions are required to prevent serious disability or death.

5. Minor:

~~4.~~**a.** For minors see Patient Care Services ~~(PCS)~~ Policy: Consent for Minors.

6. Procedures/Treatments Requiring Informed Consent/Consent forms:

~~5.~~**a.** Informed consent and a consent form are required for any procedure or medical treatment that is considered complex and involve risks that are not commonly understood. The final determination of the "complexity" of the procedure/treatment is the responsibility of the physician/~~Allied Health Professional~~**AHP**, in accordance with the criteria listed below:

~~a.~~**i.** Any procedure that requires pre-medication for sedation/analgesia.

~~b.~~**ii.** Any invasive procedure which involve incision, percutaneous puncture or insertion, and requires the services of the Endoscopy Lab, Operating Room, Cardiac Catheterization Laboratory, **or** Interventional Radiology.

~~c.~~**iii.** As required by law including, but not limited to:

1) Blood Transfusion
2) Human Immunodeficiency Virus (HIV) Blood Tests
3) Investigational Drugs or Devices
4) Human Experimentation
5) Treatment for Breast or Prostate Cancer
6) Use of Psychotropic Medications
7) Electroconvulsive Therapy

C. **PROCEDURE:**

1. A signed consent form is required prior to invasive diagnostic or therapeutic procedures.
   a. After the physician/~~Allied Health Professional~~**AHP** has obtained the patient's informed

consent, a consent form for a procedure must be signed by the patient.

b. The completed Consent for Operative or Other Procedures shall be placed on the patient's chart under Operative/Consents.

c. A copy of the signed form shall be given to the patient/legal representative.

~~c.~~**d. Exception: Treatment may be initiated without informed consent if there is documentation within the patient~~client~~'s health record that an emergency exists where there is an unanticipated condition in which immediate action is necessary for preservation of life or the prevention of serious bodily harm to the patient~~client~~ or others or to alleviate severe physical pain, and it is impracticable to obtain the required consent, and provided that the action taken is within the customary practice of physicians of good standing in similar circumstances.** ~~*9 CCR § 784.29 (f)*~~

2. Consent must include:
   a. Nature of the proposed care, treatment, services, medications, interventions, or procedures.
   b. Potential benefits, risks, or side effects of the procedure including potential problems that may occur during recuperation.
   c. Likelihood of achieving care, treatment, and/or service goals.
   d. Reasonable alternatives.
   e. Relevant risks, benefits, and side effects related to alternatives, including the possible results of not receiving care, treatment, or service.
   f. Limitations of the confidentiality of information learned from or about the patient as indicated.
   g. Any independent medical research or significant economic interests the physician/~~Allied Health Professional~~**AHP** may have related to the performance of the proposed operation/procedure.
3. The consent form must be signed prior to the administration of narcotics or mind-altering drugs.
   a. The physician/~~Allied Health Professional~~**AHP** must determine if the patient is competent to sign the consent or if the procedure must be delayed if the consent is not obtained before the administration of narcotics or mind-altering medications.
      i. The decision to continue with the procedure must be documented by the physician/**AHP** in the medical record.
4. If, in the opinion of the physician/~~Allied Health Professional~~**AHP**, the patient is permanently or temporarily incapable of giving consent, consent is obtained from one of the following, in the order listed:
   a. Surrogate decision maker who has been verbally designated to the physician/~~Allied Health Professional~~**AHP** who has undertaken primary responsibility for the patient. This verbal designation must be documented in the medical record and is valid:
      i. During the duration of the hospitalization,
      ii. The course of illness, **or**
      iii. **Sixty (**60) days, whichever is shorter.
   b. Agent identified in an advanced directive.
   c. When both an agent and surrogate are appointed by the patient, the surrogate takes precedence over the agent for the limited duration previously stated.
   d. Conservator, who has been authorized by the court to make health care decisions or guardian.~~;~~
   e. Court appointed surrogate decision maker or court order **if none of the above exist.**
   f. Closest available relative, when appropriate, to rely on the consent of this person (the person has capacity, trustworthy motives, likely that patient would consent if able, **and** no objections from close relatives). The physician/~~Allied Health Professional~~**AHP** should determine appropriateness for procedures requiring informed consent.
   g. A registered domestic partner has the same authority to make a health care decision for their incapacitated domestic partner as a spouse would have to make a healthcare decision for their incapacitated spouse.

h. Capacity refers to the mental ability to make a *particular* decision at a *particular* time; it is question- and decision-specific and should be documented relative to each decision. Assess capacity to consent for each treatment or plan of treatment. Even when a Power of Attorney (POA) for Personal Care exists, capacity for consent to the particular treatment at this time should be assessed.

i. Capacity is not static but can change over time or require distinct abilities depending on the nature and complexity of the specific treatment decision. Specific capabilities may be lost or gained at different times during the life of a patient with a disability. Situations may arise where consent to a treatment has been given or refused on a patient's behalf. However, if that patient then becomes capable of consenting to the treatment in the opinion of the health care practitioner, the patient's own decision would take precedence over that of the ~~Substitute~~Substitute Decision Maker~~,~~ (SDM).

5. The consent form must include:
   a. Full terminology of the procedure (in lay terms) without the use of abbreviations.
      i. The terminology is obtained from the physician/~~Allied Health Professional~~**AHP** order.
      ii. Right or Left shall be indicated when appropriate.
   b. Document the date and time when the patient signs the consent form.
   c. The name of the surgeon/physician/~~Allied Health Professional~~**AHP** performing the procedure and the name of the attending physician/~~Allied Health Professional~~**AHP** must be listed on the consent (first and last names).
      i. If there is the possibility that some in the medical group may cover for the procedural physician/~~Allied Health Professional~~**AHP** (i.e., call, vacation, availability, etc.) list **all** the primary physician/~~Allied Health Professional~~**AHP that may perform procedure on the consent form** ~~and the name of the medical group or "Primary physician/Allied Health Professional and associates", whichever is applicable~~.
      ii. When two **(2)** physician/~~Allied Health Professional~~**AHP**s are listed on the orders as performing the procedure together, both surgeons are listed on the consent.
   d. When two **(2)** physician/~~Allied Health Professional~~**AHP**s are performing two **(2)** different procedures on the same patient, a separate consent form shall be completed for each physician/~~Allied Health Professional~~**AHP** and corresponding procedure **as well as separate informed consent for each.**
   e. Blank lines are not permissible on the consent form.
      ~~e.~~**i. If interpreter is not needed, interpretation section may be left blank**
6. The consent form may not be altered once the patient has signed.
   a. If the physician/~~Allied Health Professional~~**AHP** alters the order, a new consent must be obtained.
   b. In the case of a clerical error on the consent, the consent must be rewritten. The patient must sign the revised consent.
7. The consent form must be signed by a competent adult patient and witnessed by a hospital employee.
   a. A mark may be placed on the consent if the patient is physically unable to sign his/her name.
      i. Two **(2)** hospital employees shall sign as witnesses to the mark.
   b. Elective surgery/procedures shall be delayed/cancelled if the patients voluntarily indicates doubt or confusion about the indicated procedure, until the physician/~~Allied Health Professional~~**AHP** obtaining informed consent has an additional opportunity to talk to the patient.
8. If the patient or patient representative cannot communicate with the physician/~~Allied Health Professional~~**AHP** or hospital representative due to a language barrier, interpretive services shall be obtained.
   ~~a. Staff and/or family members shall only be used as interpreters in emergent situations~~

~~until a medical interpreter is contacted.~~

a. For the complete policy governing use of interpreters, please refer to:
   i. Patient Care Services Policy: **Interpretation and Translation Services**
   ~~i.~~**ii.** **Patient Care Services Policy:** Communication with the Sensory Impaired and/or Persons with Language Barriers.

b. If an interpreter is used, documentation shall include the name of the interpreter, the person's position (when appropriate) ~~and that person's relationship to the patient~~ **or interpretive service company name**.

c. When telephone/video translation service is used, the following must be documented on the consent form:
   i. The name of the patient/legal representative receiving translation.
   ii. The patient's/legal representative's primary language.
   iii. The medical interpreter identification/number.

d. If the consent form is not available in the patient's or patient representative's primary language, the interpreter shall verbally translate the form and ask the patient to sign the English form if the patient or the patient's representative agrees to the terms and conditions.

9. State and Federal regulation mandate special informed consent requirements for reproductive sterilization, ~~which~~ is primarily for the purpose of rendering the person incapable of reproducing ("elective sterilization"), and elective sterilization may be performed only when the following conditions are met:

a. Informed consent has been obtained from the patient.

b. The patient shall be able to understand the content and nature of the informed consent process.

c. The patient shall not be in a condition or mental state in which judgment is significantly altered.

d. The patient shall not be in labor, or less than **twenty-four** (24) hours postpartum or post abortion.

e. The patient shall not be seeking to obtain or obtaining an abortion.

f. Medi-Cal or Federally funded patient shall have the following additional requirements:
   i. Patient shall be **twenty-one** (21) years of age or older.
   ii. Patient shall not have been declared mentally incompetent by a court of competent jurisdiction, unless a limited conservator has been appointed and specific criteria have been met.
   iii. The patient shall not be involuntarily confined or detained in a correctional or rehabilitative facility, or confined, under a voluntary commitment in a facility for the care and treatment of mental illness.

g. The sterilization consent has been signed by the necessary parties and is available on the chart prior to procedure.

h. The required waiting period has been satisfied.
   i. Thirty (30) days, but not more than 180 days, shall pass after the appropriate sterilization consent was signed by patient or conservator.
   ii. Elective sterilization shall be performed less than **thirty** (30) days after the patient has signed the consent form only in the following circumstances:
      1) Private (pay status) patient voluntarily requests in writing that the **thirty** (30)- day waiting period be waived to no less than 72 hours.
      2) The elective sterilization is performed at the time of emergency abdominal surgery or at the time of a premature delivery, and the physician/~~Allied Health Professional~~**AHP** certifies that informed consent was given and the sterilization consent form was signed at least **thirty** (30) days before the intended date of sterilization and that at least 72 hours have actually passed since consent was given and the form was signed, and the physician/~~Allied Health Professional~~**AHP**s describes the nature of the emergency, or indicates the prior expected delivery date on the

sterilization consent form.

10. State regulations mandate special requirements for physician/~~Allied Health Professional~~**AHP**s regarding informed consent for hysterectomies.
    a. The Authorization for and Consent to Hysterectomy shall be used to document these requirements.
        i. The Hysterectomy Consent form is needed in addition to the Consent for Operative or Other Procedures form.
    b. These regulations outline specific requirements for physician/~~Allied Health Professional~~**AHP**s that must be documented in the medical record, including that the physician/~~Allied Health Professional~~**AHP** must obtain "verbal and written" consent prior to the performance of the hysterectomy.
    c. The informed consent procedure by the physician/~~Allied Health Professional~~**AHP**, shall provide that at least all of the following information is given to the patient verbally and in writing:
        i. Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the hysterectomy without affecting the right to future care or treatment and without loss or withdrawal of any state or federally funded program benefits to which the individual might be otherwise entitled.
        ii. A description of the type or types of surgery and other procedures involved in the proposed hysterectomy, and a description of any known available and appropriate alternatives to the hysterectomy itself.
        iii. Advice that the hysterectomy procedure is considered to be irreversible, and that infertility will result if the patient is not already sterile or postmenopausal.
        iv. A description of the discomforts and risks that may accompany or follow the performance of the procedure.
        v. A description of the benefits or advantages that may be expected as a result of the hysterectomy.
        vi. Approximate length of stay in the hospital.
        vii. Approximate length of time for recovery.
        viii. Financial cost to the patient of the physician/~~Allied Health Professional~~**AHP**'s and surgeon's fees.
11. A signed consent form is in effect until the patient changes his/her mind, or the physician/~~Allied Health Professional~~**AHP** alters the nature of the procedure (in which case a new consent is required).
12. Consent for a medical emergency:
    ~~In the case of a medical emergency where a procedure is immediately required and necessary to prevent deterioration or aggravation of the patient's condition, treatment may proceed without the patient's consent.~~
    a. **Treatment of a medical emergency may be provided without consent where the provider reasonably believes -that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or a person authorized to consent for the patient. The law implies consent in these circumstances on the theory that if the patient were able or if a qualified legal repsrenatative were present, the consent would be given. The exception applies to minors as well as to adult patients. CHA 2019.**
    b. The physician/~~Allied Health Professional~~**AHP** must document the determination of the medical necessity in the medical record.
    c. The physician/~~Allied Health Professional~~**AHP** does not sign the consent on behalf of the patient.
        i. The unsigned consent is maintained in the medical record.
        ii. TCHD personnel shall document on the consent "See progress notes dated for physician/~~Allied Health Professional~~**AHP** documentation of medical emergency indicating need to proceed with procedure."
13. Telephone/Facsimile/Email Consent:

a. Informed consent may be obtained by telephone, facsimile, or email when the person having the legal capability to consent for the patient is not otherwise available.
   i. TCHD staff must **make a reasonable effort to** validate the person is authorized to give consent.
b. When a telephone is used, the responsible physician/~~Allied Health Professional~~**AHP** must provide the patient's legal representative with the same information as would be presented to the individual in person.
c. Two **(2)** individuals (either two **[2]** TCHD staff personnel or the physician/~~Allied Health Professional~~**AHP** and one **[1]** TCHD staff member) must witness the consent conversation.
   i. The patient's legal representative must be informed the conversation is being witnessed.
   ii. The person(s) witnessing the conversation must sign and date documentation of the conversation on the Telephone Consent Form.
   iii. The Telephone Consent **Form**~~,~~ with the signature of the two **(2)** witnesses, is placed in the medical record.
d. Physician/~~Allied Health Professional~~**AHP** instructions may be ~~telegraphed or~~ emailed to the legal representative.
   i. In cases of electronically transmitted consent, the following occurs:
      1) Specific instructions regarding where the consent will be ~~wired or~~ emailed shall be provided by the person who is legally able to consent for the patient.
      2) Written confirmation proceeding the procedure and documentation of the patient's name, secured to the cover sheet if applicable, are maintained in the medical record.
e. In cases of facsimile consent:
   i. Direct discussion with the legal representative giving consent must first occur.
   ii. The legal representative may fax the consent after receiving full information regarding the procedure.
   iii. The facsimile document(s), along with the cover sheet, is placed in the **health**~~medical~~ record.
      1) Request the legal representative to send the original signed document to TCHD. This document is filed in the patient's medical record upon receipt.

14. Consent for an incompetent patient:
a. If a patient is incompetent or otherwise unable to give informed consent and does not have a conservator or holder of a durable power of attorney for healthcare decisions, the physician/~~Allied Health Professional~~**AHP** may proceed by obtaining consent of the closest available relative.
b. The physician/~~Allied Health Professional~~**AHP** must document in the medical record that there is no known conservator or durable power of attorney for healthcare and that the procedure is necessary.
c. If there is no relative available, and if the procedure is not an emergency, the Director of Risk Management **as well as in house counsel, are**~~is~~ contacted to assist **per Administrative Policy: Decision Making for Unrepresented Patients.**

D. FORM(S):

~~Authorization for and Consent to Hysterectomy Form - Sample~~
~~Consent for Operative or Other Procedures Form - Sample~~
~~Telephone Consent Form - Sample~~

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

1. Administrative Policy: Decision Making for Unrepresented Patients 397
~~1.~~**2.** Patient Care Services Policy: Communication with the Sensory Impaired and/or Persons with Language Barriers

3. Patient Care Services Policy: Consent for Minors

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

1. **9 CCR § 784.29**
~~1.~~2. California Code of Regulations (CCR) Title XXII §51305.6 & 70707.5
~~2.~~3. California Hospital Association **(2017). California Hospital** Consent Manual ~~(2017),~~. **Sacramento, CA: California Hospital Association, Chapter 3.**
~~3.~~4. ~~Comprehensive Accreditation Manual, (2015),~~ The Joint Commission **(2015). Hospital Accreditation Standards. Illinois: Joint Commission Resources.**
~~4.~~5. **Consent by Minor, Cal. FAM § 6922 (1992).**
~~5.~~6. **General Provisions, Cal. FAM § 7002 (1992).**
~~6.~~7. **Hysterectomies, Cal.** ~~Health & Safety Code~~**HSC** §1690 – 1691 **(2009).**

Authorization for and Consent to Hysterectomy Form – Sample

11. Upon your authorization and co
with any different or further proc
emergency. The hysterectomy
unable to perform or complete
associates to whom your physic
agents of the hospital named a

12. You are making a decision whe
consent form indicates that: (a)
have been verbally informed ab
received all of the information y
performance of the hysterecto

Date: _____

Signature: _____
(patient/parent/cons

If signed by other than patient, indic

Witness: _____

Physician Certification:

I, the undersigned physician, hereb
including the risks and benefits of t
and alternative efficacious methods
interest I may have regarding this tr
the patient, *both verbally and in writi*
certify that the patient was encourag

Date: _____

Signature: _____
(physician

COPY TO

MEDI-CAL A

A copy should also accompany clai
If the patient is already sterile, the in
physician must submit a handwritten and signed statement explaining the previous sterility.

DELETE

ormed on you, together
be indicated due to any
the event that he / she is
eon) together with
re not employees or

ire on this informed
led in this form, (b) you
questions, (d) you have
rize and consent to the

dure with this patient,
ably be expected to occur,
esearch or economic
tion 1690, I have given to
onsent form. I further
ered.

ITS:
hin other federal sources.
al claim; however, the

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7420-1046

AUTHORIZATION FOR AND
CONSENT TO HYSTERECTOMY

ORIGINAL-CHART COPY-PATIENT

Affix Patient Label

Tri-City Medical Cen

AUTHORIZATI MY

1. This form is called an "informed c hysterectomy procedure you are considering. You should ay have before you decide whether or not to give you

2. All operations involve risks of uns , sometimes for reasons that we are unable to anticipate o o the results of the operation.

3. You have the right to be informed follow the hysterectomy, including the type and possible e

4. You have the right to be informed economic interests related to the performance of the ve the right to be informed of the expected benefits ds of treatment and their risks and benefits.

5. You have the right to consult a se

6. You have the right to withhold or v e before it is performed. Your withdrawal of consent shall r lt in the loss or withdrawal of any state or federall wise be entailed.

7. Your signature on this form verifie vriting, the following information:

   a. A description of the type o he proposed hysterectomy, ad a descrip ives to the hysterectomy itself.
   b. Advise that the hysterector ess you are already sterile or postmenopausal,
   c. A description of the discor ocedure, including an explanation of the type an
   d. A description of the benefi any hysterectomy.
   e. The approximate length of
   f. The approximate length of
   g. The financial cost to you o

8. The hysterectomy procedure will maintains personnel and facilities to assist your physician i s not an employee or agent of the hospital named abov

9. By your signature on this consent, you authorize the pathologist to use his or her discretion in the disposition or use of any organ, member or other tissue taken from your body during the hysterectomy.

10. The persons in attendance for the purpose of performing specialized medical services (such as anesthesiology, radiology or pathology) are not employees or agents of the hospital or of your physician. They are independent medical practitioners.

DELETE

7420-1046

Consent for Operative or Other Procedures Form – Sample

CONSENT FOR OPERATIVE OR OTHER PROCEDURES

(1) My attending physician is _____ M.D. My supervising physician

or surgeon is _____ M.D.

(2) I hereby authorize and consent to the performance of th
for treatment of my condition and such operation(s) or pr
my physician as follows:

_____

_____

By my authorization and consent, I understand and
procedure(s), together with any different or further proced
physician or surgeon may be indicated due to any emerger
or procedure(s) will be performed by the supervising phys
that physician is unable to perform or complete the pr
physician or surgeon), together with associates and assist
and radiologists from the medical staff of Tri-City Medical
surgeon may assign designated responsibilities. This info

I understand that the persons in attendance for the purpo
such as anesthesia, radiology or pathology are not ager
my supervising physician or surgeon. They are independ
my behalf.

(3) I recognize that, during the course of the operation, posto
or other procedure, unforeseen conditions may necessita
assistants, to perform such surgical or other procedures
functions.

(4) **NO GUARANTEES.** I understand there are risks involve
possible to guarantee or give assurance of a successful

(5) I consent to the observation of the operative and/or othe
medical education by students and/or provider's techn
participation of students in the operative procedure(s) for

(6) By my signature below, I understand that any tissues or p
the hospital or physician in accordance with accustomed

(7) Some commercially prepared or in-house sterilized pr
contain residues of Ethylene Oxide or Glutaraldehyde, ag
cancer, birth defects, and other reproductive harm.

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CONSENT FOR OPERATIVE
OR OTHER PROCEDURES

PATIENT'S CERTIFICATION

My signature on this document indicates that:

(1) The operation(s) or procedure(s) set forth above have been adequately explained to me by my physician.

cedure(s), including other care, treatment or medications;

s of the operation(s) or procedure(s), including potential problems

goals;

vant, risks, benefits and side effects related to such alternatives,
eceiving care or treatment and;

r significant economic interests my physician may have related to
eration or procedure.

s.

I desire concerning the operation(s) or procedure(s); and

nance of the operation(s) or procedure(s).

to me) and been offered a copy of this document.

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

by other than patient, indicate relationship:

Relative: _____ Conservator Tutor/Legal Guardian

_____

_____ _____ _____ _____
(print name) Signature Date Time

(Complete If interpretation provided)

_____ _____ ___/___/___ _____ AM/PM
ID/Name Language Date Time

_____ Signature: _____

rvices and selects (name) _____ as his/her interpreter.

_____

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CONSENT FOR OPERATIVE
OR OTHER PROCEDURES

DELETE

Telephone Consent Form – Sample

Name of Patient: _____

Name of person called: _____

Relationship (Circle one): **Parent**

Date: _____ Time called:

Name of person making call (please pr

Witness (please print): _____

I, _____ the pare
(name)

of _____ and Doctor
(Patient's name)

_____
(physician/surgeon)

_____ on
(state proc

the basis of informed consent received

I understand it is necessary for me to c cal Center and will do so immediately.

I also agree to the Condition of Admiss

Comments: _____

_____
(Signature of Person Making Date / Time

_____
(Signature of 2nd Witness) Date / Time

DELETE

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8720-1046
Rev 5/10

TELEPHONE CONSENT FORM

Affix Patient Label

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**MISCARRIAGE AND STILLBIRTH IDENTIFICATION AND DISPOSITION PROCESS**
Purpose:	To outline the proper steps in differentiating between stillbirth (fetal death in utero at equal to or greater than 20 weeks gestational age) and miscarriage. A stillborn delivery requires the family to make disposition arrangements with a mortuary/ funeral home and requires an "autopsy permit" before it is evaluated by the pathology department. If no autopsy is requested, the stillbirth is taken to the hospital morgue. A miscarriage shall be handled as a routine surgical specimen and be sent to the histology department with a tissue specimen requisition
Supportive Data:	A fetus which satisfies **any two of the following three criteria** will be classified as a stillbirth: 1. Foot length (heel to toe) greater than 3.1 centimeters 2. Crown-rump (CR) length: greater than 16.5 centimeters 3. Gestational age by dates: equal to or greater than 20 weeks
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. Chux 5. Disposable drape 6. Specimen bag 7. Tissue lab slip

A. **DEFINITIONS:**

1. MISCARRIAGE: Pregnancy loss before 20 weeks gestation without signs of life. Refer to the Supportive Data section above.
   a. Hospital is responsible for the disposition of the remains which is usually by incineration.
   b. The family may request to have remains taken to mortuary, but incur the associated costs.
2. STILLBIRTH: Fetal death occurs before the baby is born and after 20 reported weeks of gestation. Refer to the Supportive Data section above.
   a. The family is responsible for coordinating the disposition of the fetal remains with a funeral home.
   b. A "fetal death certificate" is prepared by the birth clerk.
3. NEONATAL DEATH: The death of a newborn within the first 28 days of life. (Fetus is born alive regardless of gestational age, but then dies within the first 28 days.)
   a. The family is responsible for coordinating the disposition of the remains with a funeral home.
   b. A birth certificate is issued AND a death certificate is completed by the provider verifying the death.

B. **PROCEDURE:**

1. Perform hand hygiene and don gloves.
2. Complete measurements to determine if fetus is stillbirth or miscarriage. Criteria for stillbirth require **2 or more of the following**:
   a. Foot Length (heel to big toe): > greater than 3.1 centimeters (cm)
   b. Crown- rump Length (head to buttocks): > greater than 16.5 cm
   c. Gestational Age by dates: Equal to or > greater than 20 weeks
3. If the fetal parameters/measurements are determined to be borderline, the fetus must be sent to the Histology lab for final determination of whether or not it is a miscarriage or stillbirth.

Patient Care Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Department of OB/GYN	Pharmacy & Therapuetics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors Approval
12/08, 06/11, 04/15, 09/21	04/11, 05/15, 10/21	04/11, 05/15, 11/21	03/16, 04/22	04/16, 06/22	n/a	05/11, 04/16, 06/22	08/22	06/11, 10/16, n/a	06/11, 11/16

a. The tissue requisition accompanying the fetus/specimen needs to include the anatomic measurements, gestational age by dates, and Borderline Measurements indicated.
b. The staff member transporting the specimen to the laboratory will stay until the pathologist confirms the measurements and then returns to the department and reports the result findings so disposition option can be discussed with the family.
    i. If after hours, the charge nurse will arrange to have a second staff member complete the measurements as a second validation.

4. Stillbirth
    a. A stillbirth's remains are transferred to the Morgue.
        i. If pathological examination is desired, an autopsy permit must be obtained and the Histology department notified of this request.
        ii. Staff in the ED and L&D unit shall ensure the Release of the Deceased Form is updated and has the required patient signature before discharge. The form will be given to the charge nurse for final review, then forwarded to the Administrative Supervisor.
        iii. The fetal remains will only be released to a designated mortuary.
5. Miscarriage:
    a. If the fetus fails to meet at least two of the stillbirth measurement criteria, it is considered a miscarriage and shall be taken to the lab for processing.
        i. The tissue requisition form that accompanies the specimen to the Histology department shall have the anatomic measurements, gestational age and suspected diagnosis indicated by the attending provider.
            1) The fetus will be processed by the Histology department as a surgical pathology specimen
        ii. If the family desires to make arrangements for the miscarriage remains disposition with a mortuary or funeral home this MUST be indicated on the tissue requisition form: DO NOT PROCESS, FAMILY DESIRES DISPOSITION.
            1) Staff in Emergency Department/Labor & Delivery/Post Anesthesia Care Unit shall complete the Authority for Miscarriage Remains Release form before discharge and the charge nurse will forward form to the Administrative Supervisor (AS).
            2) The AS will communicate with the family no less than weekly to update funeral home/mortuary arrangements.
            3) Once arrangements are made by the family, the AS will notify the Histology Department.
            4) The Laboratory staff will transfer the remains to the morgue.
                a) The remains will only be released to a designated mortuary.
            5) If arrangements for disposition are not made by the family within 30 days, the AS will notify the Histology department to dispose of the remains by incineration based on Health and Safety Code 7054.3.
                a) Reasonable efforts will be made by the AS to contact the family before the deadline is reached.
6. Documentation:
    a. Document the date and time of the miscarriage/delivery as a clinical note entry in the patient's electronic health record and indicate where the remains were sent.
    b. A stillborn requires a fetal death certificate to be completed by the Birth Clerk.
    c. A miscarriage requires a tissue requisition and is sent to the histology department in the lab.

C. **TECHNICAL NOTES:**

1. **Health and Safety Code 7054** states that, "(a) Except as authorized pursuant to the sections referred to in subdivision (b), every person who deposits or disposes of any human remains in any place, except in a cemetery, is guilty of a misdemeanor.

2. **Health and Safety Code 7054.3** states that, "Notwithstanding any other provision of law, a recognizable dead human fetus of less than 20 weeks uterogestation not disposed of by interment shall be disposed of by incineration."
3. **Penal Code 643** states that "No person knowingly shall dispose of fetal remains in a public or private dump, refuse, or disposal site or place open to public view. For the purposes of this section, 'fetal remains' means the lifeless product of conception regardless of the duration of the pregnancy. Any violation of this section is a misdemeanor."

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

1. Authority for Miscarriage Remains Release Sample

E. **REFERENCES:**

1. TCMC Pathology Department – Histology Policy and Procedure Manual.
2. Mattson, S., & Smith, J.E. (2011). *Core-curriculum to maternal-newborn nursing.(4th Ed.).* Philadelphia: Saunders.
3. California Health and Safety Code Section 7050.5-7055
4. California Penal Code Section 643
5. California Perinatal Quality Care Collaborative (CPQCC) Network Database, version 1.10. (11/09/2010). Manual of definitions for infants born in 2010. Retrieved on 12/28/2010: http://www.cpqcc.org/data/cpqcc_downloads

Authority for Miscarriage Remains Release Sample

A miscarriage is validated when the Estimated Gestational Age (EGA) is less than 20 weeks and/or when the head to buttocks length is **less than 16.5 cm** and the **heel to toe length is less than 3.1 cm** per Patient Care Services Miscarriage and Stillbirth Identification and Disposition Process Procedure.

Do the pregnancy remains meet miscarriage criteria?

YES_____ Please transfer the miscarriage remains to the Laboratory and review disposition options below.

Nurse Name_____ Date_____ Provider Name _____Date_____

Please be advised that you have choices concerning the final disposition of miscarriage remains, if desired.

HOSPITAL DISPOSITION

According to regulations, the hospital will dispose of the miscarriage under the terms and conditions customarily used. The hospital cannot return the remains to you.

I wish for Tri-City Medical Center to arrange for the disposition of remains under the terms and conditions customarily used.
Patient Signature _____ Date_____

ARRANGED DISPOSITION

If you would like to make alternate arrangements, the remains must be released to an approved agency for proper burial or cremation by a licensed funeral director or mortuary. **PLEASE READ and INITIAL the items BELOW:**

1. I wish to make arrangements with a licensed funeral director or mortuary and understand that I am responsible for all expenses. YES_____
2. I understand that if arrangements are not made with a funeral home/mortuary within 30 days, the Laboratory Department will dispose of the remains under the terms and conditions customarily used by the hospital. YES_____
3. Due to regulatory guidelines, there may be reasons the remains may not be able to be released. YES_____

I _____hereby authorize Tri-City Medical Center to release the remains to:
Patient

To: _____ (____)_____
Mortuary/Procurement Agency — Area Code/Phone Number

Date	Signature	Area Code/ Phone Number	Email address

Mortuary Notified: Date_____ **Time**_____ **Initials** _____

MORTICIAN'S RECEIPT OF REMAINS

Received from TRI-CITY MEDICAL CENTER, the pregnancy remains from, (Name) _____

_____ _____ _____
(Date) (Time) (Signature of Mortuary Transporter)

Released By: _____ Date: _____ Time: _____

Public Administrator Notified: _____ Date: _____ Time: _____ Initials _____

Affix Patient

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AUTHORITY FOR MISCARRIAGE REMAINS RELEASE

8720-

White: Medical Record Make (4) copies (1) Patient, (2) Administrative Supervisor (3) Laboratory (4) Mortuary

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PATIENT FOOD REFRIGERATORS/FREEZERS**
Purpose:	To ensure patient care refrigerators for food are monitored, defrosted, and cleaned.

A. **PROCEDURE:**

1. All patient food refrigerators shall be cleaned/defrosted as needed.
   a. Food and Nutrition is responsible for cleaning and/or notifying engineering of defrost for the refrigerators/freezers routinely stocked by food and nutrition personnel.
   b. Nursing is responsible for cleaning and/or notifying engineering of defrost for refrigerators not routinely stocked by Food and Nutrition Services
   c. Engineering is responsible for defrosting the refrigerator/freezer units.
2. Temperature ranges for patient food storage:
   a. Refrigerators 32 to 41.5 degrees Fahrenheit (°F).
   b. Freezers minus (-) 20 to 2 degrees Fahrenheit (°F).
3. All refrigerators/freezers **are recommended to have a back up** ~~must have a~~ thermometer **in case the electronic surveillance system malfunctions**.
4. The **e**~~E~~lectronic surveillance system monitors patient refrigerator/freezer temperatures 24 hours a day, seven (7) days a week.
5. The electronic surveillance system will send an initial notification email to the Food and Nutrition Supervisors from 0500 to 2100 and to Engineering from 2100 to 0500 if the temperature is out of range.
6. If the temperature falls outside the correct range, ~~Nursing~~**Nursing**/Food and Nutrition personnel/Supervisor/Engineering shall:
   a. Check the freezer compartment for over icing. If the freezer requires defrosting, **p**~~,P~~lace a work order to Engineering to follow up immediately.
   b. If the freezer is not the problem, **Nursing**~~Nursing~~/Food and Nutrition personnel/Engineering will adjust the thermostat, and/or implement appropriate action plan. **Nursing**~~Nursing~~/Food and Nutrition personnel /Engineering will monitor results within two (2) hours.~~.~~
7. If the temperature is not corrected within two (2) hours after adjusting the thermostat or any other corrective actions, a work order will be placed to Engineering.
   a. The electronic surveillance system will send a notification email to the Food and Nutrition Director **if the temperature is out of range for 4 hours.**.
   b. Food and Nutrition Supervisors will evaluate the need to relocate food items until temperature is corrected.
   c. Corrective actions shall be documented in the electronic surveillance system.
8. If the electronic surveillance system fails the temperature will be monitored manually.
   a. Food and nutrition personnel are responsible for documenting the temperatures one time per day for the refrigerators/freezers they routinely stock.
   ~~i.~~**b.** Nursing is responsible for documenting the temperatures for refrigerators/freezers not routinely stocked by Food and Nutrition.
   ~~b.~~**c.** Corrective actions shall be documented on the temperature log.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
04/00, 06/03, 07/07, 11/10, 10/17, 06/18, 10/21	11/10, 11/17, 08/18, 11/21, **06/22**	11/10, 12/17, 09/18, 12/21, **07/22**	n/a	n/a	n/a	10/18, 01/22, **08/22**	01/11, 01/18, n/a	01/11, 01/18, 11/18, 01/22

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/05	**SUBJECT: Privacy Code**
REVISION DATE: 08/07, 07/10, 11/10, 01/16, 02/18	~~**POLICY NUMBER: IV.CC**~~
Department Approval:	~~09/17~~04/22
Clinical Policies & Procedures Committee Approval:	~~11/17~~06/22
Nursing Leadership~~Executive Committee~~ Approval:	~~12/17~~07/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	08/22
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **DEFINITION(S):**

1. Privacy Code: a code or word selected by the patient or durable power of attorney that contains a minimum of four (4) characters.
~~1.~~2. **Permitted Disclosure: means the information can be, but is not required to be, shared without individual authorization.**

B. **PURPOSE:**

1. A privacy code is used by staff to identify patient designee who may receive healthcare information when an individual is requesting protected health information (PHI) via the telephone or in person.
   a. Exclusions:
      i. Women~~'s~~ and **Newborn**~~Children's~~ Services for infant security and privacy considerations. For infant security and safety see department specific:
         1) Patient Care Services Procedure: Identification of Newborn
         2) Women and Newborn Services Policy: Infant Safety and Security
         3) Women and Newborn Services NICU Policy: Visitation in the NICU
      ii. **Outpatient** ~~B~~**B**ehavioral Health Services patients - for privacy information for behavioral health patients see:
         1) Administrative Policy Rights to Request Privacy Protection for Protected Health Information
         2) Behavioral Health Policy: Confidentiality
         3) Behavioral Health Policy: Release of Information
      iii. Justice Involved Patients

C. **POLICY:**

1. The patient or durable power of attorney shall select a privacy code upon each admission to Tri-City Healthcare District (TCHD) as inpatient~~, observation~~, **observation** status patient or surgical patient. The patient shall be asked to update their privacy information for each new admission; this can be new information or remain the same from a previous admission.
   a. In the Emergency Department/Outpatient Areas:
      i. When the patient or durable power of attorney presents to the department, staff will obtain verbal consent to discuss care/condition with person accompanying patient.

ii. When receiving telephone requests PHI, staff will obtain verbal consent from the patient to discuss care/condition with person requesting information via the telephone.

1) Document name of person given PHI in electronic health record.

2. If the patient is unable to select a privacy code because of the patient's incapacity or emergency circumstance, disclosure may be made if the staff, in the exercise of professional judgement, determines the disclosure is in the best interest of the patient and discloses only the PHI directly relevant to the person's involvement with the patient's health care, or needed for notification purposes

a. A reasonable effort shall be made to have the patient or durable power of attorney select a privacy code during the hospital stay as soon as the patient is able to communicate.

3. The Registered Nurse completing the admission process for inpatient, observation status or surgery patients shall ensure the privacy code information has been addressed.

a. **Privacy Code** Selection Process

i. Once ~~a~~**the** privacy code **is**~~has been~~ selected**, document the following in the medical record**,

1) ~~t~~**The privacy** code ~~shall be entered into Cerner.~~

2) Privacy Code Designee's name and relationship to patient

~~i.~~**a) A maximum of four (4) privacy code designees may be listed**

ii. The patient shall be instructed to provide the privacy code to the designated family members/caregivers involved in their care. The code authorizes those family members/caregivers to receive information directly relevant to the person's involvement with the patient's health care or needed for notification purposes.

b. Declination Process

i. If the patient or durable power of attorney declines to select a privacy code, document the declination in the medical record.

ii. The patient or durable power of attorney will be educated:

1) No information related to their care will be given family or caregivers, either in person or via the telephone.

2) They will be responsible for updating family or caregivers regarding their care/condition.

4. When the staff receives a request for information on a patient, the staff shall ask who is calling, their relationship to the patient, and the privacy code.

a. Once the privacy code is verified, the staff may give the designated family member/caregiver the minimum information necessary regarding the plan of care for the patient.

~~D. FORM(S):~~

~~1. Privacy Code Form~~

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

1. Administrative Policy: Rights to Request Privacy Protection for Protected Health Information
2. Behavioral Health Policy: Confidentiality
3. Behavioral Health Policy: Release of Information
4. Patient Care Services Procedure: Identification of Newborn
5. Women and Newborn Services NICU Policy: Visitation in the NICU
6. Women and Newborn Services Policy: Infant Safety and Security

Upon each admission to Tri-City Medical Center I, the patient, shall be asked to select a four (4)-digit Privacy Code or common word.

A Privacy Code is a 4-digit code or word to be utilized by the individuals I have designated below that authorizes Tri-City Medical Center to verbally provide information on my care/condition during this hospitalization. This protects my privacy but still gives my family members/caregivers access to information relevant to the person's involvement to my healthcare or needed for notification purposes.

I, the patient, will provide the code to the designated individuals listed below. It shall be required when they call the Medical Center requesting information regarding my care/condition.

☐ I select the following Privacy Code or word (minimum 4-characters)

CODE: _____

I designate the following individuals to receive information on my care/condition:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

☐ I decline to select a privacy code. I do not authorize Tri-City Medical Center to share information regarding my care/condition with individuals requesting information about this hospitalization.

_____ _____ ___/___/___ ___:___AM/PM
Name: Patient/Durable Power of Autorney (DPOA **Signature**: Patient/DPOA **Date** **Time**

Patient verbally provided the code but is unable to sign the form, state reason: _____

_____ _____ ___/___/___ ___:___AM/PM

_____ _____ ___/___/___ ___:___AM/PM
Witness – TCHD Representative (print name) Signature Date Time

INTERPRETATION (Complete if Interpretation provided)

Interpretation provided in preferred language: _____ ☐ Telephonic ☐ VRI

☐ Face-to-face: ☐ I have accurately and completely reviewed this document in patient preferred language with:

_____ ☐ Patient

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

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

☐ Patient unable to provide privacy code. State reason: _____

_____ _____ ___/___/___ ___:___AM/PM
Witness – TCHD Representative (print name) Signature Date Time

Please place this completed form in the Inpatient chart (behind the Admission Tab) for all patients admitted to the nursing unit. This document is part of the patient's PERMANENT record.
Send to Medical Records with discharged record

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

Page 1 of 1

Privacy Code

Affix Patient Label

8700-1094
Revised (11/17)

Authorization
White – Chart Yellow – Patient

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/01 **SUBJECT: Staffing, Registry/Traveler Usage**

REVISION DATE~~(S)~~: 3/02, 6/03, 12/03, 5/05, 5/08, 3/11, 5/14, 06/14

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

A. **POLICY:**

1. Registry shall only be approved if the following criteria have been met:
   - a. **Department Leader**~~Managers~~ have exhausted all available staffing resources including Per Diem, extra shifts at regular pay, overtime, and on-call staff to cover shortage.
   - ~~b. Staffing on all units has been evaluated by the Staffing Resource Coordinator, Unit Director/Manager, and Administrative Supervisor and it has been determined that all units are delivering care with the minimum staffing required for safe provision of care.~~
   - ~~c.~~**b.** Once the above have been evaluated, Registry coverage shall be considered.
     - i. Overtime for registry may only be approved by the Clinical Administrator on call.
   - ~~d.~~**c.** Only Registry approved for use at **Tri-City Healthcare District** (TCHD) shall be contacted.
   - ~~e.~~**d.** A current, signed letter of competence (LOC) must be on file before the registry person may work.
   - ~~f.~~**e.** Registry shall be evaluated and approved on a shift-by-shift basis, after staffing needs are determined.
   - ~~g.~~**f.** Registry staff that has been scheduled to work shall be cancelled at least **two**~~one and half~~ hours before their scheduled shift if, after reassessment of staffing requirements, it is determined that they are not needed.
   - ~~h.~~**g.** If it is determined during the Registry assigned shift that other available resources can meet staffing needs, the remainder of the shift shall be cancelled.
     - i. The registry is paid a minimum of 2 hours once confirmed to work.
2. Registry personnel are utilized at **TCHD**~~TCMC~~ on an as needed basis.
   - a. They shall follow the policies and procedures of TCHD.
   - b. A **TCHD**~~TCMC~~ staff RN shall be available on the unit as a resource.
   - c. A Registry nurse may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   - d. The agency is responsible for Registry discipline.
   - e. The following shall be maintained in the Staffing Resource Center:
     - i. Letter of competence
     - ii. Evaluations
     - iii. Signed Cerner Access form
   - f. All Registry personnel shall receive evaluations from the assigned unit at the end of the first three shifts worked, for each new specialty area worked, and quarterly. Copies of

each evaluation shall be forwarded to the appropriate Registry and a copy shall be maintained in Staffing Resource.

i. Registry personnel who receive poor evaluations require counseling by their Agency and improved performance. Failure to improve performance shall result in a Do Not Return (DNR) status for the specific unit or the Medical Center.

3. Traveler contracts shall be utilized at TCHD as needed.
   a. Traveler contracts and extensions must be approved by **position control**~~the Chief Nurse Executive~~.
   b. They shall follow the policies and procedures of TCHD.
   c. A TCHD staff RN shall be available on the unit as a resource.
   d. Travelers shall be built into the regular unit schedule via the Staffing and Scheduling system.
      i. Overtime for travelers may only be approved by the **CNE**~~Clinical Administrator on call~~ **based on individual contract**.
   e. A traveler RN contract may be cancelled for unsatisfactory work performance or inappropriate conduct while on duty.
   f. The **Department Leader**~~unit manager~~**/designee**~~ or Assistant Nurse Manager~~ is responsible for discipline while the traveler is on assignment. All issues shall also be forwarded to the agency.
   g. All items as outlined in the traveler contract shall be maintained in **the designated department**~~Human Resources~~.
   h. All travelers shall receive evaluations from the assigned unit(s) at the end of the contract.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
DISTRICT OPERATIONS

ISSUE DATE:	**09/96**	**SUBJECT:**	**Charity Care, Uncompensated Care, Community Service**
REVISION DATE:	**08/97, 05/99, 08/04, 04/06, 02/07, 01/10, 10/10, 09/13, 06/14, 08/15, 06/17, 02/22**	**POLICY NUMBER:**	**8610-285**

Department Approval:	~~02/22~~05/22
Administrative Policies and Procedures Committee Approval:	~~03/22~~08/22
Finance, Operations and Planning Committee Approval:	~~03/22~~08/22
Board of Directors Approval:	03/22

A. PURPOSE:

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

B. POLICY:

1. As a benefit to the community, it is the policy of the Hospital to provide free, or partially free, health care services to community members who have demonstrated that they are either financially or medically indigent. The Hospital gives consideration to eligible patients residing within its community and to patients, whether or not they have insurance and regardless of income level, if there are exceptional circumstances.
2. Patients will be treated fairly and respectfully regardless of their ability to pay. The Hospital does not discriminate against any person on the grounds of race, creed, color, national origin, sexual, orientation or on the basis of disability or age.
3. Business Office staff will provide interested patients with financial counseling including assistance applying for local, state and federal health programs. Uninsured and underinsured patients will be informed of and assisted in applying for charity/discounted care.
4. Any patient, or legal representative of the patient, seeking financial assistance, shall provide information concerning health benefit coverage, financial status and other pertinent documentation that is necessary to make a determination regarding the patient's status relative to the hospital's charity care policy, discounted payment policy, or eligibility for local, state or federal programs. All information provided by or for the patient, will be confidential and the dignity of the patient will be maintained during this process.
5. The Hospital and/or outside agents working on behalf of the Hospital, shall not use wage garnishments or a lien on the patient's primary residence if the patient or the patient's legal representative are communicating and cooperating with the Hospital and it has been determined that the patient is eligible for charity care or discounted care.
6. An emergency physician, as defined in Section 127450 of California Health & Safety code Chapter 2.5 of Division 107, who provides emergency medical services in a hospital that provides emergency care, is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level. This statement shall not be construed to impose any additional responsibilities upon the hospital.

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

C. DEFINITIONS AND ELIGIBILITY:

1. Charity – Financial assistance to qualifying insured and uninsured patients, in whole or in part, to relieve them of their financial obligation for health care services. For individuals who meet the Hospital's charity criteria, charity care results from the Hospital's mission to provide free health care services. Charity care is measured based on revenue forgone, at full established rates. Charity care does not include contractual write-offs, courtesy discounts, prompt pay discounts, employee discounts, or friends and family discounts.
2. Charity care does not include bad debt resulting from a patient's unwillingness to pay or from a failure to meet the definitions in this financial assistance policy.
3. Definitions of Charity include:
   a. Catastrophic Charity Care - 100% write-off of the patient's liability for a patient with High Medical Cost. All charges are eligible for consideration under the Hospital's definition of High Medical Cost.
   b. Full Charity Care – 100% write-off of the patient's undiscounted responsibility.
   c. Partial Charity Care – Partial write-off of the patient's undiscounted responsibility.
   d. Special Circumstance Charity Care – Patients who do not meet other charity criteria or who are unable to follow specified hospital procedures to receive a full or partial charity care write-off of charges.
   e. The following is a non-exhaustive list of some situations that may qualify for special circumstance charity care:
      i. Bankruptcy,
      ii. Patient without a residential address (homeless), or reasonable efforts are made to locate and contact the patient, and such attempts have been unsuccessful,
      iii. Deceased patients without an estate,
      iv. MediCal/Medicaid denials – patients who are eligible for MediCal/Medicaid are also presumed to qualify for full charity care. This definition includes patient's whose MediCal/Medicaid coverage is limited or restricted, TAR denials, medical necessity denials, billing denials (i.e. untimely filing)
      v. Charges for days exceeding a length-of-stay limit for patients enrolled in MediCal/Medicaid or other state or county indigent care programs,
      vi. Non-covered services for MediCal/Medicaid eligible patients,
      vii. The patient has coverage from an entity that does not have a contractual relationship with the provider; this would include Medicaid out of state patients, or situations where the insurance carrier is not under contract with the Hospital and denies the claim.
   f. Patient Obligations for deductible and coinsurance amounts, non-covered services, or services provided to a patient where the patient's benefits are exhausted, where the insured patient qualifies for full or partial charity care are included in the definition of charity care.
4. Federal Poverty Level (FPL) – Poverty guidelines, updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of subsection (2) of Section 9902 of Title 42 of the United States Code.
5. High Medical Cost – An insured patient with high medical costs (coinsurance, deductible, and/or reached a lifetime limit, non-covered relating to services not medically necessary) High medical costs means:
   a. Annual out-of-pocket costs incurred by the patient, at the Hospital, that exceeds 10 percent of the patient's family income in the prior 12 months.
   b. Annual out-of-pocket medical expenses by the patient that exceeds 10 percent of

the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.

c. **Annual family income that does not exceed 400 % of the annual poverty level.**

6. Patient's Family and Determination of Family Income – For persons 18 years of age and older: Spouse, domestic partner, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age: parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative. Documentation of family income shall be limited to recent pay stubs and tax returns. The patient's assets or the assets of the patient's family may not be considered.
7. Reasonable payment formula - monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.
   a. "Essential living expenses" means expenses for all of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.
8. Self-pay discount discounts are provided to uninsured patients or to insured patients where the payer does not cover the services provided, or where the insured patient has exhausted their benefits. **The discount provided to uninsured is 40% of total charges.** ~~The discount provided to uninsured patients is the difference between the charges and 125% of the Medicare reimbursement.~~ This excludes self-pay discounts for OB services, which are based upon the type of delivery and the length of stay

D. **PROCEDURES:**

1. Any uninsured patient who indicates an inability to pay will be screened for charity care. Additionally, at the discretion of the Hospital, any insured patient who indicates an inability to pay their liability, after their insurance has paid, will be screened for charity care. Charity care will be granted based upon the following suggested income levels:

Income Level	Discount Amount
Up to 400% of FPL	100% Discount
401% to 500% FPL	75% Discount
Over 500% of FPL	Case by Case Discounts
High Medical Cost	100% Discount
Special Circumstance	Case by Case Discounts

   a. All patients who are registering without insurance will be registered as a self-pay or MediCal/Medicaid-pending patient, and a MediCal/Medicaid application should be taken. Elective patients who have a large deductible and/or coinsurance obligation will meet with a financial counselor and complete the Patient Financial Assessment Form (PFAF). If the patient does not qualify for charity or MediCal/Medicaid, payment will be required in advance of the service. If a charity determination is made and partial payment is required, payment is due in advance of the service unless other arrangements are pre-arranged with the Hospital financial counselor. Charity determinations over $25,000 require the approval of the Chief Financial Officer or his/her designee.
2. Application- Except in those instances where the Hospital has determined that minimal application and documentation requirements apply, in order to qualify for charity care, a PFAF should be completed.
   a. Family Members – Patient will be required to provide the number of family members in their household.
   b. Income Calculation – Patient will be required to provide their household's yearly gross income. Adult patient's yearly income on the PFAF means the sum of the total yearly

gross income of the patient and the patient's spouse or domestic partner. Minor patient's yearly income on the PFAF means income from the patient, the patient's mother and/or father and/or domestic partner and/or legal guardian.

c. Income verification – Patients will be required to verify the income set forth in the PFAF. Income documentation will include IRS Form W-2, wage and earnings statement, paycheck stub, tax returns, bank statements, or other appropriate indicators of income. Current participation in a Public Benefit Program including Supplemental Security Income (SSI), Social Security Disability, Unemployment Insurance Benefits, Medicaid, County Indigent, Food Stamps, WIC or other similar indigence related programs can be used to verify indigence.

d. Documentation Unavailable – Where the patient is unable to provide documentation verifying income, the following procedures shall be followed:
   i. Expired patients: Expired patients may be deemed to have no income.
   ii. Written Attestation: Patient can sign the PFAF attesting to the accuracy of the income information provided.
   iii. Verbal Attestation: The Hospital financial counselor may provide written attestation that the patient verbally verified the income calculation. Some attempt should be made to document the patient's yearly income before taking a verbal attestation.

3. Patients unwilling to disclose any financial information as requested by the Hospital financial counselor. The patients will be advised that unless they comply and provide the information, no further consideration for charity care processing will be made and standard Accounts Receivable follow-up will ensue.
4. Extended Payment Plans, without interest charges, will be made available and negotiated between the Hospital and the patient to allow the patient who is eligible for partial charity to pay over an extended period of time. If the Hospital and the patient cannot agree to a payment plan, the hospital will use the "reasonable payment plan" formula to determine the payment plan.
5. California Health Benefit Exchange – The Hospital will obtain information as to whether the patient may be eligible for the California Health Benefit Exchange. Information will be provided to a patient that has not shown proof of third party coverage, a statement that the patient may be eligible for coverage through the California Health Benefit Exchange or other State- or County-funded health coverage program.
6. If the patient applies, or has a pending application, for another health coverage program concurrent with an application for charity care or a discounted payment program, neither the charity care, discounted payment program, or health care coverage program applications preclude eligibility for the other program.
7. All internal and external collection activity will be based on the written procedures contained herein. The Hospital will maintain a written agreement from any external agency that collects debt that the external agency will adhere to the Hospital's standards and practices. Specifically, the external collection agency will comply with the definition and application of the Hospital's reasonable payment plan, defined herein.

E. NOTICE:

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

F. COMMUNICATION:

1. Information provided to patient – During registration, or as soon thereafter as practicable **and before discharge,** the Hospital shall provide:
   a. All uninsured patients with written information regarding the Hospital's charity care

policies and the appropriate contact information for the patient to obtain further information about these policies. The Hospital will provide the patient with a referral to a local consumer assistance center.

b. At the request of the patient, the Charity application will be provided.

c. Patient statements to patients who have not provided proof of third-party coverage will include information about charity care, the California Health Benefit Exchange and other State- or County- funded health coverage, as well as Medicare, Medi-Cal, Healthy Families and California Children's Services. The patient statement will indicate how the patient may obtain applications for coverage through the California Health Benefit Exchange and other State- or county funded health coverage programs, and the Hospital will provide these applications. Further, this information will have standard language informing patients that they may request financial screening to determine eligibility for charity care. Finally, to the extent possible, these communications will be in the primary language of the patient.

d. The patient statement will include information on the availability of charity care and discounted payments from the emergency room physicians. The statement will include contact information for the emergency room physician who treated the patient.

2. Postings and Other Notices – Information about charity care shall also be provided by posting notices in a visible manner in the admitting and registration locations.

G. FORMS/RELATED DOCUMENTS:

1. Patient Financial Assessment Form - Sample

H. REFERENCE:

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

Patient Financial Assessment Form - Sample

Tri-City Medical Center

FINANCIAL ASSISTANCE APPLICATION FORM

Provided in Accordance with Cal. Health & Safety Code §127425(e)(5)

Application Date:	Date of Service:
Patient Name:	Account Number:
Street Address:	Phone Number:
City, State, ZIP:	Patient Date of Birth:

1) Was the patient a resident of California at the time of service? Yes No_
2) Did the patient have medical insurance at the time of service? Yes No_
3) Was the patient an active Medicaid recipient at the time of service? Yes No_

**If you answered *yes* to questions 2 or 3, please attach a copy of your insurance or Medicaid card to this application.

INCOME:

- **All adult family members' income must be disclosed.** Income includes gross (before taxes) wages, rental income, unemployment compensation, social security benefits, public assistance, dividends and interest, etc.
- "Family" is defined as follows: (i) for persons 18 years of age and older, family means spouse, domestic partner and dependent children under 21 years of age, whether living at home or not; and (ii) for persons under 18 years of age, family means parents, caretakers, relatives, and other children under 21 years of age of the parent or caretaker relative. If the patient is a minor, the "family" is defined as the patient, the patient's natural or adoptive parents and the parent's other children (natural or adoptive) who live in the patient's home.

Family Member's Name	Age	Date of Birth	Relationship to Parent	Source of Income or Employer Name	Income for 3 months prior to date of service	Income for 12 months prior to date of service

**Please attach additional family member information if applicable.

- **Proof of income must be supplied at the time of application (e.g., three months of pay stubs, most recent tax return (IRS Form 1040), etc.).**
- If you report $0 income, please provide a written statement of how you (or the patient) are surviving financially, including who provides food, shelter, transportation, etc. and how long you have been without income.

MONTHLY EXPENSES:		ASSETS This information may be used if your income is above 200% of Federal Poverty Level guidelines to determine whether you may be eligible for discounted care.	
Monthly rent/mortgage	$	Checking account	$
Utilities	$	Savings account	$
Car payment	$	Business ownership	$
Medical expenses	$	Stocks and bonds	$
Insurance premiums (life, home, car, medical)	$	Real estate (excluding primary residence)	$
Clothing, groceries, household goods	$		
Other debt/expenses (e.g., child support, loans, other)	$		

My signature below certifies that everything I have stated on this application is correct and subject to review under audit. I understand that if the information I provide is determined to be false, financial assistance may be denied and I may be responsible to pay for services provided.

Applicant's Signature Date

Please return completed application to:

TRI-CITY MEDICAL CENTER
ATTENTION: PATIENT ACCOUNTING/CSR
4002 VISTA WAY
OCEANSIDE CA 92056

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 10/02

SUBJECT: Handling of Pharmaceutical Waste, Expired Medications and Expired IV Solutions

REVISION DATE: 06/03, 08/09, 08/12, 07/17

POLICY NUMBER: 8610-276

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~02/17~~01/22
Administrative Policies & Procedures Committee Approval: ~~03/17~~03/22
Medical Executive Committee Approval: n/a
Pharmacy and Therapeutics (P&T) Committee Approval: ~~05/17~~,07/22
Administration Approval: 08/22
Professional Affairs Committee Approval: ~~07/17~~ n/a
Board of Directors Approval: 07/17

A. **PURPOSE:**

1. To provide guidelines for all Pharmaceutical waste material generated within Tri-City Healthcare District (TCHD) to be separated, stored and disposed of utilizing the appropriate waste streams stipulated by Federal, State and Local regulations.

B. **DEFINITION(S):**

1. Reverse Distributor: Vendor contracted by the Pharmacy Department to manage and process the return of expired pharmaceuticals for credit or destruction.
2. Solid Waste: Includes solid items such as paper, plastic, cardboard, glass materials, and empty PVC bags. Liquids are not allowed to be disposed as solid waste. Liquids that are NOT classified as hazardous shall be disposed down the drain.
3. Pharmaceutical Waste: Any pharmaceutical that cannot be used for its intended purpose or returned to the manufacturer, wholesaler or reverse distributor for credit. This may include, but is not limited to:
   a. Partial ampoules, vials, ointments, creams, lotions, inhalers
   b. Dropped tablets or capsules, half tablets/capsules
   c. Patient own medications left at the hospital
   d. Oral liquids
   ~~c.~~**e. Expired or usable parental fluids (i.e. IV antibiotics)**
4. Pharmaceutical Liquid Waste: **Intravenous solutions with electrolytes**~~Expired or unusable parenteral/oral liquids,~~
5. Trace Hazardous Chemotherapy Waste Chemotherapy contaminated items containing equal to or less than 3% by volume and any products incidental to the preparation and administration that contain only residual amounts of anti-neoplastic drugs. Includes empty vials, ampules, IV bags, as well as syringes, gloves, gowns, tubing, absorbent pads, etc. contaminated with chemotherapy substances.
6. Bulk Chemotherapy Waste: All containers (vials, bags, syringes, etc.) containing chemo waste that exceeds 3% by volume Inclusions: Chest tube chemotherapy drainage/intraperitoneal chemotherapy drainage.
7. Hazardous Pharmaceutical Waste: Resource Conservation and Recovery Act (RCRA): As defined by Federal Regulations waste, which is listed in 40 CFR 261 or is characteristically hazardous. A brief description of the characteristics includes the following:
   a. Ignitability: Liquids having a flash point at < 60 degrees C, mixtures containing > 24%

alcohol, Examples: rubbing alcohol, absolute alcohol, flexible collodion, , tinctures, spirits and aerosols containing flammable propellants (this includes some metered-dose respiratory inhalers e.g.: albuterol, Atrovent etc.).

b. Corrosivity: Aqueous solutions having a pH less than 2 or greater than 12.5. Examples: strong acids and bases- hydrochloric acid and glacial acetic acid.

c. Reactivity: Liable to explode, or to react violently or release toxic gases if it comes in contact with water. Examples: ethylene oxide

d. Toxic Products: Determination based on the extent to which toxic materials can leach out of the waste if they are exposed to water in the environment. Waste designated as toxic by United States Environmental Protection Agency (USEPA) pursuant to 40 CFR sections 261.11. Examples: chloroform, lindane, undiluted non-admixed epinephrine, nicotine, warfarin.

e. Any commercial chemical product listed in CFR section 66261.33 having the generic name listed (e) or (f) of that subsection. This refers to a chemical substance which is manufactured or formulated for commercial or manufacturing use which consists of the commercially pure grade of the chemical, any technical grades of the chemical that are produced or marketed, and all formulations in which the chemical is the sole active ingredient.

C. **POLICY:**

1. The following types of waste shall be handled as follows:
2. Solid Waste:
   a. Waste container: regular wastebaskets.
   b. Container Label: None
   c. Liquids are not allowed to be disposed as solid waste. Liquids that are NOT classified as hazardous shall be disposed down the drain, their containers disposed in regular wastebaskets.
3. Pharmaceutical Waste:
   a. Waste Container: A leak-proof, puncture proof (may be used for sharps) container designed to maintain security of the wasted medication.
   b. Container Label: All sides of the container, including the lid, must contain the statement "Incinerate Only". The container label will contain a space to manually enter an accumulation start date and a disposal date. The accumulation date will not exceed 90 days in the pharmacy storage area.
   c. Responsible Parties: When container is full or reaches the 90-day limit, it is sealed, removed by Environmental Services or other designated personnel. Environmental Services or other designated personnel will leave a new container and enter a new accumulation date on the container label.
   d. In non-secure patient care areas, i.e. without locked medication storage area, the container must be secured to prevent diversion of contents.
4. Pharmaceutical Liquid Waste:
   a. May be disposed of down the sink and into the sewer.
5. Intact Expired Unusable Pharmaceuticals:
   a. Intact expired or unusable medications including controlled substances are collected from all pharmacy drug storage areas, by pharmacy or other designated personnel, segregated from intact, usable pharmaceuticals and stored for pick-up by a reverse distributor with the intent to return for credit.
   b. The reverse distributor shall dispose of those medications that are unable to be returned for credit.
6. Trace Hazardous Chemotherapy Waste (also known as Hazardous Chemotherapeutic/Cytotoxic Waste):
   a. Waste Container: A yellow, rigid, leak proof and puncture resistant container with tight fitting lid to preclude the loss of contents, used to store hazardous chemotherapeutic waste or yellow chemotherapy waste bag for soft products (ie. Gowns, gloves, tubing,

etc.) Container Label: Facility name and address and phone number. All containers must be labeled as "Trace Chemotherapy Waste" on top and sides of container. The words "Incinerate Only" must be on the container.

b. Responsible Party:
   i. When container is full, nursing or pharmacy staff will securely seal it. Staff will notify Environmental Services or other designated personnel for removal.
   ii. Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.
   iii. Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated Hazardous waste storage area for removal by contracted, licensed transporter of Hazardous Waste.

7. Bulk Chemotherapy Waste (also known as Hazardous Chemotherapeutic/Cytotoxic Waste)
   a. Waste Container: A black, rigid, leak proof and puncture resistant RCRA container with a tight fitting lid, to preclude loss of contents. The accumulation start date will be posted on the container.
   b. Container Label: Bulk chemotherapy waste containers shall have a "hazardous waste" label affixed with all required information entered including the following:
      i. Facility name and address and phone number
      ii. A large yellow label will be affixed with the title "HAZARDOUS WASTE, State and Federal Law Prohibits Improper Disposal", and includes the statement: "PROPERTIES/ DESCRIPTION: CHEMOTHERAPY WASTE".
      iii. Date accumulation was started for container. Total accumulation period per container may not exceed 90 days in the pharmacy storage area if facility is classified as a Large Quantity Generator or 180 days in the designated storage area if facility is classified as a Small Quantity Generator.
      iv. Responsible Party:
         1) When container is full, or no greater than 180 days, nursing or pharmacy staff will securely seal it. Staff then notifies Environmental Services or other designated personnel for removal.
         2) Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.
         3) Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated Hazardous Materials storage area, where it will remain until removed from premises by licensed, hazardous waste transporter.

8. Hazardous Pharmaceutical Waste (RCRA):
   a. Waste Container: A black, rigid, leak-proof and puncture resistant container with a tight fitting lid.
   b. Label: Facility name, address and phone number. All containers must be labeled with a red and white label that states "RCRA Hazardous Waste" on side of container.
   c. Non-chemotherapy Hazardous Waste must be segregated from bulk chemotherapy waste.

9. Controlled Substance Waste:
   a. RX Destroyer Waste Container: A rigid, leak proof container with a tight fitting lid.
   b. Responsible Party:
      i. When container is full, nursing or pharmacy staff will securely seal it. Staff will notify Environmental Services or other designated personnel for removal.
      ii. Environmental Services or other designated personnel will remove the sealed container, replaced it with a new, labeled container with the new accumulation date filled out on the label.
      iii. Environmental Services or other designated personnel will transport the sealed containers to the facilities' designated Hazardous waste storage area for removal

by contracted, licensed waste hauler.

10. Quality Assessment/Compliance Measurement:
    a. Depending on the entity, any one or combination of the following quality assessment/compliance measurement may be used to facilitate waste stream compliance:
        i. Waste grids listing disposal pathways will be posted in medication areas.
        ii. Pharmaceutical waste containers will be routinely inspected. EVS will be called for removal/replacement when full or expiration date is reached.
        iii. The EVS Manager or Designee will perform a weekly inspection for expiration date and fullness of pharmaceutical containers.
        iv. EOC/Safety Officer will include container inspection during routine inspections of drug storage areas.
        v. During inspection of Drug Storage Areas assessment of appropriateness of the pharmaceutical waste stream will be performed.
        vi. An inspection of pharmaceutical waste containers for appropriate use, expiration date and fullness will be added to the bi-annual EVS/Safety Officer hospital rounds.
        vii. Discrepancies found during inspections and rounds will be reported to Pharmacy or designated Administrator for resolution.
11. Disposal of Hazardous Waste:
    a. All shipments ~~for disposal~~ ~~of bulk~~ of hazardous waste must be manifested per regulatory requirements ~~as hazardous waste~~. When the carrier destroys the hazardous waste, a certificate of destruction (manifest) will be returned to ~~engineering~~ the Safety Officer to be kept with the original manifest.

D. **RELATED DOCUMENT(S):**
1. Waste Disposal Guidelines

E. **REFERENCE(S):**
1. Medical Waste Management Act Sections 117600 – 118360
2. "Controlling Occupational Exposure to Hazardous Drugs" OSHA Instruction CPL 2-2.20B
3. Ch-4, 4/14/95, Directorate of Technical Support
4. Title 22, Division 4.5, Chapter 11, Article4, Section 66261.32, Section 66261.33, Section 66261.24
5. Code of Federal Regulations, Section 261.24
6. J. Barnard, The New Pharmaceutical Waste Disposal Requirements, California Pharmacist, Winter 1997:22-24
7. http://www.gpo.gov/fdsys/pkg/CFR-2014-title40-vol26/pdf/CFR-2014-title40-vol26-sec261-24.pdf
8. https://www.fda.gov/RegulatoryInformation/Legislation/ucm148726.htm#

TCMC Waste Disposal Guidelines

						 
Regular Waste NO NEEDLES	**Biohazardous**	**Sharps**	**Pharmaceuticals**	**Controlled Substances**	**RCRA Pharmaceuticals**	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood (Othe Infec ▫ Blood bags, pleur ▫ Intac bottl fluid ▫ Sucti blood ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	guide wires, sharps from procedures etc.	*capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)* ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	*gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** **Return to pharmacy** all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

See updated Waste Disposal Guidelines

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf; County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 04/2017 pharmacy

TCMC Waste Disposal Guidelines

Regular Waste

NO NEEDLES, NO PHI

- Empty IV bags, Piggyback bags/tubing without PHI or PHI covered
- Empty medication vials without PHI or PHI covered
- Trash
- Dressings
- Chux
- Diapers
- Sanitary napkins
- Gloves
- Empty foley bags and other drainage bags
- Disposable patient items
- Empty irrigation syringes
- Empty syringes (without needles)

~~NO PHI~~

Biohazardous Waste

NO NEEDLES

- Blood and all OPIM (Other Potentially Infectious Material)
- Blood tubing/ bags/hemovacs/ pleurevacs
- Intact glass or plastic bottles with bloody fluid or OPIM
- Suction liners with bloody fluid or OPIM
- Soaked/dripping bloody dressings
- All disposable items soaked or dripping with blood or OPIM

When in doubt, use red bag.

Sharps

NEEDLES OK

- All sharps
  Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples
- Trocars, introducers, guide wires, sharps from procedures etc.

Pharmaceuticals

NEEDLES OK, NO PHI,

- Syringes, needles, tubexes, carpujects with **pourable** medication (pourable means there is enough liquid to pour it out, not just residual amount)
- Partially used or wasted prescription or over-the-counter medication

Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)

- Inhalers with no propellants *Examples: Advair, Foradil*

~~NO PHI~~

Controlled Substances

NO NEEDLES, NO PHI,

ALL Controlled Substances and propofol ONLY

- Solid controlled substances
  -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal
- Liquid controlled substances
  -Intravenous & oral
- Propofol

No needles, syringes, ampules, vials, bottles, or tubing

~~NO PHI~~

RCRA Pharmaceuticals

NO NEEDLES, NO PHI,

EPA designated R.C.R.A. Pharmaceuticals only:

Examples:

- *Insulin/Insulin Pen ~~(needles removed)~~*
- *Inhalers -only those w/ propellant e.g Ventolin, ~~Atrovent, Flovent, Symbicort~~*
- *Warfarin /Coumadin*
- *Used & Unused nicotine gum or patches, (include empty wrappers)*
- *Silver sulfadiazine cream*
- *Silver nitrate applicators (unused)*
- *Selenium sulfide shampoo*
- *Multiple trace elements*
- *Unused& residual alcohol/acetone/acetic acid*

~~No Needles NO PHI~~

All bulk chemo to be disposed in RCRA container

Chemo/Hazardous Waste NO PHI,

NEEDLES OK IN BIN, NOT BAG

Trace Chemo:
All supplies used to make and administer chemo medication
Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.

Hazardous Waste:
All supplies used to make and administer hazardous meds.

~~**Bulk Chemo:**~~
~~**Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container**~~

~~NO PHI~~

All bins picked up on regularly scheduled basis. Chemo/Hazardous Bin supplied by Materials (X3330). RX Destroyer and all other bins supplied by EVS (760-644-6973) If additional pick up is needed: M-F 0600-1100 page 760-926-0972. At all other times: call EVS at 760-644-6973 https://www.sandiegocounty.gov/content/dam/sdc/deh/hmd/presentations/hmd_Management_of_Pharmaceutical_Waste.pdf

References: http://cwea.org/p3s/documents/DHS%20Guidance%20Pharmacy%20Waste%20from%20Hospitals.pdf, County of San Diego Department of Environmental Health Hazardous Materials Division; Stericyle Healthcare Environmental Resource Center, Epinephrine Fact Sheet http://www.dtsc.ca.gov/LawsRegsPolicies/Title22/upload/Ch11_Art4.pdf

Revised Date: 074/202217 pharmacy

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE: 02/18

SUBJECT: Decision Making for Unrepresented Patients

REVISION DATE~~(S)~~: 02/18

POLICY NUMBER: 8610-397

Administrative Content Expert~~Department~~ Approval:	**~~07/17~~03/22**
Administrative Policies ~~&and~~ Procedures Committee Approval:	**~~07/17~~04/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/17~~06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~02/18~~ n/a**
Board of Directors Approval:	**02/18**

A. **POLICY:**

1. Preamble:
   a. Tri-City Medical Center policy provides a process for health care professionals to make medical treatment decisions on behalf of an incapacitated patient who lacks a surrogate decision maker and when there is no known family member who is alive, willing or able to make medical treatment decisions on behalf of the patient. Despite their incapacity, such "unrepresented" patients are entitled to have ethically and medically appropriate medical decisions made on their behalf and to have these decisions made in their best interest. The process set forth in this policy is intended to meet these goals. This policy is considered necessary since no clear-cut legal guidelines exist that cover these circumstances. This policy is designed to provide uniformity and consistency within the institutional setting of California's general acute care hospitals on the process to make medical treatment decisions for unrepresented patients.
   b. Decisions made without clear knowledge of an unrepresented patient's specific treatment preferences, must be made in the patient's best interest and taking into consideration the patient's personal history, values and beliefs to the extent that these are known. Decisions about treatment should be based on sound medical advice and should be made without the influence of material conflicts of interest. These decisions must be made with a focus on the patient's interests, and not the interests of providers, the institution, or other affected parties. In this regard, appropriate health care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment, or treatment that is medically ineffective or contrary to generally-accepted health care standards.
   c. This policy is procedural in nature and applies to most medical decisions for which informed consent by the patient is required. This policy is meant to support the institution's underlying consent policy.
   d. Adoption of this policy does not preclude any party from seeking judicial intervention. Appropriate judicial remedies may include a timely court order authorizing the provision, withdrawing, or withholding of treatment or appointment of a conservator; however, courts are not necessarily the proper forum in which to make health care decisions absent assignment of a conservator or public guardian.
2. When Use of This Policy is Appropriate:
   a. This policy may be used when all of the following conditions are met:

i. The patient has been determined by the primary physician (with assistance from appropriate consulting physicians if necessary) lacking capacity to make health care decisions. Capacity means a patient's ability to understand the nature and consequences of proposed health care, including its significant benefits, risks, and alternatives, and to make and communicate health care decisions. Conditions with psychiatric or psychological treatment do not, in and of themselves, constitute a lack of capacity to make health care decisions.

ii. No agent, conservator, or guardian has been designated to act on behalf of the patient.

iii. There is no individual health care directive or instruction in the patient's medical record or other available sources that would eliminate the need for a surrogate decision maker.

iv. No surrogate decision maker or family member can be located who is reasonably available, or does not exist, and who is willing and able to serve. Efforts to locate a surrogate should be diligent and may include contacting the facility from which the patient was referred, and contacting public health or social service agencies known to have provided treatment for the patient.

3. This policy does not address the criteria for determining and appointing an appropriate decision maker when one or more are available and willing to serve. Additionally, this policy is not meant to be applied in emergency medical situations.

B. **PROCEDURE:**

1. When use of this policy is appropriate, as outlined above, medical decisions will be made by a multi-disciplinary team whose members shall include, but not be limited to, individuals directly involved with the care of the patient.
2. It is recommended that the multi-disciplinary team include an attending physician, nurse familiar with the patient, social worker familiar with the patient, chair or vice-chair of the ethics committee, legal counsel, non-medical (community) member of the ethics committee or other appropriate committee and, if available and appropriate, consulting clinicians and pastoral care staff. It is very important to include on the multi-disciplinary team a person who will represent the patient's interests.
3. Some patients may have a family member or friend who is unable or unwilling to take full responsibility for making health care decisions on behalf of the patient, but who is willing to serve as part of this team. If no such person exists, the hospital may consider including an ombudsman, patient advocate, bioethicist, community member, pastoral care, or other person whose role is to protect the patients' interests. If it is not practicable to include such a person on the multi-disciplinary team in a particular case, document the reasons therefore.
4. In order to determine the appropriate medical treatment for the patient, the multi-disciplinary team should:
   a. Review the diagnosis and prognosis of the patient and assure itself of the accuracy thereof.
   b. Determine appropriate goals of care by weighing the following considerations:
      i. Patient's previously-expressed wishes, if any and to the extent known
      ii. Relief of suffering and pain
      iii. Preservation or improvement of function
      iv. Recovery of cognitive functions
      v. Quality and extent of life sustained
      vi. Degree of intrusiveness, risk or discomfort of treatment
      vii. Cultural or religious beliefs, to the extent known
      viii. Patient's current mental status
   c. Establish a care plan based upon the patient's diagnosis and prognosis and the determination of appropriate goals of care. The care plan should determine the appropriate level of care, including categories or types of procedures and treatments.
   d. Notify the patient that, once patient does not lack capacity:

i. He or she has been determined incapacitated;
ii. It has been determined that he or she lacks a surrogate decision maker;
iii. Medical intervention has been prescribed; and
iv. He or she has the opportunity to seek judicial review of the above determinations.

e. If the patient will be administered antipsychotic drugs, consider obtaining the review of an independent physician.
f. Periodically evaluate the use of the prescribed medical intervention at least quarterly or upon a significant change in the resident's medical condition.
g. Limit end of life decisions (such as withholding or withdrawing life-sustaining treatment, ordering hospice care) to patients who are terminally ill, comatose, or in a persistent vegetative state.

5. Except to the extent that such a factor is medically relevant, any medical treatment decision made pursuant to this policy shall not be biased based on the patient's age, sex, race, color, religion, ancestry, national origin, disability, marital status, sexual orientation (or any other category prohibited by law), the ability to pay for health care services, or avoidance of burden to family/others or to society.
6. Under the terms of this policy, the multi-disciplinary team may make the same treatment decisions, and will have the same limitations, as does an agent appointed pursuant to a power of attorney for health care specified under current law. However, this policy shall not apply to decisions pertaining to disposition of remains, autopsies, or anatomical gifts; specific laws apply to these procedures.
7. The multi-disciplinary team must assure itself that the medical decision is made based on sound medical advice, is in the patient's best interest and takes into account the patient's values, to the extent known. In determining the best interest of the patient, it is not required that life support be continued in all circumstances, where treatment is otherwise non-beneficial or is medically ineffective or contrary to generally-accepted health care standards, when the patient is terminally ill and suffering, or where there is no reasonable expectation of the recovery of cognitive functions.
8. Agreement on Treatment:
   a. If all members of the multi-disciplinary team agree to the appropriateness of providing treatment, it shall be provided.
   b. If all members of the multi-disciplinary team agree to the appropriateness of withholding or withdrawing treatment, it shall be withdrawn or withheld. Any implementation of a decision to withhold or withdraw life-sustaining medical treatment will be the responsibility of the primary treating physician.
9. Disagreement on Treatment:
   a. If the members of the multi-disciplinary team disagree about the care plan, the ethics committee, ethics resource expert(s) or other resource experts will meet with the team to explore their disagreement and facilitate resolution.
   b. If agreement is reached either to provide or to forgo treatment, the decision of the multi-disciplinary team then becomes final.
   c. If agreement still is not reached, current treatments will be continued and any other medically necessary treatments provided, until such time that the issue is resolved through court intervention or the disagreement is otherwise resolved. Court-imposed legal remedies should be sought only in extreme circumstances and as a last resort.
   d. In all cases, appropriate pain relief and other palliative care shall be continued.
10. Documentation:
   a. Signed, dated and timed medical record progress notes will be written by the Social Work Case Manager for the following:
      i. The due diligence findings from the multi-disciplinary team used to conclude that the patient lacks medical decision-making capacity.

1) If the multi-disciplinary team concludes the due diligence findings are not complete, documentation of the required items for the patient to be considered unrepresented.

ii. The finding that there is no advance health care directive, no conservator, guardian or other available decision maker, and no health care instructions in the patient's medical record or other available sources.

iii. The attempts made to locate surrogate decision makers and/or family members and the results of those attempts.

iv. The bases for the decision to treat the patient and/or the decision to withhold or withdraw treatment.

v. Any information from the ethics committee or other consult, should it be convened.

C. **REFERENCE(S):**

1. California Health and Safety Code Section 1418.8
2. California Probate Code Section 4735
3. California Probate Code Section 4650(c)
4. California Probate Code Section 4717
5. California Probate Code Section 4736
6. California Probate Code Section 4617
7. California Probate Code Section 4683
8. California Probate Code Section 4652
9. Health and Safety Code Sections 7100 (disposition of remains), 7113 (autopsy), and 7150 *et seq.* (anatomical gift).
10. California Probate Code Section 4734

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE: 04/18 **SUBJECT: Non-Beneficial Treatment**

REVISION DATE~~(S)~~: **POLICY NUMBER: 8610-399**

Administrative Content Expert~~Department~~ Approval:	**~~02/18~~03/22**
Administrative Policies and Procedures Committee Approval:	**~~02/18~~04/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/18~~06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~04/18~~ n/a**
Board of Directors Approval:	**04/18**

A. **PURPOSE:**

1. The purpose of this policy is to outline a process for physicians to follow when a patient or his/her designated decision maker has requested treatment that in the best judgment of the patient's physician is non-beneficial in compliance with the relevant California statutes regarding health care decisions.

B. **POLICY:**

1. Tri-City Healthcare District and physicians of the TCHD's Medical Staff are not obligated to provide a patient with medical treatment that, in the physician's best judgment, will not be beneficial. This policy applies to all patients regardless of race, color, national origin, religion, disability, age, sex, marital/familial status, socioeconomic status or sexual orientation. Disagreements concerning this issue between doctors, patients, family members, surrogates, conservators, nurses and other health care personnel will be addressed in the following manner:
   a. Preempt conflict. Attempt to promote understanding among the involved parties in advance.
   b. Negotiate solutions to disagreements using available hospital resources including the Ethics Committee, palliative care services, and chaplaincy services.
   c. An effort should be made to contact the patient's outpatient primary care physician if available.
   d. If disagreement persists, seek consultation from another physician.
   e. If the consulting physician disagrees with the attending physician, consider transfer of the patient's care to another physician.
   f. If both physicians agree, but there is still disagreement with the patient, family, conservator, or surrogate, consultation from the hospital Ethics Committee should be requested.
   g. If the Ethics Committee review disagrees with the recommendation of the two physicians, help with transfer of the patient to another physician or institution should be provided. Until such transfer can occur, the current physician remains ethically and legally responsible for the care of the patient.
   h. If the Ethics Committee review concludes that the proposed treatments are non-beneficial but there is still failure to reach consensus with the patient, family, conservator, or surrogate, the following steps should be taken:
      i. Risk Management and Administration of the hospital must be notified.
         1) Inform the patient or designated decision maker of the decision of the medical team. Document this discussion in the patient's health record.

2) The patient or the designated health care decision maker for the patient should be promptly notified in writing that the non-beneficial treatment will not be provided. A letter must be issued to the patient or designated health care decision maker on hospital stationery and signed by the patient's Attending Physician and the hospital's Chief Medical Executive, or their designees, documenting this decision. The letter will be hand delivered, if possible.

ii. Discuss the option of transfer to an appropriate care setting. It is the responsibility of the patient, family, conservator, or surrogate to find an acceptable medical practitioner or institution and arrange the transfer of the patient. Reasonable efforts will be made to assist in the transfer of the patient.

iii. Recognize the opportunity of the patient or designated decision maker to seek a judicial mandate to continue the treatments in question. Continuing care will be provided to the patient until a transfer can be accomplished or it appears that transfer cannot be accomplished. No new treatment, which has been determined to be non-beneficial, will be initiated unless court ordered.

i. If the patient has not been transferred or a judicial mandate has not been issued within a reasonable period of time, not to exceed ten (10) days from the issuance of the letter, the treatment in question may be withheld or withdrawn.

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

1. Non-Beneficial Treatment Patient Letter - Sample

D. **REFERENCE(S):**

1. California Probate Code sections 4735, 4736 and 4740

Tri-City Medical Center
ADVANCED HEALTH CARE...FOR YOU

SAMPLE

To:
[Name of patient/surrogate]
[Address]

[Date]

Re: Medical care of patient, [Name and MRN] at Tri-City Healthcare District

Dear [Name of patient/Surrogate],

We have been caring for your [relationship to patient], [Patient's Name], during his/her current hospitalization at Tri-City Healthcare District. We have been asked by you to provide treatments for [Patient's Name] which includes treatments like [Name each treatment deemed to be non-beneficial]. We understand why you are requesting this care and have carefully considered your reasons for requesting this care.
Our goal in caring for our patients is to provide them with medical treatments most appropriate for their condition. We have consulted with our colleagues and we have evaluated the potential outcomes of the treatment requested. We have also consulted our hospital ethics committee and they agree that the treatments mentioned above would not be beneficial to [Patient's Name] and would not be appropriate. After careful review and discussion, we do not believe that the requested treatments would be beneficial under the circumstances.

We are providing you with this written notice of our decision in compliance with the hospital's policy and the California Probate Code that addresses requests for medical treatments which physicians believe are non-beneficial. We have also asked our Chief Medical Executive to sign this letter. He has reviewed this matter and his signature indicates the hospital's support of our decision.

We recognize that making treatment decisions for gravely ill persons is challenging for everyone involved. If you disagree with our decision, you may seek out another physician and institution willing to accept [Patient's Name] for transfer and provide the care you are seeking. Although you are responsible for locating alternative providers, we will make reasonable efforts to assist you. You may also seek a court order that directs our hospital to continue the treatment in question. You must carry out these alternatives within 1 - 10 days of this notice. After that time, we will not continue to provide the non-beneficial treatments.

We do recognize how difficult this time is for the patient, clinicians, and family. We will continue to provide the current medical treatment to [Patient's Name], and continue to work with you to develop a mutually acceptable plan of care.

Sincerely,

[Name], MD [Name], MD Attending Physician Chief Medical Executive

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
PATIENT CARE

ISSUE DATE: 06/19

SUBJECT: Skilled Nursing Facility (SNF) Refusal to Readmit

REVISION DATE~~(S)~~:

POLICY NUMBER: 8610-300

Administrative ~~Patient Care~~ Content Expert Approval:	**~~04/19~~04/22**
Administrative Policies & Procedures Committee Approval:	**~~04/19~~04/22**
Utilization Review Committee Approval:	**05/19**
Medical Executive Committee Approval:	**~~05/19~~06/22**
Administration Approval:	**~~06/19~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/19**

A. **POLICY:**

1. The following policy is used to address situations in which Skilled Nursing Facilities (SNF) refuse to readmit their patients (from either the Emergency Department or from an acute inpatient bed).

B. **BACKGROUND**

1. Nursing homes/SNFs have a tendency to not readmit certain long-term (non-skilled) Medi-Cal/private pay patients once they transfer them to an acute care hospital due to their perception that the patient is undesirable. Reasons for this can include (but not limited to):
   a. Patient/family behavioral issues (e.g. Dementia)
   b. Nursing home's perception that patient's care is cost prohibitive
   c. Patients not paying their bill
2. The nursing home's refusal to readmit patients is viewed as illegal based on the following:
   a. As per Title 22 of the California Code of Regulations, nursing home residents have the right to be readmitted after a hospital stay. Whenever a resident is transferred to a hospital, the nursing home must provide a written notice to the patient/family of their right to hold the nursing home bed for up to seven days.
      i. For private pay patients – patient/family must pay the per-diem rate to hold the bed.
      ii. For Medi-Cal patients, Medi-Cal will pay for the bed hold up to seven days.
         1) Note: any Medi-Cal patient has a right to be readmitted to a nursing home even if the patient's hospital stay exceeds seven days (the nursing home must readmit the patient to the first available bed).
      iii. Failure of the nursing home to provide the patient with written notification of their right to a bed-hold and/or failure to honor a bed hold is considered an "involuntary transfer" and is illegal.

C. **PROCEDURE:**

1. Case Management/Social Worker (CM/MSW) – Upon being notified by a SNF of their intention to NOT readmit their patient, the CM/MSW must inquire as to whether the patient (or surrogate decision maker) agrees to return back to the SNF.
   a. If the patient agrees to return, the CM/MSW contact the SNF and inquire as to the specific reason why they refusing readmission. Inquire should include contacting the

SNF's Director of Nursing (DON) or Administrator (Adm) as to why the SNF will not readmit. Specifically:

i. What is the specific reason as to why you (SNF) will not readmit?
ii. What was the payer source used at the time of transferring the patient to Tri-City Medical Center (TCMC)?
iii. The CM/MSW should remind the SNF of their legal obligation to readmit the patient back, citing that Medi-Cal allows for a bed hold to return back to the SNF.

b. If (after contacting the SNF and addressing the above questions) the SNF continues to refuse to readmit the patient, the CM/MSW must notify Director of Case Management.
   i. Director of Case Management will then contact the SNF in an attempt to clarify the reason to not readmit and remind the SNF of their legal obligations.
   ii. If the SNF continues to refuse readmission, Director of Case Management will make it clear to the SNF that it will be the intent of TCMC to contact The California Department of Public Health (CDPH) to file a complaint on behalf of the patient regarding the SNF's decision to refuse readmission.

c. If the SNF continues to refuse, Director of Case Management must contact the CDPH office (see Reference List for office contact numbers for CDPH offices near TCMC).
   i. Director of Case Management will file a formal complaint on behalf of the patient regarding the SNF's refusal to readmit the patient. CDPH will need the following information to open the complaint process:
      1) Patient name, date of TCMC admission
      2) Name of SNF – name of SNF staff that was contacted
      3) Issue (SNF refusing to readmit patient)
   ii. CDPH will go out to the SNF and investigate the complaint with the goal of convincing the SNF to readmit the patient.

d. CDPH will contact Director of Case Management to provide the results of the investigation.
   i. If the SNF continues to refuse readmission of the patient, the Director of Case Management/CDPH will contact the Department of Healthcare Licensing Board to initiate a "Refusal to Readmit Hearing". (see Department of Healthcare Licensing Board below)

e. The Refusal to Readmit Hearing consists of the following process:
   i. CDPH will contact Director of Case Management as to the date and time of the hearing.
   ii. Hearings are held at TCMC
   iii. Participants in the hearing include:
      1) Hearing Officer
      2) Patient (and/or surrogate decision maker)
      3) SNF staff (Adm, DON)
      4) TCMC staff (Director of Case Management, MSW, CM, interpreter(s))
   iv. The focus of the hearing is for the SNF to explain their reasons to deny readmission.
   v. Approximately 72 hours after the hearing, the hearing officer will fax to all parties, the hearing decision to readmit.

f. If the decision is in favor of patient to return back to the SNF, Director of Case Management will contact the SNF and inform them of the results of the hearing and coordinate time to readmit.
   i. If the SNF continues to refuse readmission, Director of Case Management will contact TCMC Legal Counsel as to their input to address this issue.
   ii. Director of Case Management will also re-connect with the CDPH office and inform them of the SNF's intent to not readmit despite the ruling from the hearing.

g. If the SNF continues to stall and not readmit the patient, Director of Case Management will instruct the CM/MSW to go back to the patient with the goal of finding another SNF placement.

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

1. Reference List – Skilled Nursing Facility (SNF) Refusal to Readmit

E. **REFERENCE(S):**

1. California Department of Health Care Services: Transfer Discharge and Refusal to Readmit Unit (available via external link: https://www.dhcs.ca.gov/formsandpubs/laws/Pages/Transfer-Discharge-and-Refusal-to-Readmit-Unit.aspx)
2. CCR 22, sub-section 72520 (available via external link: https://govt.westlaw.com/calregs/Document/I7311F370D4BC11DE8879F88E8B0DAAAE?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=%28sc.Default%29&bhcp=1)
3. CFR 42, subsection 483.12(b) (available via external link: https://www.ecfr.gov/cgi-bin/text-idx?rgn=div8&node=42:5.0.1.1.2.2.7.4)

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION

ISSUE DATE: 04/19 **SUBJECT: Fall Risk Assessment**

REVISION DATE(~~S~~):

Cardiac Rehabilitation Department Approval:	**~~11/18~~04/22**
Division of Cardiology Approval:	**~~12/18~~05/22~~–~~**
Medical Executive Committee Approval:	**~~02/19~~06/22**
Administration Approval:	**~~04/19~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **DEFINITION(S):**

1. To provide a fall risk assessment on all patients prior to their first exercise session, and to implement appropriate fall risk interventions based upon patients' identified risk factors.

B. **PROCEDURE:**

1. A Fall Risk Assessment (form) is given to any patient who answers yes to any of the 4 questions asked on the Cardiac Rehabilitation Admission Information form filled out at patient's initial intake appointment.
2. On the Fall Risk Assessment form (7593-1037), if patient scores a 2 or higher, he/she is considered a fall risk. The supervising physician will finish completing the form with the patient, giving education/intervention strategies and instruction as necessary. The physician~~MD~~ alerts the staff of the fall risk prior to starting the exercise session.
3. The staff will highlight patient's name on chart and on his/her daily exercise prescription sheet with a yellow sharpie highlighter. Patient will also wear ECG monitor in a blue pouch with a red dot during the exercise session.
4. Fall risk patients will not be able to use the treadmill or any other upright equipment unless accompanied/directly/closely supervised by a staff member. Patients may be re-evaluated as his/her strength, balance, and fitness level improves.

C. **FORM(S):**

~~1. Cardiac Rehabilitation Physician Referral Orders - Sample~~
~~2.~~**1.** Fall Risk Assessment - Sample

SAMPLE

☐ **Tri-City Medical Center**
4002 Vista Way, Oceanside CA 92056
Phone: 760-940-3098, Fax 760-940-4056

☐ **Carlsbad Wellness Center**
6250 El Camino Real, Carlsbad CA 92008
Phone 760-476-2905, Fax 760-931-3163

Patient Name _____ DOB: _____

Home Phone: _____

DIAGNOSIS:

☐ Acute Myocardial Infa
☐ Non-STEMI (within 1
☐ Coronary Artery Byp
☐ Stable Angina Pecto
☐ Heart Valve Repair o
☐ CHF (EF documente
☐ Percutaneous Transl
☐ PTCA with Coronary
☐ Heart Transplant
☐ Phase IV Supervised

DELETE

f Onset or Intervention:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PROGRAM OPTIONS / 1

☐ Phase II Continuous
sessions in 12-18 w
- Initial Evaluat
- Progressive e
hand weights
- Education to

n patient progress to a maximum of 36

ssion, utilizing treadmill, stationary bike,
hing activities
onal health risk factors

INTENSITY:

☐ Patient will be exercised to tolerance with the following restrictions.
☐ None
☐ Based on Stress Test, completed on _____
☐ Heart Rate Range: _____ - _____
☐ Maximum Heart Rate: _____

Restrictions: _____

☐ My patient does not require a graded exercise test prior to starting the cardiac rehab program
☐ My patient has had a graded exercise test and we will fax it to the Cardiac Wellness Program
☐ My patient is able to participate in the cardiac rehabilitation MAINTENANCE program, where he/she will only be ECG monitored for 3 visits. This option is self-pay, and no insurance authorization is necessary. All fees will be the responsibility of the patient (Oceanside site only).

☐ Phase IV Cardiac Rehab Maintenance Program (Oceanside site only)

☐ Supervised exercise without Telemetry monitoring

☐ Read Back all T.O./V.O.orders	
Nurse's - Signature Date Time	Physician's - Signature Date Time

Affix Patient Label

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

CARDIAC REHABILITATION PHYSICIAN REFERRAL ORDERS
Page 1 of 1

PHYSICIAN'S ORDERS

SAMPLE

FALL RISK ASSESSMENT, INTERVENTION, AND EDUCATION

Initial ❑ Reassessment ❑

Reason for reassessment: Recent Fall ❑ Medication Change ❑

Other ❑ _____

_____

Check all measures that apply

❑ Dizziness / disorientation
❑ Medical problems affecting ambulation
❑ History of falls within the last six months
❑ Receiving medications affecting balance or mobility
❑ Use of assistive devices / ambulatory aids

_____ *Total number of measures checked*

No Fall Risk = Score of 0 or 1 ❑
Fall Risk = Score of 2 or higher ❑

** If a score of 2 or higher, need Fall Risk Interventions and Education

❑ Initiate individualized treatment recommendations and interventions / note on initial treatment plan
❑ Educated patient regarding medication side effects
❑ Educated patient prone to dizziness to move slowly
❑ Instructed patient to rise out of chair slowly
❑ Educated patient regarding use of assistive devices to prevent falls
❑ Educated patient regarding wearing proper shoes and walking near walls or with assistance
❑ Educated regarding calling out loud for help as needed for assistance
❑ Alerted staff regarding the patient being at risk for falls

I understand the information I have been given to help me prevent falls.

_____

Patient Signature Date / Time

_____

Physician Signature Date / Time

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7593-1037

FALL RISK ASSESSMENT

Affix Patient Label

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 11/88

SUBJECT: **Outpatient Medical Records Storage and Retention**

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

Cardiac Rehabilitation Approval:	~~02/20~~07/22
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/13

A. **PURPOSE:**

1. To ensure the appropriate storage of cardiac rehabilitation outpatient charts.

B. **POLICY:**

1. Cardiac rehabilitation outpatient medical records shall be stored in the Cardiac Rehab facility in a protected file cabinet.

C. **PROCEDURE:**

1. All current rehabilitation service medical records shall be stored in a file cabinet in the department.

~~1.~~**2. Once the outpatient is not longer active chart is sent over to Medical Records to be scanned per policy**

~~2. All non-current charts of outpatients that are over one (1) year old shall be sent to Iron Mountain, the offsite storage facility utilized by the Medical Center or sent to medical records for scanning into patient's electronic record. Proper bar-coded labels shall be placed on records before being sent to medical records via the yellow confidentiality bags through interoffice mail. A chain of custody log shall be sent with yellow bag to ensure proper delivery of records.~~

~~3. List of stored files and instructions for Iron Mountain are to be kept in Archived Reports notebook~~

~~4.~~**3.** Medical records shall be maintained in accordance with Tri-City Medical Center's policies.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT POLICY MANUAL

ISSUE DATE: NEW	**SUBJECT:** Behavioral Health – Room Safety Check
REVISION DATE:	**POLICY NUMBER:** N/A

Emergency Department Approval:	~~04/20~~03/22
Department of Emergency Medicine Approval:	04/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval	

A. **PURPOSE:**

1. To define a process for the management of patients who are at risk for self harm/harm to others while in the ED. Patients may or may not be on a 5150 hold, but have demonstrated a risk based on criteria.

B. **PROCEDURE:**

1. Staff responsibilities:
   a. Identify patient is at risk.
   b. Instruct the patient to undress and don a hospital gown.
   c. Place **patient** belongings in a ~~patient~~ **labeled** bag and secure as appropriate. Locked storage areas are available for patient security.
   d. Patient medications will be inventoried by two ~~hospital~~ **Registered Nurses** (RN)s and secured in locked cabinets. A red tag will be placed on the patient belongings alerting the staff that medications are located in the secure locker compartments. Belongings will be subject to search by the security staff as appropriate.
   e. ~~Apply Purple ID Band and place a Purple Star on the Cerner tracker to alert team members that patient should not be allowed to leave.~~
   f. Notify the Physician of the patient's status and discuss medical or psychiatric need to hold the patient in the event of an elopement attempt.
   g. Alert ~~ANM and/or Charge RN,~~ **ED Charge RN,** Security, and Team members of patient at risk for self harm/harm to others.
   h. Communicate patient is at risk in handoff reports.
   i. Escort all patients at risk for self harm/harm to others to the restroom and monitor the area while the patient is in the restroom.
   ~~i.~~**j.** Patients with suicidal ideation should **have 1:1 observation at all times.** ~~be kept in line of sight while in the restroom.~~
   ~~j.~~**k.** Do not allow patients to leave the ED to smoke.
   ~~k.~~**l.** Provide finger food on safety trays without utensils, cans, plates, or other sharp/breakable objects. Food or drinks will not be allowed to be provided by visitors.
   ~~l. Visitors will be limited to a maximum of two at a time and will be subject to removal at the discretion of the security and clinical staff.~~
   m. ~~A Room~~ **An Environmental Room** Safety Checklist form will be completed in **the electronic health record (EHR)**~~Cerner~~ **every shift.** ~~.~~Procedures for removing hazards from the room will be followed accordingly. The room will be restocked completely after the patient is discharged.

2. Identifiers of risk for self harm/harm to others:
   a. ~~SADPERSONAS scale >4.~~ **Suicide Risk Assessment based on the Columbia-Suicidal Risk Assessment (C-SSRS).**
   b. Clinical evidence of intoxication by drugs or alcohol. (ie: elevated **blood alcohol level,**~~BAL~~, positive toxicology screen, ataxia, slurred speech.)
   c. Confusion, agitation, combativeness or clinical evidence of impaired judgment.
   d. Verbalization of threats to self or others.

C. **DOCUMENTATION:**

1. **C-SSRS on admission and as needed.** ~~Complete a clinical note in the patient's chart, which includes the rationale for identifying the patient as at risk for self harm/harm to others.~~
2. **Environmental Room Safety Checklist every shift in the EHR.**
2. ~~Document any directives/physician orders.~~
3. Complete the Room Safety Checklist ~~(ad hoc form)~~**in the EHR.**
4. **Suicide observation.**

D. **FORM(S):**

1. **Suicide Observation Documentation 8610-1002 SAMPLE**

Suicide Observation Documentation 8610-1002 SAMPLE

Date _____

Activity Code		
A – Watching TV	D – Sleeping & Breathing	G – With MD / Therapist
B – With Visitors	E – Lying / Sitting	H – Transport
C – Eating	F – Walking / Pacing	I – Other: _____

Time	Staff Initials	Activity Code (Optional)	Time	Staff Initials	Activity Code (Optional)	Time	Staff Initials	Activity Code (Optional)
12:00AM			08:00			16:00		
12:15			08:15			16:15		
12:30			08:30			16:30		
12:45			08:45			16:45		
01:00			09:00			17:00		
01:15			09:15			17:15		
01:30			09:30			17:30		
01:45			09:45			17:45		
02:00			10:00			18:00		
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06:30			14:30			22:30		
06:45			14:45			22:45		
07:00			15:00			23:00		
07:15			15:15			23:15		
07:30			15:30			23:30		
07:45			15:45			23:45		

Print Name	Initials	Print Name	Initials

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

8610-1002
(Rev. 5/10)

SUICIDE
OBSERVATION
DOCUMENTATION

Affix Patient Label

Tri-City Medical Center	EMERGENCY DEPARTMENT
PROCEDURE:	**HOSPITAL EMERGENCY OPERATIONS PLAN, EMERGENCY DEPARTMENT RESPONSE**
Purpose:	To prepare the Emergency Department to respond to internal and external emergencies of sufficient magnitude that they may overwhelm the capabilities of the department.
Supportive Data:	**Hospital Incident Command System** (HICS)
~~Equipment:~~	
Issue Date:	**NEW**~~Revision Date(s):~~

~~A. DEFINITIONS:~~

~~HICS: Hospital Incident Command System.~~

~~1. EOC: Environment of Care.~~

~~2. Incident Command System~~

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

1. Recognition of an external disaster may occur as a result of prehospital radio notification or through a surge of walk in victims.
2. The Emergency Department **(ED)** may be the first level of response in a disaster and will be responsible for initiating and implementing the Hospital Emergency Response Plan in that instance.
3. The need for Mass Casualty support and/or activation of the **Hospital Incident Command System** (HICS)/ **Environment of Care** (EOP) will be determined by the ED Leadership Team, the ED Medical Leadership, the Administrator on Call, and EOC/Safety Officer.

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

1. ED Charge RN
   a. Confer with the ED physician to identify need to implement this policy.
   b. Contact ED Leadership and Administrator on call to determine need for activation of the EOP. Prepare to give a brief status report of the situation including type of incident, number of victims, anticipated duration, **immediate needs, and** special needs (eg: decon, radiation). ~~and immediate needs.~~
   c. Upon approval for activation, Dial 66 and request that Code Orange be paged overhead.
   d. Obtain Security support to secure/lock the main ED entrance and ambulance doors.
   e. Assign additional radio RN and walk in triage RN support.
   f. Appoint a Triage Unit Leader.
   g. Obtain disaster supplies to be staged at walk in area.
   h. ~~Distribute appropriate Job Action Sheets.~~ **Assign ED staff to specific areas.**
   i. Immediately facilitate discharge of all patients from the ED who may be safely discharged.
   j. Immediately facilitate admission of all patients who may be moved from the ED.
   k. Direct ancillary staff to set up triage area as needed.
      i. Consider ~~using Fast Track and Station D~~ **an** area for staging and triage of lesser volume incidents.
      ii. Consider implementation of ~~Triage~~ tents for larger patient events (eg: >15).
   l. Direct activation of staff ~~call back list~~ as needed**, utilizing mass text or phone call.**
      i. Determine immediate staff needs and direct staff to respond in to the hospital if <30 minutes away.
      ii. Instruct staff >30 minutes away to standby at home for further direction.
2. ED Physician
   a. Station C physician to assume responsibility as Medical Care Branch Director until otherwise assigned. Station B physician may be considered as an alternative as necessary.
   b. Contact ED Medical Director on call.
   c. Assist in communication with responding agencies as applicable to provide destination

guidance hospital capability as appropriate.

d. Identify patients appropriate for immediate discharge and communicate with the Charge RN.
e. Initiate medical care to arriving victims.
f. Direct activation of ED physician call back list as needed.
g. Prepare to give a brief status report of the situation including type of incident, number of victims, anticipated duration, **immediate needs, and** special needs (eg: decon, radiation)**.** ~~and immediate needs.~~
h. Provide direction to oncoming first response medical staff.

3. MICN
   a. Facilitate information distribution via radio to the hospital
   b. Obtain and report bed capacity information.
   c. Notify surrounding facilities of status as appropriate.

~~D.~~C. FORMS:

1. Bed count
2. HICS Standard Forms

~~E.~~D. RELATED DOCUMENTS

~~1. Job Action Sheets~~
~~2.~~1. Nuclear Response Plan

~~F.~~E. EXTERNAL LINKS:

1. SD County Mass Casualty Plan/Medical EOP – Annex D http://sdcounty.ca.gov/oes/emergency_management/protected/docs/2010_Complete_Plan_w_Annexes.pdf

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT ~~POLICY MANUAL~~

ISSUE DATE: 05/04	**SUBJECT: ED Saturation, Ambulance Diversion**
REVISION DATE: 04/06, 06/06, 06/09, 02/11, 12/14	**POLICY NUMBER:** 7010-002

Department Approval ~~Date(s)~~:	~~10/14~~03/20
Department of Emergency Medicine Approval ~~Date(s)~~:	~~10/14~~04/22
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	n/a
Administration Approval:	08/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~11/14~~ n/a
Board of Directors Approval ~~Date(s)~~:	12/14

A. **POLICY:**

1. As a designated Base Hospital it is the responsibility of Tri-City Medical Center (TCMC) Mobile Intensive Care Nurse (MICN) in coordination with the Base Hospital Emergency Medicine Physician (BHMD) **and ED Charge RN** to make decisions regarding ambulance destination and diversion in accordance with County and State regulatory standards.

B. **GRANTING DIVERSION: ONLY THE FOLLOWING REASONS MAY BE USED.**

1. Emergency Department (ED) Saturation: –The hospital's ED resources are fully committed and are not available for additional incoming ambulance patients. This includes such things as no monitors available for use in the ED; ED MD and **Nurse Leader/designee**~~Assistant Nurse Manager (ANM) or Charge RN~~ agree that overall patient volume and acuity in the department have reached or exceeded a maximum level that can be safely handled by the current nursing and medical staff available.
2. **Specialty Diversion:**
   - **a. Code STEMI see Patient Care Services Policy: Code STEMI**
   - **b. Labor & Delivery: the Labor & Delivery resources are fully committed and are not available for additional incoming ambulance patients.**
   - ~~a.~~**c.** Neuro/Ct Scan Unavailability: The hospital is unable to provide appropriate care due to non-functioning CT scan and/or unavailability of a Neurosurgeon (only for patients exhibiting possible neurological problems).
3. ~~2.~~ Internal Disaster: The hospital cannot receive any patients because of a disaster leading to a physical plant or operational breakdown (e.g. fire, bomb threat, power outage, etc.).

C. **PROCEDURE:**

1. The following reasons individually are NOT acceptable for approving ED diversion: (combined situations may be appropriate)
   - a. Full waiting room or long waiting room time.
   - b. No intensive care (ICU) or telemetry beds.
   - c. CT Scan down, with the exception of section B.2 which would be patient specific.
   - d. Staffing shortage, with the exception of B.1 above.
2. Before placing TCMC on diversion the following chain of communication will be followed for the purpose of problem solving, notification and final approval:
   - a. Emergency Department **Clinical Manager**~~ANM or Charge RN~~.
   - b. Emergency Department **Director**~~Clinical Operations Manager~~**mentor**~~.~~.
3. When TCMC ED goes on diversion the MICN will change the bypass screen in the ~~QA net computer.~~**County of San Diego Image Trend Bridge System.**

4. The ED will **reevaluate the need for diversion hourly and** come off diversion as soon as possible ~~or after one (1) hour to receive at least one ambulance patient. At this time the ANM and/or Charge RN will notify the MICN to enter information into the QA Net Computer.~~
~~5. In order to return to diversion status, the steps in #2 and #3 must be followed.~~
5. In the case of anticipated prolonged periods of diversion, greater than three (3) hours, notification shall be made to the ED Clinical ~~Operations~~ Manager and Base Hospital Nurse Coordinator.
6. Base Hospital will attempt to honor diversion requests by the patient or EMS provider if:
   a. The involved MICU (Mobile Intensive Units or ambulances) estimates that it can reach an "alternate" facility within a reasonable time. ~~—~~Reasonable considerations should be given to limit transport time to no more that twenty (20) minutes.
   b. Patients are not perceived as exhibiting uncontrollable life threatening problems in the field (e.g. unmanageable airway, uncontrolled non-traumatic hemorrhage, or non-traumatic full arrest) or any other condition that warrants immediate physician intervention.
   c. Patients meeting trauma criteria shall be transported according to Trauma Policies and Procedures.
7. When all the area receiving hospitals are requesting diversion due to ED saturation, diversion requests may not be honored and patients will be transported to the most accessible emergency medical facility within the area involved.
8. MICN's and Prehospital personnel will make the best effort to ensure ambulance patients are transported to their requested facility or **to the** facility ~~where~~ **the** patient claims to ~~obtain their healthcare.~~**be their medical home.**

D. **REFERENCES:**

1. California Health and Safety Code, Division 2.5, Section 1797.222.
2. California Code of Regulations, Title 13, Section 1105c.
3. San Diego County Division of Emergency Medical Services Policy S-010.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	**07/05**	**SUBJECT:**	**ED Scope of Practice/Definition of Emergency Department**

REVISION ~~DATE(S)~~: 07/05; 02/11; 10/11; ~~06~~08/14, ~~10/16~~ POLICY NUMBER: 7010-001

Emergency Department Approval ~~Date(s)~~:	**~~07/14~~02/20**
Department of Emergency Medicine Approval:	**~~10/14~~04/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~08/14~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**08/14**

A. **DEFINITIONS:**

1. To delineate the scope of services provided throughout the various areas of the Emergency Department.

B. **SCOPE OF SERVICES:**

1. This is a basic Emergency Department (ED)/Paramedic Base Station. It is a non-bedded (episodic) department with a total of treatment areas and two (2) Triage stations. It is located on the first floor of the southwest side of the medical center. The ED includes . areas for care and treatment with a Triage station for patient sorting. A Clinical Operations Manager, Assistant Nurse Managers (ANM) and a Hospital Base Station Coordinator lead and manage the services and staff 24 hours/7 days per week. Tri-City Emergency Medical Group (TCEMG) provides medical management and leadership.
   a. Treatment Area Scope:
      i. Triage is staffed 24 hours/7 days per week with an RN. During peak hours there is an additional RN and EMT. The area is not equipped with monitors, but can accommodate portable monitoring equipment.
      ii. Stations A, B, C and D have a total of 41 treatment bays and are the primary acute areas. They are equipped to accommodate all ages and types of illnesses and injuries for this level of emergency services, 24/7. It is staffed at all times with at least one physician who is board-certified or board-eligible in emergency medicine, along with an RN at a ratio of at least 1:4 and a supporting staff comprised of EMTs and ACTs.
      iii. Fast Track has six (6) minor treatment bays. It is non-monitored, designed to accommodate lower acuity illnesses and injuries than those seen in stations A-D. The hours of service are variable and are subject to change in volume. It is staffed with an RN, EMT and a Physician who is board-certified or board-eligible in emergency medicine. TCEMG may alternatively designate a Physician Assistant (PA) experienced in emergency medicine in lieu of a Physician.
   b. Community Relationships:
      i. Guidelines for the relationship between pre-hospital providers and Tri-City Medical Center (TCMC) may be found in the Base Station Administrative Committee Bylaws.
      ii. Participating agreements for disaster drills and planning are referenced in the TCMC Disaster Manual Guidelines.
      iii. Trauma transfer facilities are the following:
         1) Sharp Memorial Hospital.

2) Scripps Memorial Hospital, La Jolla.
3) Scripps Mercy Hospital and Medical Center.
4) Palomar Medical Center.
5) Rady Children's Hospital, San Diego.
6) UCSD Medical Center, Hillcrest.

c. Staffing:
i. The ED is staffed with variable FTEs based on patient volume which includes a Clinical Nurse Educator/CNS, Case Manager, Assistant Nurse Manager (ANM) or Charge RN, Registered Nurses (RN), EMTs, ACTs and Unit Secretaries (US).

2. Staffing Considerations will take into account the following variables:
a. *Patients:* Patient characteristics and the number of patients for whom care is being provided.
b. *Complexity of Care:* Individual patient complexity, across the department complexity, variability of care and volume.
c. *Context:* Architecture and physical limitations of the facility; technology and variability of equipment; clustering of patients within geographic locations.
d. *Expertise:* Learning curve for individuals and groups of nurses; staff consistency; continuity and cohesion; cross training;; control of practice; involvement in quality improvement activities; professional expectations, preparation and experience.
e. *ANMs and Charge RNs:* The ANM and/or Charge RN for the day is responsible for making assignments. The ANM and/or Charge RN is accountable for maintaining the appropriate skill mix required for comprehensive, holistic care. The ANM and/or Charge RN has the authority to increase staff levels when census and patient stability deem it necessary. They may make adjustments to the staffing plan as needed in order to provide the best staffing options for optimum patient outcomes while considering regulatory and budgetary issues. The authority to decrease staff will rest with the ANM and/or Charge RN.

3. Environment of Care:
a. One (1) airborne precaution room (#C26) provides negative pressure ventilation for patients requiring airborne precautions.

4. Methods Used to Assess Patient's Needs:
a. Initial assessments are performed by the Registered Nurse upon arrival of the patient in the ED. Reassessments are performed as needed when a change in status occurs, when there is a change in the caregiver and at a minimum once every shift. RNs utilize a variety of sources to gather pertinent information like physical assessment, data from the patient's chart, observation of team members, patient, families or significant others and other disciplines.

C. **QUALIFICATIONS OF STAFF:**

1. Registered Nurses in the ED are required to be certified in basic life support (BLS) and advanced care life support ACLS upon hiring, within six (6) months Pediatric Advanced Life Support (PALS) and/or Emergency Nursing Pediatric Course (ENPC) and within three (3) months Non-Violence Crisis Intervention (NVCI) certified. Triage education is required and offered to staff after eighteen (18) months of ED experience. RNs are required to attend at least one (1) clinical education event per year, complete orientation materials, initial and annual competencies and complete all educational tools and activities given to them by the Clinical Nurse Educator/CNS.
a. A minimum of eighteen (18) months of ED experience is required to be an MICN or Triage RN. Additionally, in order to become an MICN or Triage RN, nurses must complete training and pass an examination specific to those roles.
b. In order to respond to Code Pinks, an ED RN must have a certificate in Pediatric Advanced Life Support (PALS) or Emergency Nursing Pediatric Course (ENPC).

2. EMTs are unlicensed personnel in the ED. They are required to be certified in basis life support (BLS) and perform patient care activities delegated to them by an RN, PA or Physician. All EMTs and ACTs are required to complete orientation materials, initial and annual competencies, educational tools and activities given to them by the Clinical Nurse Educator/CNS. Per the Board

of Registered Nursing, EMTs in the ED are **NOT ALLOWED** to perform those functions that require a substantial amount of scientific knowledge and technical skills, including but not limited to the following:

a. Venipuncture or IV therapy.
b. Parental or tube feedings.
c. NG tube, catheter insertions and/or removal and tracheal suctioning.
d. Assessment of patient condition.
e. Patient and family education for care or post discharge care.
f. Moderate complex lab testing.

3. Individuals and multidisciplinary groups provide in-services. The Clinical Nurse Educator/CNS and Leadership arrange for vendor in-services, self-study modules, case study presentations, department-based competencies as well as peer mentoring with experienced ED team members. The education needs are identified through chart reviews, patient complaints, and direct communication relating to the educational needs of the ED, surveys, audits and peer review activities.
4. The nursing service abides by regulations by California Title XXII, JCAHO, HCFA and BRN.

D. **COMMUNICATION, COLLABORATION AND FUNCTIONAL RELATIONSHIP:**

1. Communication is shared through monthly department meetings, staff mailboxes, e-mails, mailing to staff members homes, communication books and communication/educational boards located throughout the ED. Practicing the TCMC Mission and Values is an expectation, as is teamwork, professionalism and a positive attitude.

E. **DEPARTMENTS LEVEL OF CARE/SERVICE:**

1. The level of care provided by the Emergency Department meets the needs of outpatients through availability of staff who are competent to provide service for the current patient population and the coordination of nursing services with services of other disciplines.

F. **PERFORMANCE IMPROVEMENT:**

1. In order to improve patient care, several indicators are monitored to measure care given and effect change. Data is reported quarterly to the Quality Council.

G. **MISSION OF THE EMERGENCY DEPARTMENT:**

1. The Mission of the Emergency Department is to deliver exceptional care and service to all patients and their families by providing timely service, individualized care and excellent customer service.

Tri-City Medical Center	EMERGENCY DEPARTMENT
PROCEDURE:	**TRIAGE OF EMERGENCY DEPARTMENT PATIENTS** **7010-014**
PURPOSE: ~~Purpose:~~	To provide a standardized system whereby patients presenting to the Emergency Department are treated in order of priority based upon acuity utilizing the Emergency Severity Index.
Supportive Data:	Agency for Health Quality Research, Emergency Severity Index, Version 4.
Issue Date:	**1/07** ~~**Revision Date(s): 10/10; 11/14; 02/20**~~

A. **DEFINITION(S):**

1. Triage: The purpose of triage in the emergency department (ED) is to prioritize incoming patients and to identify those who cannot wait to be seen.
2. Emergency Severity Index: The Emergency Severity Index (ESI) is a tool for use in emergency department (ED) triage. The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups, from level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing ED patients by both acuity and resource needs.
3. Acuity: Acuity is determined by the stability of vital functions and the potential threat to life, limb, or organ.
4. Resource Needs: The number of resources a patient is expected to consume in order for a disposition decision to be reached. The triage nurse estimates resource needs based on previous experience with patient presenting with similar injuries or complaints.

B. **POLICY:**

1. All patients presenting to the Emergency Department will be triaged by a registered nurse (RN) who has demonstrated competency in triage utilizing the Emergency Severity Index.
2. All patients presenting to the Emergency Department requesting treatment shall be entered into the electronic medical record.
3. Triage in the emergency department occurs utilizing a two-tier triage process.
   a. All patients presenting for treatment are assessed by a Registered Nurse, receive a first-tier triage assessment, and are assigned an acuity level based on the Emergency Severity Index.
   b. When there are available beds in the Emergency Department, patients are immediately placed in a bed and receive a second-tier triage assessment by the Primary Nurse.
   c. When there are no available beds, second-tier triage assessment occurs by a Registered Nurse in triage.
   d. Patients arriving by ambulance will receive a first-tier triage by the ambulance bay pivot ~~first available~~ Registered Nurse. ~~This may include the Charge Nurse, Team Leader, or the patient's Primary Nurse.~~ Patients arriving by ambulance will receive a second-tier triage assessment by the Primary Nurse.

C. **PROCEDURE:**

1. First-Tier Triage:
   a. All patients presenting to the Emergency Department will be assessed by the First Nurse; responsible for the initial assessment of patients.
   b. The First Nurse will obtain the following information:
      i. The patient's chief complaint.
      ii. With the assistance of emergency technicians, the First Nurse will ~~obtain~~**obtain** set of vital signs (including a height and weight on **all patients** ~~pediatric patients~~).
   c. The First Nurse will assign an acuity based on the patient's chief complaint, expected resource utilization, and vital signs.
   d. The First Nurse will ensure registration staff has entered the patient's information into the electronic medical record and that the patient has an appropriate name band placed.
      i. If there are available open emergency department beds:
         1) The First Nurse will assign the patient to an available bed.

Department Review	Department of Emergency Medicine	~~Medical Staff Department/Division~~	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/07, 10/10, 01/14, **05/20**	07/14, **04/22**	~~07/14~~	n/a	08/14, **06/22**	**08/22**	01/11, 10/14, **n/a**	~~01/11, 11/14~~

2) Frist Nurse assigned bed. who have stable vital signs and are not at risk for deterioration by the Emergency Technician. Patients who have unstable vital signs or who are at risk for deterioration will be transported by **the Registered Nurse**

3) Hand off will occur from triage personnel to the primary nurse.

2. Second-Tier Triage

i. If there are no available emergency department beds: Patient's will receive a second-tier triage assessment and await bed availability in the Emergency Department waiting room

~~ii. Information gathered during the second-tier triage process includes:~~

~~1) Chief complaint~~

~~2) Allergies~~

~~3) Suicide Risk Assessment~~

~~4) Fall Risk~~

~~iii.~~**ii.** The First Nurse will communicate with the Emergency Department Charge Nurse regarding bed availability and assign patients to beds as they become available.

~~1) Patients will be transported by the emergency technician and hand off communication will occur to the Primary Nurse.~~

~~iv.~~**iii.** Reassessments (vital signs, including pain) will be documented in the ED record and any clinically significant changes will be communicated to the ED ~~ANM/~~Charge RN.

1) Patients waiting for placement in bed will be reassessed as deemed appropriate Registered Nurse.

~~v.~~**iv.** These patients will have vital signs repeated every two hours while waiting.

3. Vital Signs

a. Vital signs will be obtained during the first-tier triage process.

b. Vital signs include:

i. Temperature

ii. Pulse

iii. Respirations

iv. Blood Pressure

1) Blood pressure is obtained with other vital signs in children 2 years of age and older.

2) Blood pressure is obtained in children under 2 years of age if indicated (i.e.; signs and symptoms of dehydration, shock, or sepsis).

v. Pain Assessment

vi. Weight

1) Weight is obtained on all patients ~~under 18 years old~~.

4. Emergency Severity Index

a. The Emergency Severity Index is an algorithm in which the Registered Nurse assesses acuity level as well as expected resource utilization to categorize emergency department patients. Initially, the triage nurse assesses only the acuity level. If a patient does not meet high acuity level criteria (ESI level 1 or 2), the triage nurse then evaluates expected resource needs to help determine a triage level (ESI level 3, 4, or 5).

b. ESI level is a measure of acuity assessment at the time triage was completed. ESI level is not a measure of ongoing patient acuity and should not be changed as the patient's condition improves or deteriorates.

c. ESI level is determined utilizing an algorithm with 4 decision points:

i. Does the patient require lifesaving intervention?

ii. Is this a patient who shouldn't wait?

iii. How many resources will this patient need?

iv. What are the patient's vital signs?

5. Emergency Severity Index Acuity Levels

a. Level 1:

i. ESI acuity level 1 patients have emergency medical or surgical conditions that require immediate lifesaving interventions.
ii. These patients typically require a team response where both medical and nursing care are initiated simultaneously to prevent deterioration in the patient's 'condition.
iii. Examples of ESI level 1 patients include but are not limited to:
1) Cardiac arrest or respiratory arrest
2) Severe respiratory distress with SpO2 less than 90, agonal or gasping type respirations
3) Critically injured trauma patient who presents unresponsive
4) Severe bradycardia or tachycardia with signs of hypoperfusion
5) Hypotension with signs of hypoperfusion
6) Chest pain, pale, diaphoretic, blood pressure 70/palp
7) Anaphylactic shock,
8) Baby that is flaccid
9) Unresponsive patient with a strong odor of alcohol
10) Hypoglycemia with a change in mental status

b. Level 2:
i. ESI acuity level 2 patients are high-risk patients. ESI level 2 patients present with symptoms that are suggestive of conditions that require time sensitive treatment, have conditions that may deteriorate, and have a potential threat to life, limb, or organ. This level of acuity also includes patients who have an acute alteration in the level of consciousness or neurological status.
ii. Patients with severe pain or distress, as evidenced by a pain score of 7/10, may also be assigned to ESI acuity level 2.
iii. Examples of ESI level 2 patients include but are not limited to:
1) Active chest pain, suspicious for acute coronary syndrome but does not require an immediate life-saving intervention, stable
2) ~~A needle stick in a health care worker~~ (delete)
3) Signs of a stroke, but does not meet level-1 criteria
4) A rule-out ectopic pregnancy, hemodynamically stable
5) A patient on chemotherapy and therefore immunocompromised, with a fever
6) A suicidal or homicidal patient or a patient experiencing delusions
7) New onset of confusion in an elderly patient
8) The 3-month-old whose mother reports the child is sleeping all the time
9) The adolescent found confused and disoriented

c. Level 3:
i. ESI level 3 patients are patients with stable conditions that have been determined to not meet criteria to be classified as ESI level 1 or 2.
ii. The Registered Nurse, after determining the patient's condition is stable, predicts the number of resources the patient will require is 2 or more.
iii. Vital signs are required to assign an ESI level 3.
1) Patients with abnormal vital signs may require a reassignment of ESI level 2.
iv. Examples of ESI level 3 patients include but are not limited to:
~~1) Assault~~[CMK1]
~~2)~~**1)** Abdominal pain with stable vital signs
~~3)~~**2)** Headache
~~4)~~**3)** Mild/moderate difficulty breathing with stable vital signs
~~5)~~**4)** Nausea, vomiting, diarrhea with stable vital signs
~~6)~~**5)** Minor trauma
~~7)~~**6)** Mild/moderate difficulty breathing (croup, bronchiolitis, pneumonia, known asthma with worsening symptoms)
~~8)~~**7)** Seizure, alert on arrival

d. Level 4:

i. ESI level 4 patients are patients with stable conditions that have been determined to no meet criteria to be classified as ESI level 1 or 2.
ii. The Registered Nurse, after determining the patient's condition is stable, predicts that the number of resources the patient will require is 1.
iii. Vital signs are not required to assign an ESI level 4.
iv. Examples of ESI level 4 patients include but are not limited to:
1) Chronic back pain
2) Isolated eye complaints
3) Headache with normal vital signs and normal mental status
4) Minor head injury
5) Minor trauma (isolated extremity injury, minor MVA)
6) Minor psychiatric complaints (depression/anxiety)
7) Simple lacerations requiring sutures
8) Uncomplicated URI symptoms

e. Level 5:
i. ESI level 5 patients are patients with stable conditions that have been determined to no meet criteria to be classified as ESI level 1 or 2.
ii. The Registered Nurse, after determining the patient's condition is stable, predicts that the number of resources the patient will require is 0.
iii. Vital signs are not required to assign an ESI level 5.
iv. Examples of ESI level 5 patients include but are not limited to:
1) Dressing changes
2) Earache
3) Minor Flu Symptoms
4) Medication refills
5) Minor trauma (superficial lacerations/abrasions)
6) Isolated sore throat, no respiratory symptoms
7) Wound rechecks

6. Special Considerations:
a. Pediatric Fever:
i. The following guidelines should be used when evaluating pediatric patients who present with fever:
1) 1-28 days of age and Temperature greater than 38.0 C (100.4 F) assign ESI Level 2
2) 1-3 months of age and Temperature greater than 38.0 C (100.4 F) consider ESI Level 2
3) 3 months – 3 years of age and Temperature greater than 39.0 C and the patient has incomplete immunizations or no obvious source of fever consider ESI Level 3

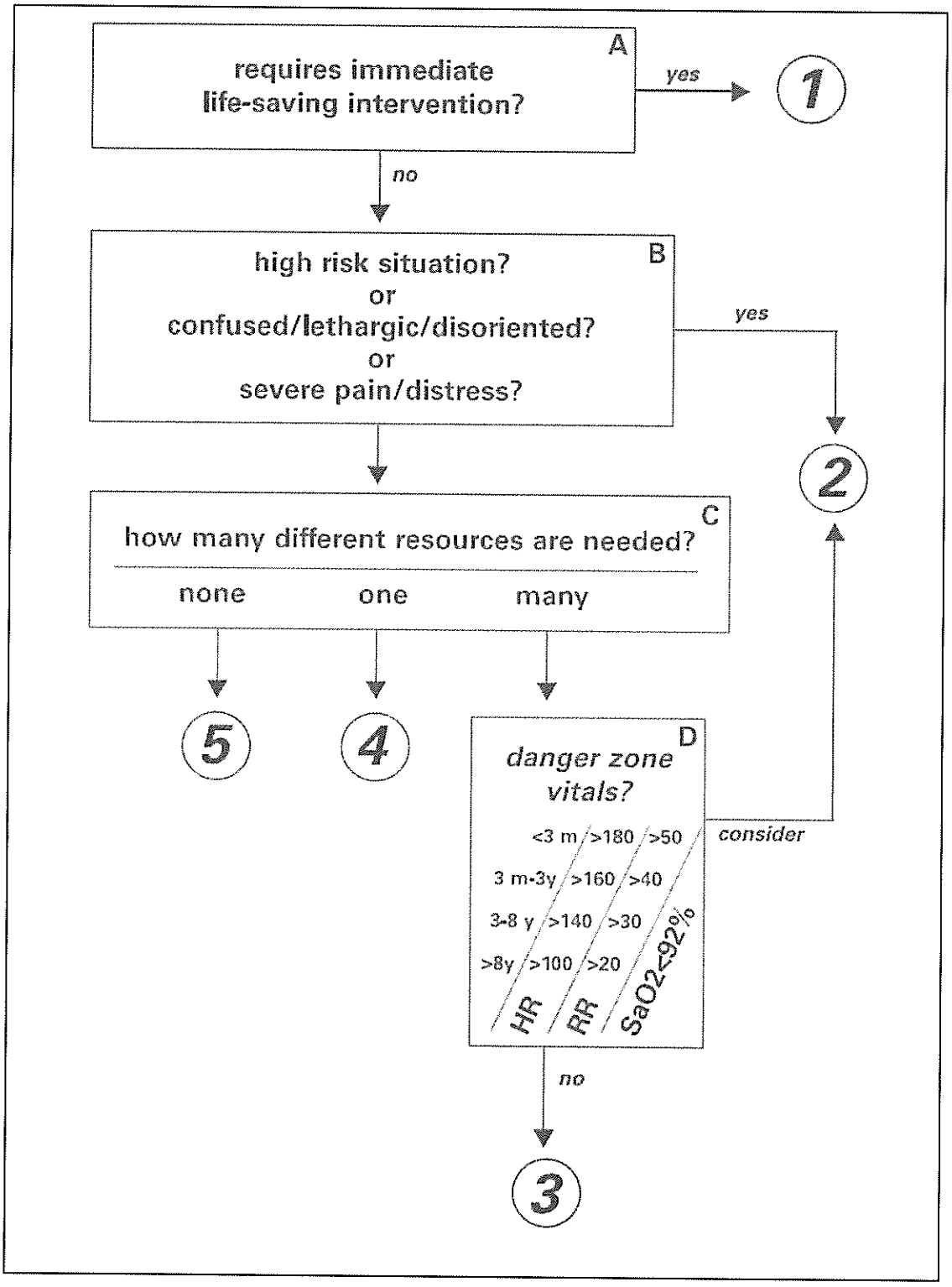
b. Emergency Department Standardized Procedures:
i. Emergency Department Standardized Procedures should be initiated when the physician is not readily available to assess and initiate care on patients.
ii. ED Standardized Procedures may be initiated in any area of the emergency department by a Registered Nurse who has demonstrated competency.

D. **RELATED DOCUMENT(S):~~DOCUMENTS~~**
1. ~~Appendix A:~~ **Emergency Severity Index Version 4 Algorithm**
2. ~~Appendix B:~~ **Lifesaving Interventions, Resources, Danger Zone Vital Signs**

E. **REFERENCES ~~LIST~~:**
1. **Agency for Healthcare Research and Quality (2012). "Emergency severity index: A triage tool for emergency department care, version 4."**

~~1.~~

~~Appendix A:~~ Emergency Severity Index Version 4 Algorithm



~~Appendix B:~~ Lifesaving Interventions, Resources, and Danger Zone Vital Signs

A. Immediate life-saving intervention required: airway, emergency medications, or other hemodynamic interventions (IV, supplemental O2, monitor, ECG or labs DO NOT count); and/or any of the following clinical conditions: intubated, apneic, pulseless, severe respiratory distress, SPO_2<90, acute mental status changes, or unresponsive.

Unresponsiveness is defined as a patient that is either:
(1) nonverbal and not following commands (acutely); or
(2) requires noxious stimulus (P or U on AVPU) scale.

B. High risk situation is a patient you would put in your last open bed.

Severe pain/distress is determined by clinical observation and/or patient rating of greater than or equal to 7 on 0-10 pain scale.

C. Resources: Count the number of different types of resources, not the individual tests or x-rays (examples: CBC, electrolytes and coags equals one resource; CBC plus chest x-ray equals two resources).

Resources	*Not Resources*
• Labs (blood, urine) • ECG, X-rays • CT-MRI-ultrasound-angiography	• History & physical (including pelvic) • Point-of-care testing
• IV fluids (hydration)	• Saline or heplock
• IV or IM or nebulized medications	• PO medications • Tetanus immunization • Prescription refills
• Specialty consultation	• Phone call to PCP
• Simple procedure =1 (lac repair, foley cath) • Complex procedure =2 (conscious sedation)	• Simple wound care (dressings, recheck) • Crutches, splints, slings

D. Danger Zone Vital Signs
Consider uptriage to ESI 2 if any vital sign criterion is exceeded.

Pediatric Fever Considerations
1 to 28 days of age: assign at least ESI 2 if temp >38.0 C (100.4F)

1-3 months of age: consider assigning ESI 2 if temp >38.0 C (100.4F)

3 months to 3 yrs of age: consider assigning ESI 3 if: temp >39.0 C (102.2 F), or incomplete immunizations, or no obvious source of fever

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 10/88 **SUBJECT: Diet Manual**

REVISION DATE(~~S~~): 08/06, 01/10, 02/12, 06/18

Food & Nutrition Department Approval:	**~~02/17~~04/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**~~07/18~~07/22**
Medical Executive Committee Approval:	**~~08/18~~07/22**
Administration Approval:	**~~09/18~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **POLICY:**

1. Food and Nutrition may adopt a diet manual for standardized nutrition care practices as compiled by other facilities or organizations, i.e. the Academy of Nutrition and Dietetics (AND) .
2. Available nutrition care manuals are reviewed and a suitable one is adopted.
3. Nutritional deficiencies of any diet (not in compliance with the RDA's/RDI's) are identified.
4. The diet manual is utilized as a guide to ordering diets.
5. A copy of the diet manual is provided for each patient care unit via the Intranet after the receipt of approval from the medical staff. The AND Nutrition Care Manual is available as a web based manual via the TCMC Intranet under Clinical References.
6. The Director of Food & Nutrition reviews the AND Nutrition Care Manual on an ongoing basis. All therapeutic diets outlined in the Nutrition Care Manual are reviewed. ~~-~~A meal plan crosswalk is defined to identify typical diet orders and the appropriate nutrition therapy (see below). Additionally, the formulary is customized to TCMC.
7. The Nutrition Care Manual (diet manual), along with any edits specific to TCMC, is reviewed and/or revised every three years and is approved by the Pharmacy & Therapeutics Committee.

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

1. Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

The following table maps the condition to the corresponding diet available at TCMC and nutrition therapy food lists and sample menus in the client education.

Condition	TCMC Diets	Client Education	Translations Available
Addiction		Sobriety Nutrition Therapy (Large Print): Foods; Menu	
Anemia		Iron-Deficiency Anemia Nutrition Therapy: Foods, Menu	
		Iron-Rich Nutrition Therapy	Spanish
		Sickle Cell Disease Nutrition Therapy: Foods; Menu	
Bariatric Surgery	Bariatric Clear Liquid Diet	Bariatric Liquid Protein Supplements	Spanish (**new 2016**)
		Bariatric Surgery Soft Protein-Rich Foods Nutrition Therapy	Spanish (**new 2016**)
		Bariatric Surgery Vitamin and Mineral Supplements	Spanish (**new 2016**)
		Roux-en-Y Gastric Bypass/Sleeve Gastrectomy Discharge Nutrition Therapy	
		High-Calorie, High-Protein Nutrition Therapy (Large Print)	Spanish
		High-Calorie, High-Protein Recipes	
		Suggestions for Increasing Calories and Protein	Spanish
Burns		Burns Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)
Cardiovascular Disease	Cardiac Diet, Low Cholesterol	Cardiac-TLC Nutrition Therapy (Large Print): Foods; Menu	
		Coronary Artery Bypass Graft (CABG) Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)
		Heart Failure Nutrition Therapy (**updated 2016**)	Spanish
		Heart Failure Nutrition Therapy for the Undernourished	Spanish (**new 2016**)
		Heart-Healthy Eating Fiber Tips	Spanish
		Heart-Healthy Eating Label Reading Tips	Spanish
		Heart-Healthy Eating Nutrition Therapy (Large Print): Menu (Note: Under Review for Revision)	Spanish

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Heart-Healthy Eating: Cooking Tips	Spanish
		Heart-Healthy Eating: Omega-3 Fatty Acids	Spanish
		Heart-Healthy Eating: Shopping Tips	Spanish
		Heart-Healthy Eating: Soy Protein	Spanish
		Heart-Healthy Eating: Sterol and Stanol Tips	Spanish
		High Cholesterol Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)
		High Triglycerides Nutrition Therapy (Large Print): Foods; Menu	
		Hypertension Nutrition Therapy: Foods; Menu (**updated 2016**)	Spanish (**new 2016**)
	2gm Sodium Diet. No Added Salt Diet	Low-Sodium Nutrition Therapy (**updated 2016**)	Spanish (**new 2016**)
		Reduce Cholesterol and Sodium	**REMOVED**
		Sodium-Free Flavoring Tips	
		Stroke Nutrition Therapy: Foods; Menu	Spanish
		Transient Ischemic Attack (Ministroke) Nutrition Therapy: Foods; Menu	Spanish
		Vitamin K and Medications	Spanish
	Carbohydrate Controlled Diet	Carbohydrate Counting for People with Diabetes	Spanish
		Carbohydrate Counting for Vegetarians with Diabetes	
		Carbohydrate Counting for People with Cystic Fibrosis–Related Diabetes	
Diabetes	No Concentrated Sweets Diet	Choose Your Foods: Food Lists for Diabetes (**updated 2016**)	Spanish (**new 2016**)
		Diabetes Label Reading Tips	Spanish
	Sweet Success Diet	Gestational Diabetes Nutrition Therapy	Spanish (**new 2016**)
	Gluten-Free /Carbohydrate ControlledDiet	Gluten-Free Carbohydrate Counting for People with Celiac Disease and Diabetes	Spanish (**new 2016**)
		Hypoglycemia (Not Caused by	Spanish

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Diabetes) Nutrition Therapy	
		Type 1 Diabetes Nutrition Therapy	Spanish
		Type 2 Diabetes Nutrition Therapy	Spanish
		Type 2 Diabetes Vegetarian Nutrition Therapy	
		Using Nutrition Labels: Carbohydrates	
Dysphagia	Pureed Diet	Dysphagia Level 1: Pureed Foods	Spanish
		National Dysphagia Diet: Level 1 Tips	
	Mechanical Soft Ground Diet	Dysphagia Level 2: Mechanically Altered	Spanish
		National Dysphagia Diet: Level 2 Tips	
	Mechanical Soft Chopped Diet	Dysphagia Level 3: Advanced	
		National Dysphagia Diet: Level 3 Tips	Spanish
Eating Disorders		Anorexia Nervosa Meal Planning Tips	
		Binge Eating Disorder Meal Planning Tips	
		Bulimia Nervosa Meal Planning Tips	
Food Allergies		Corn Allergy Nutrition Therapy: Foods; Menu	Spanish
		Corn Allergy Tips	
		Egg Allery Nutrition Therapy: Foods; Menu	Spanish
		Egg Allergy Tips	
		Fish Allergy Nutrition Therapy: Foods; Menu	Spanish
		Fish Allergy Tips	
		Fructose Intolerance Nutrition Therapy: Menu	
		Galactose-Controlled Nutrition Therapy: Menu	
	No Dairy Diet, No Milk	Milk Allergy Nutrition Therapy: Foods; Menu	Spanish
		Milk Allergy Tips	
		Multiple Food Allergies Nutrition	Spanish

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available	
		Therapy: Foods; Menu		
		Managing Multiple Food Allergies Tips		
		Peanut Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Peanut Allergy Tips		
		Shellfish Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Shellfish Allergy Tips		
		Soy Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Soy Allergy Tips		
		Tree Nut Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Tree Nut Allergy Tips		
		Wheat Allergy Nutrition Therapy: Foods; Menu	Spanish	
		Wheat Allergy Tips		
		5 Sample Menus for Gradually Increasing Fiber		
	Gluten Free Diet	Celiac Disease Nutrition Therapy: Foods; Menu (**updated 2016**)	Spanish (**new 2016**)	
		Celiac Disease Healthy Eating Tips (**updated 2016**)	Spanish (**new 2016**)	
		Celiac Disease Label Reading Tips (**updated 2016**)	Spanish (**new 2016**)	
		Cirrhosis Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)	
Gastrointestinal Disease		Colostomy Nutrition Therapy: Foods; Menu (**updated 2016**)	Spanish	
		Constipation Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)	
		Constipation Meal Planning Tips	Spanish (**new 2016**)	
		Diarrhea Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)	Chinese (**new 2016**)
		Esophageal Surgery Nutrition Therapy		
	Low Fat Diet	Fat-Restricted Nutrition Therapy	Spanish	Chinese (**new 2016**)

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available	
		Fat Restricted Nutrition Therapy Sample 5-Day Menus		
	Fiber-Restricted Diet (Low-residue diet)	Fiber-Restricted Nutrition Therapy (**updated 2016**)	Spanish (**new 2016**)	
		Gallbladder Nutrition Therapy: Foods; Menu		
		Gastric Surgery Nutrition Therapy: Foods; Menu **Removed for Update**	Spanish (**new 2016**)	
	Bland Diet	Gastroesophageal Reflux Disease (GERD) Nutrition Therapy: Foods; Menu	Spanish	
		Gastroparesis Nutrition Therapy (**updated 2016**)	Spanish (**new 2016**)	
	Gluten Free Diet	Gluten-Free Nutrition Therapy: Menu	Spanish	
		Hepatitis Nutrition Therapy: Foods; Menu		
	High Fiber Diet	High-Fiber Nutrition Therapy (Large Print): Menu	Spanish	
		Getting More Fiber Cooking Tips		
		Ileostomy Nutrition Therapy	Spanish (**new 2016**)	
		Inflammatory Bowel Disease (IBD) and Crohn's Disease Nutrition Therapy: Foods; Menu		
		Irritable Bowel Syndrome (IBS) Nutrition Therapy: Foods; Menu	Spanish	
		Jaw Fracture Nutrition Therapy: Foods; Menu	Spanish (**new 2016**)	
	Lactose Free Diet	Lactose-Controlled Nutrition Therapy: Foods; Menu	Spanish	
		Lactose Intolerance Label Reading and Cooking Tips		
		Low-Fiber Nutrition Therapy: Foods; Menu	Spanish	
		Nausea and Vomiting Nutrition Therapy: Foods	Spanish	Chinese (**new 2016**)
		Pancreatitis Nutrition Therapy (**updated 2016**)	Spanish (**new 2016**)	
		Pancreatitis Label Reading Tips		
		Peptic Ulcer Nutrition Therapy: Foods; Menu		

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Whipple Surgery Nutrition Therapy (**updated 2016**)	Spanish (**new 2016**)
	Regular Diet	General, Healthful Nutrition Therapy (Large Print)	Spanish
	Kosher Diet	Kosher Dietary Guidelines (**updated 2016**)	
		20 Ways to Enjoy More Fruits and Vegetables	Spanish
		Eating Right for a Healthy Weight	Spanish
		Eating Right Tips for Older Adults	Spanish
		Healthy Eating on the Run	Spanish
		Power Up with Breakfast	Spanish
		Shop Smart Get the Facts on Food Labels	
General, Healthful Nutrition		Smart Snacking for Adults and Teens	Spanish
		16 Health Tips for 2016	
		25 Healthy Snacks for Kids	Spanish
		Good Nutrition Reading List	
		Healthy Eating Tips for Vegetarians	Spanish
		Color Your Plate with Salad	
		Eating Right with Less Salt	Spanish
		Eating Right on a Budget	Spanish
		Eat Right with MyPlate	Spanish
		Everyday Eating for a Healthier You	
		Exercise for HIV/AIDS Patients	
		Food Safety for HIV/AIDS	
		HIV/AIDS Managing Diarrhea	
		HIV/AIDS Managing Nausea and Vomiting	
HIV/AIDS		HIV/AIDS Micronutrients (Vitamins and Minerals)	
		HIV/AIDS Nutrition Therapy	
		Nutrition Recommendations to Reduce Side Effects of Medications	
Inborn Errors of Metabolism		Phenylketonuria (PKU) Tips	

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available	
Modified Consistency	Mechanical Soft Diet	Mechanically Altered Foods Nutrition Therapy (Large Print): Foods; Menu		
	Pureed Diet	Pureed Foods Nutrition Therapy (Large Print); Foods; Menu		
	Soft Diet	Soft Foods Nutrition Therapy (Large Print): Foods; Menu		
Neurological		Epilepsy Nutrition Therapy: Foods; Low GI Menu		
		Modified Atkins Menu;		
		Kitchen Tips		
		Guidelines for High-Calorie Nutrition Therapy (Large Print)		
Nutrient Lists	Low Phosphorus Diet	Calcium Content of Foods	Spanish	
		High-Calcium Foods List	Spanish	
		Fiber Content of Foods	Spanish	
		High-Fiber Foods List	Spanish	
		Lower-Fiber Foods List	Spanish	
		Iron Content of Foods	Spanish	
		High-Iron Foods List	Spanish	
		Magnesium Content of Foods	Spanish	
		High-Magnesium Foods List	Spanish	
		Phosphorus Content of Foods	Spanish	
		Potassium Content of Foods		Chinese (**New 2016**)
	Low Potassium Diet	High-Potassium Foods List	Spanish	
		Lower-Potassium Foods List	Spanish	
	High Protein Diet	Protein Content of Foods	Spanish	
		High-Protein Foods List	Spanish	
		Sodium (Salt) Content of Foods	Spanish	
		Lower-Sodium (Salt) Foods List	Spanish	
		Vitamin K Content of Foods	Spanish	
		Water Content of Common Foods and Beverages		
Older Adults		Finger Foods		
		Food Sources of Vitamins and		

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Minerals	
		Fiber Tips	
		Tips for Adding Calories	
		Tips for Adding Protein	
Metabolic Syndrome	Carbohydrate Controlled / Cardiac Diet	Metabolic Syndrome Menu (**New for 2016**)	Spanish (**new 2016**)
Mood Disorders	Tyramine-Restricted Diet	Tyramine-Restricted Nutrition Therapy: Menu	Spanish
Musculoskeletal		Amputations: Menu	Spanish (**new 2016**)
		Osteoarthritis Nutrition Therapy: Foods; Menu	
		Rheumatoid Arthritis Nutrition Therapy: Foods; Menu	
Reproduction		Breastfeeding Nutrition Therapy (**New for 2016**)	Spanish (**new 2016**)
		Gestational Diabetes Nutrition Therapy	
		Morning Sickness Nutrition Therapy: Foods; Menu	
		Multiple Gestation Nutrition Therapy: Foods; Menu	
		Pica Nutrition Therapy: Menu	
		Preeclampsia/Eclampsia Nutrition Therapy: Foods; Menu;	Spanish
		Preeclampsia and Eclampsia Label Reading Tips;	
		Preeclampsia and Eclampsia Meal Planning Tips	
		Pregnancy Nutrition Therapy: Foods; Menu	Spanish
		Healthy Pregnancy Tips (**2016 Update**)	
	Vegetarian Diet	Vegetarian Pregnancy Nutrition Therapy	
Oncology		Head and Neck Cancer Prevention (Large Print)	Spanish (**new 2016**)
		Head and Neck Cancer Nutrition Therapy (Large Print)	Spanish (**new 2016**)
		Nutrition During and After Cancer Treatment	
		Oncology: Cooking Tips (Large Print)	Spanish (**new 2016**)

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Oncology: Nutrition Tips for Well-Being (Large Print)	Spanish (**new 2016**)
Oral Health		Dentures Nutrition Therapy (Large Print)	Spanish, Large Print
		Difficulty Eating for People with Diabetes Nutrition Therapy (Large Print)	Spanish, Large Print
		Difficulty Eating Nutrition Therapy (Large Print)	Spanish, Large Print
		Dry Mouth (Large Print)	Spanish
		Nutrition Recommendations After Oral Surgery (Large Print)	Spanish, Large Print
		Nutrition Recommendations After Oral Surgery for People with Diabetes (Large Print)	Spanish, Large Print
		Nutritional Recommendations for Orofacial Pain (Large Print)	
		Nutritional Recommendations When Wearing Partial Dentures (Large Print)	Spanish, Large Print
Organ Transplant	Neutropenic Diet	Food Safety Nutrition Therapy	Spanish (**new 2016**)
		Low-Microbial Nutrition Therapy: Foods	
		Nutrition Therapy for Individuals with Lowered Immunity	
		Organ Transplant Nutrition Therapy: Foods; Menu; Tips	
Osteoporosis		Osteoperosis Nutrition Therapy: Foods; Menu	
Overweight & Obesity	Calorie Controlled Diet	1,200-Calorie 5-Day Menus	Spanish
	Calorie Count Diet	1,500-Calorie 5-Day Menus	
		1,600-Calorie 5-Day Menu	Spanish
		1,800-Calorie 5-Day Menus	Spanish
		1,200-Calorie Sample Meal Plan	
		1,300-Calorie Sample Meal Plan	
		1,400-Calorie Sample Meal Plan	
		1,500-Calorie Sample Meal Plan	
		1,600-Calorie Sample Meal Plan	
		1,700-Calorie Sample Meal Plan	
		1,800-Calorie Sample Meal Plan	
		1,900-Calorie Sample Meal Plan	

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		2,000-Calorie Sample Meal Plan	
		2,200-Calorie Sample Meal Plan	
		Roux-En-Y Gastric Bypass Sleeve Gastrectomy Discharge Nutrition Therapy	Spanish
		Weight Loss Tips	Spanish
		Weight Management Cooking Tips	
Pulmonary		Chronic Obstructive Pulmonary Disease (COPD) Nutrition Therapy: Menu	
		Pulmonary Nutrition Therapy: Menu	Spanish
Renal	Renal Diet	Acute Kidney Injury Nutrition Therapy: Foods; Menu	Spanish
		Chronic Kidney Disease Stage 5 Nutrition Therapy (Large Print): Foods; Menu	Spanish
		Chronic Kidney Disease Stage 5 Tips for People Not on Dialysis	Spanish
		Chronic Kidney Disease Stage 5 Tips for People on Dialysis	Spanish
	Carbohydrate Controlled diet / Renal Diet	Diabetes and Chronic Kidney Disease Stages 1 through 4: Nutrition Guidelines	
		Diabetes and Chronic Kidney Disease Stages 1 through 4 Meal Planning Appendix for RDs	
		Kidney Stones Nutrition Therapy	Spanish
		Kidney Stones Nutrition Strategies	
		Low-Purine/Purine-Restricted Nutrition Therapy: Foods; Menu	Spanish
		Nephrotic Syndrome Nutrition Therapy: Foods; Menu	Spanish
		Urinary Tract Infection (UTI) Nutrition Therapy: Menu	
		Underweight Nutrition Therapy: Foods; Menu	
Underweight	High-Calorie, High Protein Diet	High-Calorie, High-Protein Nutrition Therapy (Large Print);	Spanish
		High-Calorie, High-Protein Recipes	

Tri-City Medical Center Nutrition Care Manual Meal Plan Crosswalk

Condition	TCMC Diets	Client Education	Translations Available
		Suggestions for Increasing Calories and Protein	Spanish
Vegetarian Nutrition	Vegetarian Diet	General, Healthful Vegetarian Nutrition Therapy	
		Lacto-Ovo Vegetarian Menu	
		Red Meat Avoidance Menu	
	Vegan Diet	Vegan Menu	
Surgical and Chronic Wounds		Pressure Ulcers Nutrition Therapy	Spanish

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE: 03/88

SUBJECT: Nutrition Assessment and Care for Adult Geriatric Patients

REVISION DATE~~(S)~~: 06/08, 10/10, 11/11, 02/12, 03/18, 02/19

Food and Nutrition Services Department Approval:	~~07/18~~10/21
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~11/18~~07/22
Medical Executive Committee Approval:	~~01/19~~07/22
Administration Approval:	~~01/19~~08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **POLICY:**

1. A systematic method for the Registered Dietitian (RD) **to assess the nutrition status and provision of appropriate evidenced based nutrition recommendations and interventions in collaboration with Physician/Allied Health Professional (AHP) and interdisciplinary teams.** ~~to collaborate with the physician/Allied Health Professional (AHP) in the assessment of nutrition status of patients, the education of patients regarding nutritional therapies, and the provision of appropriate medical nutrition therapy given the patient's medical diagnosis and assessed nutritional requirements for~~ **for** patients age fourteen (14) years of age and older admitted to Tri-City Healthcare District.
2. **Dietitian consults are** ~~Referrals for a nutrition assessment are~~ **auto-**generated **for criteria within the EMR that may indicate a patient may be nutritionally at risk.** ~~if certain criteria are met via the adult admission assessment in the Electronic Medical Record.~~
3. RD will assess nutritional status of **consulted patients within** ~~triggered patients within~~ **72 hours of receiving consult.** ~~48 hours of referral,~~ **considering, but not limited to,** ~~considering~~ age of patient, **diagnosis, weight history,** ~~disease states~~, nutrition history, medical history, medical therapies/treatments, **po intake,** ~~and~~ laboratory values.
4. RD **will assess nutritional risk and complete nutrition assessment form per level of nutrition risk. Patients with higher nutrition risk will be prioritized first. Dietitian will complete Adult Nutrition Assessment form for all patients with LOS greater than seven days without previous Dietitian consult. Reassessments will be completed per level of nutrition risk. Nutrition status will be determined by assessing nutritional pertinent data within the EMR.** , ~~may assess nutrition status of any patient and implement an appropriate nutrition care plan, to include evaluation and recommendations for enteral and parenteral nutrition support, addition of supplements, modification of food texture, and education of patients/families regarding appropriate nutrition intervention for a particular disease state~~.

B. **PROCEDURE:**

1. **Dietitian consults are automatically generated for specific data defined from the Nutrition Screen section of the Adult Patient History Form**
   a. **Enteral feeding, TPN, Bariatric Diet, skin breakdown or pressure ulcer, or MST score of 2 or higher .**
2. **Dietitian consults are also automatically generated from Physician Power Plans for diagnosis with significant nutrition needs. The Physician/AHP determine need for Dietitian consult within the Power Plans.**

~~———~~Any significant change in the patient's condition, i.e. surgery, intubation, or significant change in diagnosis warrants a reassessment. If the RD is not currently following the patient, the Physician/AHP/Nurse **are responsible for entering a Dietitian consult into the EMR**~~should enter a nutritional consult into the Electronic Medical Record.~~

~~1.~~**3.** ~~Referrals for nutrition assessment are generated if any of the following criteria are met upon completion of the admission data base by nursing~~:

~~a. Surgical patient Greater than (>) 75 years of age~~
~~b. Currently receiving total parenteral nutrition (TPN) or enteral feedings~~
~~c. Unplanned weight loss of greater than or equal to (≥) 5% in the last month or greater than or equal to (≥10% in last 6 months~~
~~d. Presence of pressure injury or skin breakdown~~
~~e. Impaired nutritional intake~~
~~f. Nausea/vomiting/diarrhea~~
~~g. Intake less than (<) 50% of normal in the last three (30) days~~
~~h. Chewing/Swallowing~~

~~2. RD assesses all medical/surgical patients for nutrition risk upon referral. Upon completion of assessment, appropriate nutrition care plans are implemented.~~

1. Upon receiving Dietitian consult, RD will **screen patient to assign nutrition risk.** ~~review~~ **by reviewing the following criteria if available.**

~~3.~~ **age of patient, diagnosis, weight history, nutrition history, medical history, medical therapies/treatments, po intake, laboratory values, and MST score accuracy.** ~~patient's medical history and current medical status.~~

~~4. RD will assess patient's nutrition history, indicating patient's ability to tolerate various modes of feeding, recent intake, previous diet modification, food allergies or aversions, and appropriateness/adequacy of patient's current diet order.~~**Dietitian will complete a full initial assessment and complete Adult Nutrition Assessment Form for patients with more severe nutrition risk within 72 hours of receiving initial consult and will make every attempt to**

~~5. RD~~ **conduct Nutrition Focused Physical Exam to assess malnutrition using American Society of Parenteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines, following department protocols** ~~will document height/weight, ideal body weight (IBW), usual body weight and any other appropriate anthropometric measurements. Usual body weight is more useful than IBW in ill population.~~

~~Calculation of IBW~~
~~1) Males: 106 pounds for first 5 feet; 6 pounds for each inch over 5 feet~~
~~2) Females: 100 pounds for first 5 feet; 6 pounds for each inch over 5 feet~~

~~a. Body Mass Index (weight [kg]/height [m2] is determined to assess health and body fat).~~

~~Body Mass Index Body Size Classification Table~~
~~Underweight less than (<) 18.5~~
~~Normal Weight 18.5 -24.9~~
~~Overweight 25 - 29.9~~
~~Obesity greater than (>) 30~~
~~Extreme Obesity greater than (>) 40~~

~~6. Patient will be assessed for malnutrition based on current American Society of Parenteral and Enteral Nutrition (ASPEN) and Academy of Nutrition and Dietetics (AND) guidelines after assessment of weight history, appetite change, and nutrition focused physical assessment is completed.~~

~~7.~~**2.** ~~Dietitian will evaluate nutritional related labs.~~.

~~8. RD will evaluate factors, which may affect nutrition intake, digestion, and absorption, including: medications, previous GI surgeries, on-going treatments, and chronic disease states, i.e. cancer or alcoholism.~~

3. Patients with lower nutrition risk will be seen within 7 days and complete Adult Nutrition Assessment Form.

4. Dietitian will complete Adult Nutrition Assessment form and include all pertinent and appropriate nutrition data whenever documenting an assessment or reassessment

a. Dietitian will recommend and document calorie, protein, and fluid requirements using evidenced based guidelines and referencing Nutritional Requirement for Specific Disease States Guide

~~9.~~ **5.** RD will **communicate pertinent nutrition interventions and concerns with Physician/AHP and interdisciplinary team through the Adult Nutrition Assessment Form, Interdisciplinary rounds, or through hospital approved communication.** ~~confer with nursing, pharmacist, and physician/AHP regarding pertinent factors affecting nutrition status (medication, intake and output (I&O) intake, Braden Score, presence of decubitus ulcers, presence of diarrhea, vomiting, reduced oral intake, etc.).~~

~~10. RD will determine patients at nutrition risk based upon above assessment and to include, but not limited to, patients with actual or potential malnutrition, patients on altered diets or diet schedule, patients with inadequate nutrition intake, lactating and pregnant women, and geriatric surgical patients.~~

~~11.~~**5.** ~~RD will document protein /calorie and fluid requirements for patients as indicated. See Tri-City Healthcare District Nutritional Requirement for Specific Disease States.~~

~~12.~~ RD will develop, **document and execute an evidenced based** ~~a~~**individualized** nutrition **plan of** care ~~plan indicating~~, **with appropriate nutrition interventions and individualized goals.** ~~type of nutritional support (i.e. oral, oral with supplements, appropriate enteral feeding, or suggestion of parenteral feeding) to be given and its implementation. Determination of care plan will be based on assessment. Care plan will be individualized to meet specific needs of each patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Nutrition care plans are documented within the nutritional assessment. RD will confer with physician for appropriate ordering and intervention, with register nurse (RN) for delivery of nourishment, with pharmacy and nursing for TPN and Drug Nutrient Interaction.~~

6. Reassessments with be scheduled per nutrition risk and Dietitian's clinical judgement.

a. Documentation of changes in the nutrition related problem's signs and symptoms, intervention compliance, and progress towards goals will be addressed and documented upon scheduled reassessment.

~~13. RD will monitor intake, input and output, weight, changes in medical condition and/or treatment and laboratory data and make recommendations as necessary. Intake may be monitored via calorie count. (Refer to Policy and Procedure for Calorie Count.)~~

~~14. RD will document patient's reaction and tolerance to dietary regimen.~~

~~15. RD will assess adequacy of enteral and parenteral feedings in relation to patient's nutritional requirements (see Food & Nutrition Policies: Enteral Feedings and Nutrition Assessment of TPN Patient).~~

~~16. RD may offer appropriate nutritional supplements with Physician/AHP approval when a patient is consuming less than 75% of assessed calories/protein requirements. Selection of appropriate supplement will be based upon assessment of patient's diagnosis, laboratory values, tolerance, and personal preference.~~

~~17.~~**7. It is within the** RD **scope to** ~~may implement~~ downgraded texture changes ~~in foods~~ when indicated based upon patient tolerance and/ or personal preference ~~(i.e. regular to mechanical soft or pureed).~~

~~18. RD will periodically reassess patient's nutritional status throughout hospital stay and document on Nutrition Reassessment form in Electronic Medical Record every one (1) to seven (7) days depending upon patient's status and individualized needs.~~

~~19.~~**8.** Obstetric patients will not be assessed unless RD is requested to do so by Physician/AHP/Nurse. (See Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient)

~~20.~~**1.** Any significant change in the patient's condition, i.e. surgery, intubation, or significant change in diagnosis warrants a reassessment. If the RD is not currently following the patient, the Physician/AHP/Nurse should enter a nutritional consult into the Electronic Medical Record.

~~21. Upon completion of the assessment, the dietitian will complete the initial nutrition assessment form. Additional documentation may be noted in the progress notes of the paper medical record.~~

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

1. Food & Nutrition Policy: Nutrition Assessment of High Risk OB Patient
2. Food & Nutrition Policy: Nutrition Assessment of TPN Patient
3. Food & Nutrition Procedure: Calorie Count
4. Food & Nutrition Procedure: Enteral Feedings
5. Tri-City Healthcare District Nutritional Requirement for Specific Disease States

C. **REFERENCE(S):**

1. Gottlischlich, MM, ed in chief: *The Science and Practice of Nutrition Support: A Case Based Core Curriculum.* Kendall/Hunt Publishing Company, Dubuque, IA, 2001.
2. *Manual of Clinical Dietetics*, online edition. Academy of Nutrition and Dietetics, Chicago, IL, 2017.
3. *Manual of Clinical Dietetics*, online edition. American Dietetic Association, Chicago, IL, 2000
4. Mueller, Charles, ed in chief: *The A.S.P.E.N Adult Nutrition Support Core Curriculum.* American Society for Parenteral Enteral Nutrition; 2nd ed. edition (2012)
5. Shikora, SA, Martindale, RG, Schwaitzberg, SD, eds: *Nutritional Considerations in the Intensive Care Unit: Science, Rationale, and Practice.* Kendall/Hunt Publ Co, Dubuque, IA, 2002.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**12/98**	**SUBJECT:**	**Admission to Service**
REVISION DATE:	**10/04, 07/05, 12/06, 11/07, 08/08 09/09, 02/10, 06/11, 07/13**	**POLICY NUMBER:**	**303**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~Tri-City Home Care~~	~~Distribution: Clinical Staff~~
~~**POLICIES: UNIT SPECIFIC POLICY MANUAL – HOME HEALTH**~~	
~~**Subject: ADMISSION TO SERVICE**~~	
~~**Policy: 303**~~	

A. **PURPOSE**:

1. To define the requirements, responsibility and steps necessary for admission of the patient to the Agency.

B. **POLICY**:

1. The Agency will **accept patients for treatment and service for whom there is a reasonable expectation that it can provide adequate care and meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.** ~~admit patients to service when all appropriate criteria are met for admission.~~

C. **PROCEDURE**:

~~1. Referrals for Service~~

~~a.~~**1.** Referrals are received from acute care Hospitals, Skilled Nursing Facilities, Residential Care facilities for the elderly, physician offices, and from individuals and/or their families within the community with a physician's order.

~~b.~~**2.** Referrals are received by telephone, fax, letter, ECIN or in person.

~~c.~~**3.** Referrals will be received Monday through Friday from 8:00 am to 5:00 pm and Saturday and Sunday 8:00 am to ~~4~~**5**:00 pm. Referrals are received**, entered,**~~d~~ and followed up by the Intake ~~Coordinator, Supervisor, n~~**Nurse to obtain necessary clinical documentation.** ~~or RN.~~

~~d.~~**4.** ~~Initial contact~~ **Initiation of care** will be within 24-48 hours based on diagnosis, acuity, and discharge from inpatient facility. Patients are admitted by the Agency only if the Agency is capable of providing needed care/resources at the level and intensity required by the patient's condition in the patient's place of residence and if the patient meets admission criteria. ~~Patients such as those requiring experimental drugs, pregnant patients, patients on ventilators, or patients requiring the administration of blood or blood products in the home are not accepted by the agency~~. Resources are defined to include, but are not limited to, factors such as the ability and availability of staff, and the provision of care in a timely manner following the receipt of a referral. Patients receiving skilled nursing or rehab care in their home, from another agency will not be accepted.

~~e.~~**5.** A clinician is assigned to conduct an assessment of patient for admission criteria.

~~f.~~**6.** A Registered Nurse or Physical Therapist will perform the ~~the~~ initial evaluation within 48 hours of referral. **The exception to this is physician/patient/family preference for another day. The exceptions are documented and the physician is notified if the patient/family has requested another day. All disciplines and MD will be notified of the delay in rendering**

care to the patient. When both disciplines are initially ordered, the Registered Nurse will do the initial evaluation per regulation. ~~The exception to this is physician/patient/family preference for another day. The exceptions are documented and the physician is notified if the patient/family has requested another day. All disciplines and MD will be notified of the delay in rendering care to the patient.~~

~~g.~~**7.** The need for additional services such as: Nursing, CHHA, Social Services, Rehab and Dietitian will be discussed with the patient/family/physician after the ~~clinical~~ **comprehensive** assessment. Services, when provided shall be offered in a manner consistent with accepted standards of practice.

~~2.~~**8.** Admission Criteria Includes:

a. The patient is **18 years of age or older and** under the medical care of a licensed physician**, dentist or podiatrist or other licensed practitioner within his or her scope of practice.** ~~and is 18 years of age or older.~~

b. The attending physician is located in the State of California and possesses a current California license or is a military physician practicing in the State of California.

c. The patient's physician is willing to establish a medical treatment plan in conjunction with the Home Health team and is willing to direct the care, and provide review of the treatment plan on an ongoing basis.

d. The patient must have a place of residence that is adequate for his/her proper and safe care. For example: people, who are homeless, living in cars or tents, will not be admitted to Home Health services.

e. Treatments ordered by the physician are in accordance with the Home Health philosophy within the community standard of practice, and are not illegal or experimental in nature.

f. There is reasonable expectation that the patient's physical and psychosocial needs can be met adequately in the patient's place of residence.

g. The patient/family are willing to participate in the Home Health program as evidenced by their indication of commitment and signing of the Home Health consent.

h. There is someone in the patient's place of residence who is able and willing to care for the patient between visits from the agency if the patient is unable to provide safely for themselves ~~except as provided in section C.2.j~~.

i. There is a legal representative to sign the consent form when the patient's cognitive ability limits understanding of the consent. When there is a possibility of impaired understanding, despite documentation of **cognitive competence**, the physician will be called to determine the severity of the impairment. Any impediment to this process will be referred to legal counsel. In all cases spouses, parents, children, siblings and caregivers, when no legal or family representative is known, can sign the consent for the patient. It must be documented why the patient cannot sign. When the legal representative is not present for the initial visit, verbal consent may be obtained via telephone. This must be heard / witnessed by two licensed professionals. Both witnesses should sign the consent and document "verbal consent obtained from _____ (DPOAHC, sister, spouse etc.)" A faxed signature from the DPOAHC may also be obtained prior to rendering services.

~~j. Patients without a primary caregiver may be admitted to the Agency under the following conditions:~~

~~i. Able to move self out of home in an emergency~~
~~ii. Able to identify an emergency~~
~~iii. Able to obtain assistance via telephone or Life-Line~~
~~iv. Able to manage or follow medication regimen~~
~~v. Able to perform ADL and IADL functions~~

~~k.~~**j.** Patients receiving renal dialysis will be admitted to Home Health with the understanding that services the dialysis staff provides will not be duplicated by Home Health staff.

~~l.~~**k.** The patient will be evaluated for admission without regard to her/his race, color, religion, national origin, gender, ancestry, age, financial situation or mental or physical disability.

~~m.~~**l.** Patients who have been deemed cash pay without benefit of ~~pending~~ payer source and refuse to sign the financial agreement for payment will not be admitted to service.

~~n. Patients without a community-based Physician may be admitted to the agency with the following process: (See Face-to-Face Encounter Policy for further instructions regarding certifying and admitting Medicare Patients):~~

~~i. The Hospital Case Manager will assist the patient in identifying a community-based Physician or PCP.~~

~~ii. The Community-based Physician or PCP will be asked if he would be willing to sign the plan of care and cover any needs until the physician sees the patient in their office.~~

~~iii. If the PCP refuses to sign the plan of care or give orders for the patient until they are seen, then the Hospitalist or Home Health Medical Director will sign the plan of care and provide for any orders needed until the Community-based Physician or PCP sees the patient.~~

~~iv. The Medical Director will provide coverage for Home Care POC/orders until the Primary Care Physician assumes responsibility.~~

~~v. The admitting clinician will provide the Medical Director information on the assessment and plan of care needs after admitting the patient.~~

~~vi. The patient will be transferred to the PCP after their first MD visit.~~

~~vii. See policy for Physician Orders (D.11) for process of changing the physician overseeing the plan of care.~~

~~3.~~**9.** Admission Process if Criteria Are Met:

a. Upon receiving a verbal/faxed order from the physician for care, the patient will be assigned to a Case Manager team if nursing involved and to a rehab discipline if only rehab involved. A comprehensive assessment will be done by the admitting discipline. The patient will be entered into the computer system and assigned a medical record number. The primary disciplines able to initiate a start of care are nursing and physical therapy. The staff will make an initial evaluation visit to assess the patient's needs, and the appropriateness of the environment for the level of care required. The patient/client will be evaluated within 24-48 hours of the referral date.

b. ~~For any reason any clinician can not make an evaluation visit~~**The initial evaluation cannot be made** within the 24-48 hours, **for any reason,** ~~that~~ clinician will report the reason to the physician and document ~~for~~ **in the assigned** ~~the~~ medical record. The patient always has the right to delay a visit by any discipline, however, a communication note must be written, ~~and~~ the physician informed, ~~.~~**and a Physician Order written.**

c. **Before providing treatment, the staff member will review the patient rights and responsibilities and secure the patient's signature on the admission consent form.** If the patient meets the criteria for admission, the nurse/therapist will provide the treatment ordered by the physician and will forward the verbal orders, committed to writing, to the physician for signature. ~~Before providing treatment, the staff member will review the patient rights and responsibilities and secure the patient's signature on the admission consent form and advise the patient of the State Hotline number for complaints.~~ Written orders must be signed and received back from the attending physician within 30 calendar days.

~~i.~~ The **Patient Admission Booklet is provided to every patient and is used by the clinician to explain services and to educate** patient **to include, but not limited to the following:** ~~is informed and given copies of:~~

1) **Office Hours/After Hours Coverage**
2) **Individualized Emergency Management Care Plan**

3) **Home Health Agency Overview including Scope of Care**
~~1)~~4) Patient~~'s/Client's~~ Rights and Responsibilities
5) Notice of Privacy Practices
6) **Advance Health Care Directive**
7) **Emergency Preparedness**
8) **Home Safety**
9) **Infection Prevention and Control**
10) **Patient Medication Profile**
11) **Drug Class and Food Interaction Patient Teaching Tool**
12) **Vendor Resources**
13) **Local Resources**
14) **Discharge, Transfer and Referral Policy**
15) **How to contact Administrator, Director and Clinical Manager**
~~Scope of Care~~
16) **State toll free home health telephone hot line, contact information, hours of operation, and its purpose to receive complaints or questions about local HHAs.**
~~2)~~17) The ~~charges and~~ policy concerning **expected insurance coverage** ~~payment~~ for services **and the charges the patient may have to pay that may not be covered**, to the extent possible.~~, insurance coverage and other methods of payment.~~
~~3)~~1) Scope of Care
~~4)~~1) Notice of Privacy Practice

ii. The patient/caregiver reads and signs/initials:
1) Patient Admission ~~Agreement~~ **Consent** which includes **acknowledgement of** the Notice of Privacy Practice
2) **Problem Solving Procedure and how to contact Clinical Manager**
3) **Oxygen Safety**
~~1)~~4) **Financial Agreement Form, if applicable**
~~2) Acknowledgement of the Notice of Privacy Practice~~

~~iii. The patient/caregiver reads and signs/initials the Funding Form when applicable~~
~~iv. The patient/caregiver is given a copy of the Patient Handbook (see copy)~~

d. Clinician **initiates** care ~~is now rendered~~ as ordered.
e. Referrals are made as appropriate to internal and/or external **care providers** ~~agencies~~ for necessary support services.

~~4.~~**10.** If Admission Criteria are Not Met
a. The Nurse, Case Manager, **Clinical Manager,** ~~or~~ Clinical Supervisor, **or Director** will notify the patient, physician and the referring entity.
b. The patient will be provided with information regarding alternative services. Medicare patients will be provided Home Health Advance Beneficiary Notice. All patients will have the option to pay privately for services if they meet admission requirements.
c. Patients, who are referred for admission, are entered into the database. If they do not meet criteria and are not admitted, they are identified as "non-admissions" and removed from active status.
~~d. Documentation is retained for 8 years.~~
~~e. It is the policy of the Agency that the following disciplines are required to contact a patient and~~
~~i. set up the initial evaluation within 72 hours after receiving the referral/order.~~
~~f. Registered Dietician~~
~~g. Speech Pathologist~~
~~h. Occupational Therapy~~
~~i. LCSW and MSW~~

j. CHHA

k. The admitting clinician will determine if the needs of the patient require immediate visits from the above disciplines.

5. Adult Protective Services will be the referral of choice for those patients deemed in jeopardy by the admitting clinician. A confidential written report will be faxed to them as soon as possible.

Issued:	Reviewed:	Revised:	Approved:
12/98	1/05, 10/05, 12/06, 5/07, 11/07, 5/08, 3/09, 12/09, 3/11, 6/12, **2/13**	5/04, 10/04, 5/05, 7/05, 10/05, 12/05, 2/06, 12/06, 5/07, 5/08, 3/09, 12/09, 10/10, 7/12, 6/13	7/05, 7/07, 11/07, 8/08, 9/09, 2/10, 6/11, 2/13, **7/13**

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**07/04**	**SUBJECT:**	**Agency Right of Refusal of Care**
REVISION DATE:	**0704, 06/07, 06/08, 07/09, 05/10, 09/11, 07/12, 02/13**	**POLICY NUMBER:**	**313**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 7/04~~	~~SUBJECT: Agency Right of Refusal of Care~~
~~REVISION DATE: 6/07, 6/08, 3/10, 7/12~~	~~POLICY NUMBER: 313~~
~~REVIEW DATE: 6/07, 6/08, 3/09, 3/10, 7/11, 7/12~~	~~APPROVAL: 7/19/04, 7/30/ 07/5/09, 5/10, 9/11, 2/13~~

A. **PURPOSE:**
1. To state the conditions under which the Agency reserves the right to refuse care and/or discharge a patient and the procedures to be followed if such refusal is necessary.

B. **POLICY:**
1. The Agency has the right to refuse/discharge a patient from service when criteria is not met.

C. **PROCEDURE:**
1. The Agency has the right to refuse care to a patient when a staff member reports any of the following situations/incidents occurring in the patient's home while the staff member is providing patient care:
   a. The use of illegal drugs by a patient, family member, or friend affecting care
   b. The consumption of alcohol by the patient, family member, or friend to the point where the user exhibits unacceptable behaviors and/or affects delivery of care
   c. Open sexual activity, unnecessary nudity, exhibitionism by the patient, household member(s), or guest(s)
   d. Actions by the patient or another person in the home that are threatening or abusive to the staff member
   e. Sexual advances toward the staff member by **patient or** another person in the home~~.~~
   f. Refusal by the patient or a household member to restrain or contain an animal in the presence of the staff member when behavior is threatening or impeding care
   g. Patient refuses visits that could compromise recovery
   h. Agency is unable to locate the patient after 3 attempts~~.~~
   i. Consistent failure to follow medical regimen **as outlined in plan of care** ~~(Refer to D/C policy)~~.
2. The Director ~~or Quality and Outcomes Manager~~ will review and investigate all R/L Solutions reports and -consult with **Chief of Patient Care Services, Home Health Administrator, and** the Risk Management **and Compliance** Department of Tri-City Health Care District to determine **if discharge for cause is necessary (Refer to Discharge Policy).** ~~the course of action, which may include:~~

~~a. Warning the patient that services may be discontinued if the incidents continue.~~
~~i. All warnings will be issued in writing~~

ii. All warning letters will be mailed certified with return receipt requested.
b. Alterations of care plan and/or addition of Social Worker visit
c. Accompaniment of local law enforcement to patient's home during visit
d. Termination of services.
i. All termination notices will be given to patients by certified mail with return receipt.
ii. If possible, the patient will be given two weeks notice prior to termination in order to make arrangement for alternative services.
iii. Services may be discontinued immediately if there is sufficient risk to the staff as determined by the Quality and Outcomes Manager
iv. Primary Physician will be notified.

Tri-City Home Care	~~Distribution:~~ ~~Nursing Supervisors, RN's,LVN's~~
PROCEDURE:	ASEPTIC PROCEDURE/ WASTE DISP
~~PURPOSE:~~	~~To promote wound healing by aseptically cleaning~~ ~~infection or other complications. To properly disp~~ ~~infectious. Biohazardous waste is not regulated in~~ ~~entially~~
~~SUPPORTIVE DATA:~~	
~~EQUIPMENT:~~	

DELETE – follow Elsevier Skill: Dressing: Dry and Moist to Dry and Hydrocolloid, Foam and Absorption

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ISSUE DATE: **SUBJECT: Aseptic Procedure/ Waste Disposal**

REVISION DATE: **POLICY NUMBER:**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~**I. POLICY:**~~

~~All caregivers will follow physicians' orders in treatment of wounds regarding type of dressing and frequency of dressing change using aseptic technique. (See hand washing policy).~~

~~**II. PROCEDURE:**~~

1. ~~Assist to position of comfort/privacy and expose area of wound.~~
2. ~~Assemble necessary equipment.~~
3. ~~Cleanse hands, put on gloves and open sterile package/dressing supplies.~~
4. ~~Loosen and remove old dressings. Adhesive remover wipes may be used to loosen adhesive.~~
5. ~~Discard old dressing materials in plastic bag.~~
6. ~~If needed remove old adhesive with adhesive remover wipes.~~
7. ~~Discard gloves in plastic bag.~~
8. ~~For dressing:~~
   - a) ~~Cleanse hands.~~
   - b) ~~Put on gloves.~~
   - c) ~~Clean wound in a direction from the least contaminated area to the most contaminated area and away from drain sites using clean product per stroke until exudate is removed.~~
   - d) ~~Remove gloves and cleanse hands.~~
   - e) ~~Apply new gloves.~~
   - f) ~~Complete dressing change per MD order.~~
   - g) ~~Remove gloves.~~
   - h) ~~Secure with tape.~~
   - i) ~~Securely tie the leak-proof plastic bag of gloves and all old dressing material, and place with other trash in the home.~~
   - j) ~~Cleanse hands.~~
   - k) ~~All sterile liquids used for wound care, i.e. – NS, H2O, etc., need to be dated upon opening and discarded after 7 days.~~

~~**IV. RESPONSIBILITY:** All RNs & LVNs~~

~~**V. DISTRIBUTION:** Supervisors, Coordinators, RN's, LVN's~~

~~Issued:~~	~~Reviewed:~~	~~Revised:~~	~~Approved:~~
	~~7/94, 8/00, 5/01, 1/06, 1/08, 8/12~~	~~7/96, 8/98, 7/99, 7/01, 5/03, 1/06~~	~~7/94, 8/98, 7/99, 7/01, 5/03~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 04/05	SUBJECT: Comprehensive Assessment
REVISION DATE: 05/05, 04/07, 10/08,12/10, 03/11, 03/12	POLICY NUMBER: 318

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/12

A. PURPOSE:

1. To **determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.** ~~delineate the areas of assessment and reassessment of the Home Health patient.~~

B. POLICY:

1. It is the policy of the Agency for **each patient to receive, and a** clinicians to **provide, a** ~~perform a~~ comprehensive assessment~~. at the beginning of care, resume care, recertification and when the patient exhibits new or changed symptoms.~~
2. **A registered nurse must complete an initial comprehensive assessment visit within 48 hours of the patient's return home, or on the physician-ordered start of care date.** ~~Reassessment is performed when there is an exacerbation of symptoms, presentation of new symptoms, re-certification and change of situation requiring reassessment and possible intervention.~~
3. ~~3.~~ **When rehabilitation therapy service (speech-language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial comprehensive assessment visit may be made by the appropriate rehabilitation skilled professional. The occupational therapist may complete the initial comprehensive assessment if the need for occupational therapy establishes program eligibility. A qualified therapist (registered and/or comprehensive assessment for those patients receiving therapy services.** ~~Reassessment can also be done to evaluate the patient's response to treatment, services and education given.~~
4. ~~4.~~ **The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. The start of care date is the date of the initial assessment and the comprehensive assessment must be completed within 5 calendar days of that date.** ~~The physician is notified immediately of any exacerbation of symptoms or presentation of new symptoms that may or may not require intervention. Documentation of the change and notification of the physician is required in the medical record.~~

~~C.~~ ~~NURSING~~:

5. **The content of the** A comprehensive initial assessment **must accurately reflect the patient's status, and must include, at a minimum, the following information:** ~~for nursing would include but not be limited to:~~
   a. **The patient's current health, psychosocial, functional, and cognitive status:**

b. The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the Agency;
c. The patient's continuing need for home care;
d. The patient's medical, nursing, rehabilitative, social, and discharge planning needs;
e. A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
f. The patient's primary caregiver(s), if any, and other available supports, including their:
   i. Willingness and ability to provide care, and
   ii. Availability and schedules;
g. The patient's representative (if any);
~~1.~~h. Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

~~a. Living arrangements pertaining to safety and composition of household.~~
~~b. Medical equipment in home~~
~~c. Diagnosis~~
~~d. Medical History including drug allergies~~
~~e. Current, pertinent laboratory values affecting care and treatment~~
~~f. Vital signs~~
~~g. Sensory status vision, hearing~~
~~h. Communication speech, understanding in appropriate language learning ability~~
~~i. Pain location, frequency, type, intensity~~
~~j. Integumentary status~~
~~k. Nutrition food intake need for Dietitian~~
~~l. Swallowing difficulties need for Speech~~
~~m. Wounds type, location, size, drainage need for ET~~
~~n. Respiratory status lung sounds, dyspnea, cough characteristics~~
~~o. Cardiovascular status~~
~~p. Elimination status bowel and bladder~~
~~q. Neurological status~~
~~r. Behavioral or Psychosocial~~
~~s. Religious or cultural practices affecting care and/or treatment~~
~~t. ADL and IADL need for PT and/or OT~~
~~u. Musculoskeletal~~
~~v. Medications~~
~~w. Homebound status for Medicare patients~~
~~x. Patient ,family, caregiver or other situations requiring the intervention of Social Work~~

~~D. REHABILITATION:~~
~~1. Physical Therapy:~~
~~a. Physical Status ROM/MMT~~
~~b. Pain~~
~~c. Functional Status~~
~~i. Bed Mobility~~

ii. Transfer
iii. Gait
d. Safety
e. Medical equipment
2. Occupational Therapy:
a. Physical Status
b. Activity intolerance
c. Self-Care deficit
d. Functional status
e. Safety
f. Medical Equipment
3. Speech:
a. Dysphagia/swallow impairment
b. Language/speech/cognitive
c. Receptive /expressive language

E. **MEDICAL SOCIAL WORKER:**
1. Functional Limitations
2. Contributing Medical Factors
3. Living Arrangements
4. Limitations of Caregiver/Support System/Environment
5. Financial/Legal needs
6. Psychosocial factors Impacting Medical Condition or Treatment

F. **REGISTERED DIETICIAN:**
1. Dietary Modifications
2. Swallow Impairment
3. TPN
4. Tube Feedings
5. Stage 3 & 4 wounds
6. Weight loss
7. The Registered Dietician may do a telephone evaluation using the Mini Nutritional Assessment

i.

Tri-City Home Health	Distribution: RN / LVN

PROCEDURE: CARE AND MAINTENANCE OF INDWELLING PLEURAL CATHETER (PLEURX)

DELETE Use Elsevier's Pleural and Abdominal Catheter Drainage System

~~Purpose: Registered Nurses and Licensed Practical Nurses may assist/perform ordered drainage.~~

~~Note: A treatment for malignant pleural effusion is intermittent drainage with a chronic indwelling pleural catheter. The Pleurx system is a silicone rubber catheter with a one way access valve, which prevents fluid or air from passing in either direction through the catheter unless linked to the accompanying drainage tubing and vacuum bottle.~~

Equipment:

~~This equipment is obtained from an outside company:~~

~~One (1) pouched plastic vacuum bottle~~

~~One (1) procedure pack which includes:~~

- ~~3 packages alcohol~~
- ~~8 gauze pads (4x4)~~
- ~~1 foam catheter pad~~
- ~~1 valve cap~~
- ~~1 pair gloves~~
- ~~1 self-adhesive dressing~~
- ~~1 CSR wrap~~
- ~~1 slide clamp~~
- ~~Patient Care Notes~~

ISSUE DATE:

SUBJECT: Care and Maintenance of Indwelling Pleural Catheter (PLEURX)

REVISION DATE:

POLICY NUMBER:

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~CARE AND MAINTENANCE OF INDWELLING PLEURAL CATHETER (PLEURX)~~

~~CHANGING THE PLEURX VACUUM BOTTLE~~

1. ~~Wash hands.~~
2. ~~Explain procedure to the patient.~~
3. ~~Glove.~~
4. ~~Remove dressing from over catheter.~~
5. ~~Wash hands.~~
6. ~~Open procedure pack.~~
7. ~~Open vacuum bottle and drainage line pouch. Place bottle next to sterile wrapping. Place end of drainage line on sterile wrapping.~~

~~Issued:~~	~~Reviewed:~~	~~Revised:~~	~~Approved:~~

8. Apply sterile gloves from procedure kit.
9. Open alcohol pads and place them on sterile procedure wrap.
10. Open valve cap packet and place cap on sterile wrap.
11. With procedure hand (non-dominant hand which will become unsterile) clamp the drainage line completely closed. NOTE: Clamp must fully close the drainage line. If tubing is not completely closed, some of the vacuum in the bottle may be lost.
12. With drainage line in sterile hand, remove the tip cover with the non-dominant hand.
13. Place tip of catheter back on the sterile wrap.
14. Grasp catheter valve with non-dominant hand and remove cap (no longer sterile).

Tri-City Home Health	Distribution: RN / LVN
PROCEDURE: CARE AND MAINTENANCE OF INDWELLING PLEURAL CATHETER (PLEURX)	

15. Hold valve with non-sterile hand and wipe around external surfaces of opening with alcohol swab using sterile hand. While holding valve, pick up drainage line with sterile hand and insert tip of drainage line into catheter valve. Click will be heard and felt when locked together.
16. Release clamp on drainage line. Fluid will flow into vacuum bottle. Pinching clamp partially closed may slow flow.
17. When bottle is full or flow stops, pinch the clamp completely closed.
    NOTE: Never drain more than 1000ml total at one time.
18. Pull access tip out of valve, set drainage line down.
19. Wipe valve with alcohol pad.
20. Place new cap over catheter valve, twist it clockwise until it snaps into locked position.

PLACING NEW DRESSING

1. Clean around catheter with alcohol pad, using sterile hand.
2. Place foam catheter pad around catheter.
3. Wind catheter into loops and place over the foam pad. Cover catheter with gauze pads.
4. Apply self-adhesive dressing from procedure pack.
5. Dispose of unused, soiled equipment and vacuum bottle in appropriate container in home. Do not transport.
6. Push down "T" plunger and move plunger in a circular motion to puncture the foil seal.
7. Remove flexible cap and drainage line from bottle.
8. Empty bottle into toilet. Double bag bottle and discard in trash.

REFERENCE:

- DRAINAGE KIT INSTRUCTIONS FOR USE
- BROCHURE AND VIDEO ARE AVAILABLE FOR REFERENCE WITH UNIT
- EDUCATION SPECIALIST, 2004

Issued:	Reviewed:	Revised:	Approved:

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT:** Care Coordination
REVISION DATE~~(S)~~: 05/04, 07/07, 05/10, 10/11	**POLICY NUMBER:** 301

Home Health Care Approval:	~~06/20~~05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/20~~06/22
Administration Approval:	~~08/20~~08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To ensure the coordination of services for each patient.

B. **POLICY:**
1. The primary nurse/clinician assigned to the patient is responsible for providing coordination of patient care involving all health care team members and overseeing the plans of care. In therapy only cases, the therapist will assume the oversight, and coordination for the patient. Timely and ongoing communication is the responsibility of each team member, and will be appropriate to the needs and the abilities of the patient and relevant to the care provided.

C. **PROCEDURE:**
1. Each patient will be assigned a clinician (nurse or therapist) upon admission. The clinical nursing manager or rehab supervisor will assign the case to a clinician based on the patient's need and level of care required (acuity), geographic area (zip code), and qualifications of agency personnel needed.
2. Rehab Therapists and Social Services will provide care in coordination with the primary nurse/clinician assigned.
3. The primary nurse/clinician coordinates a goal directed plan of care with all disciplines and provides oversight of the CHHA assigned to the case.
   a. Maintains communication with all disciplines by:
      i. Multidisciplinary team conference
      ii. Voice mail
      iii. Verbal discussion
      iv. Faxing of information
      v. Written communication
   b. Oversees scheduling of nursing and CHHA's to assure frequency/duration, overall coordination of care and consistency. Maintains regulatory compliance by assuring CHHA Supervisory visits are done in a timely manner.
   c. Assures communication with all physicians involved in the plan of care and integrates orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
   d. Integrates services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

e. **Coordinates care delivery to meet the patient's needs, and involves the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.**

f. **Ensures that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training, as appropriate, regarding the care and services identified in the plan of care and provides ongoing training, as necessary, to ensure a timely discharge.**

~~e. Maintains communication with the physician for oversight of plan of care and patient status.~~

~~d.~~**g.** Ensures for proper communication and hand-off between the different levels of care.

4. The **Clinical** Nurse Manager, ~~Quality Manager~~ **Rehab Supervisor** and/or Director assists the primary nurses and therapists in development of plans of care for complex patients and provides oversight and clinical guidance as needed.

5. Agency personnel will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and home visits. Documentation of all communications will be included in the clinical record on an interdisciplinary communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication.

~~6. When patients require more than one service from the agency, the primary nurse/clinician will be responsible for cooperative care planning in order to assure that goals, actions, and the inter-relationship of services is not duplicated.~~

~~7.~~**6.** Patients may be case conferenced at the beginning of service, recertification, resumption of care and whenever there is a significant change in patient condition or environment and/or a complex or non-compliant patient. Written evidence of care coordination will be found on the interdisciplinary communication form or Case Conference Summary forms in the patient's clinical record. All agency personnel involved in patient care~~,~~ will have access to the plan of care to ensure coordination and continuity

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 12/11	**SUBJECT: Communication with the Sensory Impaired (Blind/Deaf)**
REVISION DATE: 01/12, 02/13	**POLICY NUMBER: 331**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 12/11~~	~~SUBJECT: Communication with the Sensory Impaired~~
~~REISION DATE:~~	~~POLICY NUMBER: 331~~
~~REVIEW DATE: 12/11, 8/12~~	~~APPROVAL: 1/12, 2/13~~

A. **POLICY**:

1. Tri-City Home Health will take the necessary steps to ensure effective communication for patients ~~with~~ **who are deaf or hard of hearing or visually impaired (visual impairment, partial sight, low vision, legally blind or totally blind)** ~~impaired sensory or speaking skills.~~ **and will follow Patient Care Services (PCS) Policy: Communication with the Sensory Impaired (Blind/Deaf).**
   a. **See Waiver of Interpretation Services Form**
~~1.~~**2.** **As part of the home health admission process, Tri-City Home Health will evaluate any deaf or hard of hearing patient to determine what auxiliary aid(s) or service(s) will be most appropriate for that patient and will provide interpreter services, if necessary, free of charge.**

~~B. DEFINITIONS:~~

~~1. A hearing impaired individual has difficulty hearing and/or discriminating oral conversation either in a face-to-face situation or over the telephone. An individual with this impairment may require a hearing aid, telephone amplifier, telecommunication device for the deaf (TDD) or sign language.~~

~~2. A visually impaired individual has some difficulty seeing or reading information and may require special assistance and/or supportive tools including non-visual resources.~~

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

1. For patients who are deaf/~~hearing impaired~~ **or hard of hearing** and who use sign-language as their primary means of communication, the Agency will make every effort to provide a qualified sign-language interpreter to communicate both verbal and written information **as available**. ~~Sign language charts are available on the Tri-City Medical Center Intranet under "Patient Information." Many hearing impaired patients are lip readers, but it is important to assess proficiently and understanding. Telecommunication via text messaging can also be utilized.~~

~~2. Ten Golden Rules When Speaking with the Deaf~~

~~a. Make sure that background noise is at a minimum~~

~~b. Make sure you have their attention and they are looking at you~~

~~c. Ideally be between 3 to 6 feet of the person you are speaking to~~

~~d. Always look at the face of the person~~

~~e. Make sure that the light is on your face and do not obscure your face or mouth with hands~~
~~f. Speak normally but slowly and distinctly~~
~~g. Do not shout~~
~~h. Use facial expressions and hand gestures wherever possible~~
~~i. If a sentence is not heard, do not keep repeating it, but try to rephrase the sentence or confirm by writing information down~~
~~j.~~ ~~Be patient!~~

~~3.~~**2.** In addition, The Deaf and Disabled Telecommunications Program (DDTP) is a public program mandated by the California State Legislature and administered by the California Public Utilities Commission. The program provides access to basic telephone services for Californians who have difficulty using the telephone. For further information or an application, patients can visit **www.ddtp.org.**

~~4.~~**3.** Some persons who are deaf or hard of hearing may prefer or request to use a family member or friend as an interpreter. However, family members or friends of the person will not be used as interpreters unless specifically requested by that individual and after an offer of an interpreter at no charge to the person has been made by the agency. It is not recommended that children be used as interpreters.

~~For the visually impaired all documents that patients are asked to read or sign shall be read aloud to the visually impaired patient, questions shall be addressed and patient verbalization of understanding documented.~~

4. Home Health will utilize established methods of communication in the home that are effective for the patient.

C. RELATED DOCUMENT(S):

~~5.~~**1. Patient Care Services Policy: Communication with the Sensory Impaired (Blind/Deaf).**

Tri-City Medical Center
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 11/05	**SUBJECT:** Critical Lab Values
REVISION DATE~~(S)~~: 01/06; 11/06, 11/07, 10/08, 03/11 08/20	**POLICY NUMBER:** 406

Home Health Care Approval:	~~06/20~~05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/20~~06/22
Administration Approval:	~~08/20~~08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. **PURPOSE:**
1. To define the acceptable time between ordering and reporting critical lab values and between the availability of the value and the receipt by the Agency clinician.

B. **POLICY:**
1. It is the policy of Tri-City Home Health (TCHC) to report all critical lab values when received from the laboratory within 30 minutes or sooner to the ordering physician.

C. **CRITICAL VALUES:**
1. Critical values are laboratory results which indicate a condition likely to require prompt clinical intervention. All abnormal critical tests are considered panic values.
2. Panic lab value reports are taken only by LVN's and/or RN's during business hours, Monday through Friday and by a RN after business hours.
3. Critical lab "panic values" are received by phone from the laboratory and are documented in the patient note section in EMR. It is the expectation of the Agency that labs will call TCHC with panic values. If the Agency is not called regarding a panic value, ~~a~~ unusual occurrence report will be written and follow up will be conducted.
4. Items to be documented in the EMR are as follows:
   a. Time Received
   b. Time reported to the MD
   c. MD notified and name
   d. Verbal read back of lab values
5. The Home Health clinician will take appropriate action when directed by physician.
6. This may require a phone call to the patient or care giver to increase, decrease or stop dosage of medication.

D. **CRITICAL TESTS:**
1. Critical tests within normal limits are not considered panic values.
2. Critical tests are performed within 24 hours of receipt of the order or when a specific time is indicated by the ordering physician.
3. The reporting time for non-panic critical test values is 2-3 working days and is faxed to the agency by various laboratories.
4. The critical test results are faxed to the ordering physician within 1-3 hours of receipt.
5. Copies of the results and fax confirmation are given to the Patient Flow Coordinator/Clinical Supervisor and medical records after the fax confirmation has been received.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**04/04**	**SUBJECT:**	**~~Interpretation Culturally and Linguistically Appropriate Services~~ Interpretation and Translation Services**
REVISION DATE:	**05/04, 11/06, 11/07, 10/08, 12/10, 03/11, 01/12**	**POLICY NUMBER:**	**332**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 4/04~~	~~SUBJECT: Culturally and Linguistically Appropriate Services~~
~~REVISION DATE: 10/05, 9/06~~	~~POLICY NUMBER: 332~~
~~REVIEW DATE: 11/06, 12/10, 3/11, 12/11~~	~~APPROVAL: 5/04, 11/06, 11/07, 10/08, 3/11, 1/12~~

A. **PURPOSE**:

1. **Communication is a cornerstone of patient safety and quality care and every patient, including the patient representative, has the right to receive information in a manner he or she understands.** To ensure that all patients receive effective, understandable, and respectful care that is compatible with their ~~cultural beliefs and practices and~~ preferred language.

B. **POLICY**:

~~1.~~ It is the policy of the Agency to provide **interpreting and translation services, as necessary and that the information provided to the patient, including patient representative, is tailored to the patient's age, language, and ability to understand. The agency communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that is understandable, accessible, and timely to meet the patient's needs.** ~~information in culturally appropriate formats in a manner tailored to the patient's language and ability to understand.~~

C. **PROCEDURE**:

1. **Patients with limited English proficiency are provided language services at no cost, including oral interpretation and written translations.** ~~Language services are made available free of charge to each patient with limited English proficiency, regardless of the size of the individual's language group in our service area.~~ Such a patient cannot speak, read, or understand the English language at a level that permits him or her to interact effectively with staff.

~~1.~~a. **See TCMC Patient Care Services Policy: Interpretation and Translation Services**

2. ~~Language services include, as a first preference, the availability of trained bilingual staff who can communicate directly with the patient in their preferred language. When such staff members are not available, face-to-face interpretation provided by trained staff or volunteers, is the next preference.~~ A patient may choose to use a family member or friend as an interpreter

after being informed of the availability of free interpreter services, however, it is not recommended that minor children be used as interpreters.

~~2.~~**a.** **See Waiver of Interpretation Services Form**[MJT1]

~~3.~~ ~~Telephone interpreter services should be used when a face-to-face interpreter is not available or when services are needed in an infrequently encountered language. Tri-City Home Health contracts with~~ **~~an interpretation services~~**~~Language Services Associates, which can be accessed 24 hours a day, 7 days a week, by~~ **~~current vendor~~**~~calling 1-855-273-6410.~~ In the event, that the telephone **interpreter service** ~~system~~ or an appropriate translator is not available at the time of the scheduled visit, **the interpreter service is provided no later than the completion of the second visit from a skilled professional.** ~~the visit will be rescheduled as soon as possible for appropriate translation.~~

4. Written Materials routinely provided in English to patients, should be available in the commonly encountered languages, such as Spanish. On patient admissions where the primary language is identified as Spanish, a**n admission** booklet with information written in Spanish will be given to the patient ~~regardless of interpreter availability.~~ This booklet will include**, but is not limited to the following:**

- **a.** ~~a c~~**C**onsent for treatment~~,~~
- **b.** **Charges and methods of payment**
- **c.** **Discharge, Transfer and Referral Policy**
- **d.** **Problem Solving Procedure and contact information**
- **e.** Advanced **Health Care** Directive information ~~and the~~
- **f.** Notice of Privacy Practic~~ee.~~
- **g.** **Emergency Management Plan**
- **h.** **Notice of Medicare Non-Coverage**
- **i.** **Oxygen Safety**

5. When necessary, the Home Health Beneficiary Notice will be given.

~~4.~~**6.** The consent for all Spanish speaking patients will be signed by the patient unless the patient has a Conservator or DPOH, then the consent will be signed in the appropriate language of that individual. ~~This will be audited for compliance.~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**05/04**	**SUBJECT:**	**Discharge**
REVISION DATE:	**10/05, 11/06 , 06/07, 08/08, 05/09, 10/10, 06/11, 02/13, 07/13**	**POLICY NUMBER:**	**304**

Home Health Care Approval:	**05/2**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~**Tri-City Home Health**~~	~~Distribution:~~
~~**Policies:**~~	~~**UNIT SPECIFIC POLICY MANUAL – HOME HEALTH**~~
~~**Subject:**~~	~~**DISCHARGE**~~
~~**Policy Number:**~~	~~**307304**~~

A. **PURPOSE:**

1. **To delineate the policy and procedure for patient discharge from Agency and** ~~T~~to define responsibilities of all team members regarding discipline or agency discharge

B. **POLICY:**

1. It is the policy of the agency for each discipline to adhere to the standards for agency discharge.
2. Nursing and Rehab services are the only disciplines permitted to discharge patients from the agency.

C. **PROCEDURE:**

1. Discharge of the patient must occur on or before the last day of the certification period if the patient is not being recertified.
2. ~~1.~~ Any discharge from a single discipline will be communicated to all team members. ~~Documentation for discharge and a current list of medications will be~~ **faxed to MD by Medical Records if requested.** ~~entered into the computer.~~
   a. ~~Medical records will fax to MD if requested.~~ The case manager will assume the responsibility of the rehab instructions for the CHHA when rehab has discharged ~~and~~ if applicable.
3. ~~2.~~ If nursing has discharged and rehab is still involved in the case, rehab will assume oversight of the CHHA.
4. ~~3.~~ Case manager designation on the patient ~~information packet~~ **admission booklet** in the home will be changed appropriately upon change of case manager.
5. ~~4.~~ The original case manager will continue management of the case until the first visit by the new case manager has been completed and a report has been given. This will occur after verbal communication and documentation has been completed. The case manager assuming care will be responsible for oversight of care plan goals for that certification period.
6. ~~5.~~ When a patient is discharged from the agency as a whole, the agency is no longer able to provide care, instruction or advisement. Patients contacting the ~~A~~agency after ~~agency~~ discharge will be referred to their primary physician.
7. ~~6.~~ **Discharge from individual disciplines or the agency may occur for the following reasons:** ~~When any of the following criteria are met, the patient will be discharged from individual disciplines or the agency as a whole.~~

~~a. Plan of care goals met.~~
~~b. No other needs identified by patient, family, agency, and/or physician.~~
a. **The physician who is responsible for the home health plan of care and the Agency agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the Agency and the physician who is responsible for the home health plan of care agree that the patient no longer needs the Agency's services;**
b. **The discharge is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the Agency's capabilities;**
c. **The patient or payer will no longer pay for the services provided;**
d. **The patient refuses services, or elects to be discharged;**
e. **The discharge is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency must arrange a safe and appropriate discharge to other care entities when the needs of the patient exceed the Agency's capabilities;**
~~c.~~**f.** The patient and/or caregiver refuse to cooperate in attaining treatment objectives or to use the equipment required to safely perform care.
~~d.~~**g.** Written treatment objectives are no longer attainable.
~~e.~~**h.** The condition of the patient changed to the point that intermittent care is not appropriate and other arrangements must be made.
~~f.~~**i.** Stabilization has been achieved and other suitable arrangement for care must be made.
~~g.~~**j.** The patient is no longer homebound and/or no further services are needed. Further services are needed will be provided at the physician's office or outpatient services. The Medicare patient has the right to appeal the discharge by completing the Notice of Medicare Non-Coverage form for Medicare and Medicare HMO patients and the Home Health Advance Beneficiary Notice for Medicare patients.
~~h.~~**k.** The physical environment is no longer suitable for the patient's care, the family situation has changed resulting in the patient's inability to manage his/her own care, or there is no longer anyone available in the home to give the required care between visits by agency personnel.
~~i. Patient requests discharge from the Agency.~~
~~j.~~**l.** The patient moves from the geographic area served by the agency.
~~k.~~**m.** Death of the patient
~~l. The patient or family is physically or verbally abusive to staff or there is a potential safety risk to the staff member.~~
~~m.~~**n.** The physician fails to renew medical orders by the recertification date or the patient changes physician and orders cannot be obtained from the new physician.
~~n.~~**o.** The physician gives orders, which are not consistent with the stated diagnosis and/or existing policy/practice, and fails upon request **by TCMC physician representative and/or Medical Director** to **resolve discrepancy**~~give the needed orders requested by a medical representative of the GPP~~.
~~o.~~**p.** The patient's insurance company no longer authorizes payment for services, the insurance policy coverage is exhausted and the patient is able to receive care elsewhere (i.e. caregiver assumes care, clinic, physician assumes responsibility) or the patient elects not to pay privately. If the insurance is Medicare HMO or regular Medicare, the patient may appeal the decision by completing the Notice of Medicare Non-Coverage form.
~~p.~~**q.** The agency is closing out a particular service, or **ceases to operate**~~all of its service~~.

r. ~~Per CMS regulations, the patient will be discharged if~~ A face to face encounter does not occur related to the primary reason for Home Health. This face to face encounter must be made by a certifying physician within ninety (90) days prior or within thirty (30) days of the initiation of Home Health.

8. **Agency may Discharge for Cause for the following reasons:**
   a. **Patient (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of Agency to operate effectively is seriously impaired; the patient or family is physically or verbally abusive to staff or there is a potential safety risk to the staff member;**
   b. **The Agency must do the following before it discharges patient for cause:**
      i. **Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the Agency (if any) that a discharge for cause is being considered;**
      ii. **Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;**
      iii. **Provide the patient and representative (if any), with contact information for other agencies or providers who jay be able to provide care; and**
      ~~c.~~**iv. Document the problem(s) and efforts made to resolve the problem**

~~7.~~**9.** Discharge planning with all disciplines and the patient commences at the time of admission. The discipline managing the case will work with the physician, patient, and/or family in making alternate plans for continuing care when further health care is needed. Clear documentation of ~~such activities~~ **discharge planning and care coordination** must be reflected in the patient ~~Home Care records~~**medical record.**~~.~~

~~8.~~**10.** The physician shall be verbally notified of the discharge if the plan of care does not include to discharge when goals are met. If goals are not met, the physician will be contacted, the status and plan of care will be discussed with the physician and a written order will be obtained for discharge. If goals are met and there is an order to discharge when those goals are met on the plan of care, no written order will be necessary.

~~9.~~**11.** ~~Generally it~~It will be the practice for the staff member to make the last visit to the patient for discharge. Telephone discharge may be done in certain situations:
   a. The patient has left the geographic area.
   b. The patient refuses the final visit or a visit cannot be arranged.
   c. The patient's insurance company will not authorize payment for the visit.
   d. The insurance policy coverage is exhausted and the patient has signed the Notice of Medicare Non Coverage without requesting an appeal or agreeing to pay for the services.

~~2.~~**12.** If the discipline feels the discharge from service and/or from the agency as a whole is appropriate and the physician disagrees:
   ~~a. The patient will be informed and will be offered the ability to continue services as a cash patient. Medicare patients will also be provided the opportunity to continue receiving services upon understanding and completing the Home Health Advanced Beneficiary Notice.~~
   ~~e.~~**a.** The discipline shall consult with the **Director, Clinical Manager and or Rehab** Supervisor~~/DPCS~~.
   ~~f.~~**b.** The **Director, Clinical Manager and or Rehab** Supervisor ~~and DPCS pursued~~**discuss** the patient discharge with the physician. If the physician still disagrees, the ~~Supervisor/DPCS~~**Medical Director** will **be** consult**ed** ~~with the Medical Director~~.

c. If the Medical Director is in concurrence with the **discharge**~~Director~~, she/he will discuss the case with the patient's physician and notify the physician the patient will be discharged consistent with the Agency policy.

~~g.~~**d. The patient will be informed and will be offered the ability to continue services as a cash patient. Medicare patients will also be provided the opportunity to continue receiving services upon understanding and completing the Home Health Advanced Beneficiary Notice.**

~~10. For Quality Improvement purposes, client satisfaction surveys are sent to discharged patients by an outside vendor, Press Ganey. Results are evaluated, summarized, trended randomly for opportunities for improvement and reported on a quarterly basis to GPP. Leadership is advised of negative comments for follow up when necessary.~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~05/04~~	~~1/05, 10/05, 11/06, 6/07, 5/08, 3/09, 10/10, 3/11, 6/12~~	~~10/05, 6/07, 5/08, 3/09, 10/10, **2/13, 7/13**~~	~~5/04, 8/08, 5/09, 10/10, 6/11, 2/13, **7/13**~~

Tri-City Health Care District	Home Health Care
PROCEDURE:	**DISPOSAL OF NEEDLES & SYRINGES; HAZARDOUS MATERIALS**
Purpose:	To properly dispose of syringes and needles to prevent injury/accident to employees, patients, and caregivers.
Equipment:	A locked puncture proof container with a slot in the top for dropping in syringes and needles.
Issue Date:	09/03

A. **PROCEDURE:**

1. Used syringes and needles will be placed in a puncture resistant hazardous waste container with a slot in the top. Home Care **Health** uses commercial containers.
2. Entire used syringe and needle is dropped into the container. The needle is not recapped.
3. Container is transported by the Home Health Care nurse into the home when it is anticipated that syringes **and needles** will be used.
4. Patients and families are instructed to use the locked puncture proof container supplied by infusions companies if needles and sharps are used by patient or care giver.
   a. **Note:** Families with small children in the home should be cautioned to place barrier over opening of the puncture resistant container.
5. Used containers are stored and placed in a biohazardous waste receptacle within a locked area in suite 212 outside of the Home Health Office.
6. Any employee transporting sharps and specimens must carry an Agency copy of Limited Quantity Hauler Exemption.
7. ~~7.~~ Containers are intended for one time use and are not to be recycled.
8. These containers weighing under 20 pounds, are picked up from the locked storage area every month by Facilities Department.
9. Containers are ordered from the purchasing department.
10. No other biohazardous material is transported by agency staff.

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/96, 11/97, 08/98, 07/99, 08/00, 03/03, 01/06, 12/08, 08/12, 06/20 **05/22**	07/20, **07/22**	08/20, **07/22**	09/20, **08/22**	n/a	08/12, 09/20

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 10/10	SUBJECT: Clinical Records~~Documentation~~
REVISION DATE: 03/11, 02/13	POLICY NUMBER: 401
Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/13

~~ISSUE DATE: 10/10~~	~~SUBJECT: Documentation~~
~~REVISION DATE:~~	~~POLICY NUMBER: 401~~
~~REVIEW DATE: 10/10, 1/11, 6/12~~	~~APPROVAL: 3/11, 2/13~~

A. PURPOSE:

1. ~~To define necessary elements of available patient information necessary for individuals providing Home Health services and the correction of information when found to be incorrect.~~**To maintain a clinical record containing past and current information for every patient accepted and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.**

B. POLICY:

1. **The contents of the clinical record must include:**
   - a. **The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders;**
   - b. **All interventions, including medication administration, treatments, and services, and responses to those interventions;**
   - c. **Measurable goals in the patient's plans of care and the patient's progress toward achieving them;**
   - d. **Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);**
   - e. **Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge; and**
     - i. **A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge within 5 business days of the patient's discharge; or**
     - ii. **A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or**
     - iii. **A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving**

care in a health care facility at the time when the agency becomes aware of the transfer.

~~1. All information involving physical, emotional, or educational support will be documented appropriately according to Standards of Care.~~

~~C. **PROCESS**:~~

~~1. Required information for all patients~~

~~a. Age~~

~~b. Sex~~

~~c. Current Medications~~

~~d. Diagnoses, Comorbidities, and Concurrently Occurring Conditions~~

~~e. Relevant Laboratory Values~~

~~f. Allergies and Past Sensitivities~~

~~g. Current Hospitalizations, Rehab or SNF~~

~~h. Current Physician Overseeing The Plan of Care~~

~~i. Other patient information necessary for the medication management and follow through of the plan of care will be available to appropriate staff with documentation as appropriate.~~

~~2. Identification~~

~~a. All disciplines sign with signature, discipline title, date, and time of visit on each note.~~

~~b. All documentation must be written in black ink and legible to at least two individuals.~~

2. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

~~3. Non-approved Abbreviations~~

~~a. A list of prohibited abbreviations are on the TCMC website.~~

~~4. All documentation shall be completed on Agency acceptable forms.~~

~~5. All telephone orders for treatments, medications and labs must be "read back" as heard and recorded when given.~~

3. Medical Record ~~Corrections~~**Retention, Protection and Retrieval**

a. Clinical records will be retained for 7 years after the discharge of the patient.

b. If the agency discontinues operation, the department of public health will be informed where clinical records will be maintained.

c. The clinical record, its contents, and the information contained therein will be safeguarded against loss or unauthorized use.

~~6.~~**d. A patient's clinical record will be made available free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).**

~~a. An Agency Clinical Supervisor or RN case manager with written or verbal agreement of the primary author may make clinical additions or corrections to the medical record. Agency supervisors, or designee, may make non-assessment corrections with written agreement. Signed clinician written agreement on file.~~

~~b. Non-clinical errors or omissions may be corrected by any Agency supervisor without verbal agreement of the author.~~

~~c. All errors of Agency personnel no longer employed by the Agency may be corrected by a Clinical Supervisor.~~

~~i. Example: "OK'd by BLB/MVD, R.N. 8-31-12~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 10/05	**SUBJECT: End of Life Decisions**
REVISION DATE: 04/06; 01/07, 08/09, 09/11	**POLICY NUMBER: 325**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/11**

~~ISSUE DATE: 10/05~~	~~SUBJECT: End of Life Decisions~~
~~REVISION DATE: 3/06, 12/06, 6/07~~	~~POLICY NUMBER: 325~~
~~REVIEW DATE: 12/06, 1/07, 6/07, 5/09, 7/11~~	~~APPROVAL: 4/06; 1/07, 8/09, 9/11~~

A. **PURPOSE**:
1. To delineate the Agency's position on patient**s'**~~'s~~ end of life decisions.

B. **POLICY**:
1. It is the policy of the Agency to respect and support the decisions of patients regarding end of life. The Agency will attempt to inform patients about options and requests that can be made prior to death.

C. **PROCEDURE**:
1. Admitting clinicians will ascertain if the patient has a **Do Not Resuscitate** (DNR) **request. Once informed the admitting clinician** ~~and if so,~~ will indicate the information on the referral sheet in the appropriate box~~,~~ on the consent form and will affix a DNR label to the front of the ~~Home folder~~**Patient Admission Booklet**. The clinical team is informed of this by the copy of the consent in the ~~home folder~~**Patient Admission Booklet** and by the Case Manager.
2. If the patient requests a DNR, the clinician will follow up with the primary physician for an order and disseminate the information to the health care team. ~~-~~Information about the County DNR form will be given to the patient if requested.
3. The patient has the right at any time during the course of service to revoke the DNR decision.
4. The clinician will assess if a patient has an Advanced Directive **(AD)** during the initial evaluation and obtain a copy if available. If not available, the clinician will make every effort to ascertain the contents of the A**D**~~dvanced Directive~~ via questioning of patient and caregiver. ~~-~~These comments and the location of the A**D**~~dvanced Directive~~ will be noted on the Patient Consent for communication to the clinical team.
5. If the patient does not have an A**D**~~dvanced Directive~~, information regarding the **AD**~~advanced directive~~ is provided to the patient via the Patient **Admission Booklet**~~Handbook~~.
6. The Agency does not require a copy of the **AD**~~advanced directive~~ to provide care. ~~-~~Artificial means to prolong care, as stated in advanced directives, would require the order of a physician. It is not necessary for the Agency to know specific patient wishes because the clinicians cannot act without the order of the physician.
7. The Agency will support all end of life decisions of the patient with appropriate medical orders that are deemed ethical by community standards.
8. Any conflicts that may occur concerning care will be brought to the Ethics Committee for resolution.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 04/11	**SUBJECT:** Face-to-Face Encounter
REVISION DATE: 06/11, 12/11	**POLICY NUMBER:**
Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/11

~~ISSUE DATE: 4/1/2011~~	~~SUBJECT: Face-to-Face Encounter~~
~~REVISION DATE:~~	~~POLICY NUMBER: 502~~
~~REVIEW DATE: 5/11, 12/11~~	~~APPROVAL: 6/11, 12/11~~

A. **PURPOSE**:

1. To ensure greater physician accountability in certifying a patient's Medicare eligibility for Home Health -Services by requiring a Face-to-Face encounter in accordance with **Affordable Care Act** ~~the Patient Protection and Affordable Care Act Provisions~~.

B. **POLICY**:

1. It is the agency's policy to comply with all aspects of the Face-to-Face rule. It is understood that having a valid **Face to Face Encounter is mandated by the Affordable Care Act (ACA) as a condition for coverage and payment. The Face-to-Face encounter must occur no earlier than 90 days prior to the Start of Care (SOC) or within 30 days after the Start of Care. If the face to face encounter meets the timeframe guidelines (within 90 days of the SOC), but the encounter does not relate to the primary reason for the home health admission, then a new encounter is needed to be completed within 30 days from the SOC.**

~~1. recertification is a statutory requirement for coverage and payment.~~

C. **PROCEDURE**:

1. **The initial (Start of Care) certification must include documentation that an allowed physician or non-physician practitioner (NPP) had a face-to-face (FTF) encounter with the patient. The FTF encounter must be related to the primary reason for the home care admission. This requirement is a condition of payment. Without a complete initial certification, there cannot be subsequent episodes. Claims may be denied if the FTF documentation is not complete.** ~~The certifying physician must document that he or she or an allowed non-physician practitioner (NPP) had a face-to-face encounter with the patient.~~
2. **The FTF encounter must be performed by the allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health), or an allowed non-physician practitioner (NPP). An NPP in an acute or post-acute facility from which the patient was directly admitted to home health is able to perform the FTF encounter in collaboration with or under the supervision of the physician who had privileges and cared for the patient in the acute or post-acute facility. Only the certifying physician can attest to the date of the encounter on either the certification, or a signed addendum to the certification.**

~~Certain NPPs may perform the face-to-face encounter and inform the certifying physician regarding the clinical findings exhibited by the patient during the encounter. However, the certifying physician must document the encounter and sign the certification. NPPs who are allowed to perform the encounter are: A nurse practitioner or clinical nurse specialist working in collaboration with the certifying physician in accordance with State law; A certified nurse-midwife as authorized by State law; A physician assistant under the supervision of the certifying physician~~

3. **Documentation in the certifying physician's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined. Only Medicare enrolled physicians may certify Medicare beneficiaries for Medicare certified Home Health Services.**
4. **To be eligible for the home health benefit, a physician must certify that the patient meets the following requirements.**
   a. **Be confined to the home;**
   b. **Under the care of a physician or an allowed practitioner;**
   c. **A plan of care has been established and is periodically reviewed by a physician or allowed practitioner; and**
   d. **The services are or were furnished while the patient is or was under the care of a physician or allowed practitioner**
5. **The home health agencies generated medical record documentation, by itself, is not sufficient in demonstrating the patient's eligibility for the home health benefit. Therefore, home health documentation such as, an admit summary, part of the OASIS, or a therapy evaluation/therapy notes, nurses notes that support the certification must be signed off by the certifying physician and incorporated into the physician or acute/post-acute care facility's medical record to help support the FTF. Documentation must correspond to the dates of service being billed and not contradict the certifying physician's and/or the acute/post-acute care facility's own documentation or medical record entries.**
6. **Documentation from the certifying physician's medical records and/or the acute /post-acute care facility's medical records (if the patient was directly admitted to home health) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services (CMS).**
7. **The certifying physician and/or the acute/post-acute care facility medical record (if the patient was directly admitted to home health) for the patient must contain the actual clinical note for the face-to-face encounter visit that demonstrates that the encounter:**
   a. **Occurred within the required timeframe,**
   b. **Was related to the primary reason the patient requires home health services; and**
   c. **Was performed by an allowed provider type**
   Note: This information can be found most often in clinical and progress notes and discharge summaries.
8. A **hospitalist**~~HOSPITALIST~~ or an attending physician who cares for the patient in an acute care setting but may not follow the patient in the community **may certify**~~MAY CERTIFY~~ the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute care physician would then transfer/hand off the patient's care to the designated community-based physician who assumes care for the patient. **Or, A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.**
9. **As the billing entity, it is the responsibility of the Agency to:**
   a. **Facilitate and coordinate between patient and physician to ensure the FTF occurs timely;**
   b. **Ensure all FTF requirements are met;**

c. Delay submission of the final claim until all FTF requirements and documentation is met.

~~1.~~**10. Exceptional Circumstances: When a home health patient dies shortly after admission, before the face-to-face encounter occurs, if the contractor determines a good faith effort existed on the part of the Agency to facilitate/coordinate the encounter and if all other certification requirements are met, the certification is deemed to be complete.** ~~**5. If the below conditions are met, an encounter between the home health patient and the attending physician who cared for the patient during an acute/post-acute stay can satisfy the face-to-face encounter requirement. A physician who attended to the patient in an acute or post-acute setting, but does not follow the patient in the community (such as a hospitalist) may certify the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute/post-acute physician would then transfer/hand off the patient's care to a designated community-based physician who assumes care for the patient. Or, A physician who attended to the patient in an acute or post-acute setting may certify the need for home health care based on his/her contact with the patient, initiate the orders for home health services, and transfer the patient to a designated community-based physician to review and sign off on the plan of care.**~~

~~2. Only Medicare enrolled physicians may certify Medicare beneficiaries for Medicare certified Home Health Services.~~

~~3. A HOSPITALIST or an attending physician who cares for the patient in an acute care setting but may not follow the patient in the community MAY CERTIFY the need for home health care based on his/her contact with the patient, and establish and sign the plan of care. The acute care physician would then transfer/hand off the patient's care to the designated community-based physician who assumes care for the patient.~~

~~4. The Face-to-Face encounter must occur no earlier than 90 days prior to the Start of Care (SOC) or within 30 days after the Start of Care. If the face-to face encounter meets the timeframe guidelines (within 90 days of the SOC), but the encounter does not relate to the primary reason for the home health admission, then a new encounter is needed to be completed within 30 days from the SOC.~~

~~5. The documentation must include the date when the physician or allowed NPP saw the patient, and a brief narrative composed by the certifying physician who describes how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services. The certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. It may be written or typed. The document must be separate and distinct and clearly titled. It is acceptable for the certifying physician to dictate the documentation content to one of the physician's support personnel to type. It is also acceptable for the documentation to be generated from a physician's electronic health record. It is unacceptable for the physician to verbally communicate the encounter to the Home Health Agency, where the Home Health Agency would then document the encounter as part of the certification for the physician to sign.~~

~~6. A discharge summary or discharge plan from an allowed NPP or physician who cared for the patient in an acute or post-acute facility can serve as the face-to-face physician encounter documentation as long as it includes the signature of the certifying physician and the required content. Therefore, it is acceptable for the certifying physician or his/her support staff to attach a communication (i.e., discharge summary) from an allowed NPP or hospitalist who cared for the patient in a facility and performed the encounter, to the certification as an addendum as long as the required content is present and the certifying physician signs and dates the communication. This was clarified within the Home Health PPS 2012 Final Rule.~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 01/06	**SUBJECT: Fall Prevention**
REVISION DATE: 04/06, 04/08, 06/11, 02/13	**POLICY NUMBER: 328**
Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 1/06~~	~~SUBJECT: FALL PREVENTION~~
~~REVISION DATE: 3/06, 4/08,8/11~~	~~POLICY NUMBER: 328~~
~~REVIEW DATE: 4/08, 3/11, 6/12~~	~~APPROVAL: 4/06, 4/08, 6/11, 2/13~~

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

1. The Agency recognizes that falls in the home can lead to negative outcomes for the patient and can hasten death or admission to a skilled nursing and/or acute facility. ~~Therefore, fall prevention and education are part of initial and ongoing patient assessment~~.
~~POLICY:~~
2. **Staff will** ~~It is the policy of the Agency to~~ assess and educate patients for fall risks and **implement**~~take~~ appropriate intervention when needed if a fall occurs. ~~The~~ ~~MedPass~~ **MAHC-10** Fall Risk Assessment will be the assessment tool at **Start of Care** ~~SOC~~, Resumption and Recertification.
~~PROCEDURE:~~
3. All patients and their home environment **will be** ~~are~~ evaluated for fall risk at admission~~,~~ and ongoing throughout the course of service.
   a. Education is provided at admission via the Patient Admissions Booklet and ancillary handouts documented as fall prevention education.

~~1.~~**4.** **Staff will make every effort to** ~~It is important to~~ actively engage the patient and caregiver in all aspects of **the** Fall Prevention Program.

~~1.~~**5.** When a fall occurs **(witnessed by** ~~with~~ the clinician present or **informed** ~~is told~~ of the event at the patient visit the following steps should be **impletmented**~~taken~~:

a. **Notify the** ~~The~~ Physician ~~is informed~~ of ALL falls
b. ~~The patient is c~~**Checked** **the patient** for injury, if needed,
c. **Send**~~sent~~ **patient** ~~to~~ the Emergency **Department**~~Room,~~ or ~~an order is~~ obtained **an order** from the Physician for further interventions, if appropriate, such as wound care, change in medication, or additional durable medical equipment.
d. A referral is made to Physical Therapy, Occupational Therapy, or Medical Social Services.

~~b.~~**e.** **Document the** ~~The~~ fall ~~is documented~~ in the patient's medical record with the contributing information.

f. **Re-educate the** ~~The~~ patient and caregiver ~~is re-educated~~ regarding causes and prevention of falls.

~~c.~~**g.** **Enter the details of the fall in the hospital reporting system e.g., RL Solutions.**

6. **Director of Home Care or designee will:**
   a. **Review the falls detail in the hospital reporting system**

b. Obtain, review and analyze all falls data from reports received from Risk Management and from Strategic Healthcare Solutions (SHP).

c. All falls data is reported to the appropriate hospital committee(s).

~~2. A Quality Review Report (QRR) is completed in RL Solutions and reviewed by the Manager of Quality and Outcomes and forwarded to TCMC Risk Management. The Quality and Outcomes Manager obtains fall reports and analytical data from Risk Management and also from Strategic Healthcare Solutions. (SHP) This information is reported to the Leadership team and to the GPP.~~

~~2. When a patient experiences two or more falls, discussion will occur in a multidisciplinary case conference, where appropriate measures will be looked at.~~

~~3.~~**7.** The **Director of Home Care or RN designee** ~~Manager of Quality and Outcomes~~ will be an active member of the TCMC Patient Safety Committee and the Falls ~~Prevention Sub-~~ Committee.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**02/06**	**SUBJECT:**	**Hand Off Communication**
REVISION DATE:	**04/06, 07/07, 05/09, 10/10, 09/11, 02/13**	**POLICY NUMBER:**	**323**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 2/06~~
~~REVISION DATE: 5/07, 6/08, 2/09, 9/11~~
~~REVIEW DATE: 5/07, 6/08, 10/08, 2/09, 9/10, 7/11, 6/12~~

~~SUBJECT: HAND OFF COMMUNICATION~~
~~POLICY NUMBER: 323~~
~~APPROVAL: 4/06, 7/07, 5/09, 10/10, 9/11, 2/13~~

A. **PURPOSE**:

1. To provide a consistent, standardized approach to hand-off communications between the patient's caregivers **to maintain continuity and to ensure that accurate and timely information reaches those who need it at the appropriate time.**
2. **To** ~~and~~ provide an opportunity for the receiving caregiver to ask and respond to questions about a patient's care.
3. ~~1.~~**To** ~~E~~ensure~~ing~~ proper communication hand-off~~s~~ between caregivers ~~and improves~~ **to ensure** patient safety and **quality** care.

B. **POLICY**:

1. Hand-off~~s~~ should include the opportunity for verbal communication interaction so questions concerning the patient's care can be answered. **Such interaction may include information such as the patient's condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.** Telephone conversation with the receiving party will occur when needed. If the information is communicated via fax, the fax cover sheet shall include a contact person and number to call if more information is needed.
2. A consistent method of hand-off communication about a patient will be done throughout the Agency including, but not limited to, the following:
   a. Discharged to the primary physician
   b. Discharged to another Home Health Agency
   c. Discharged to Hospice
   d. Transfer to an acute setting
   e. Transferred/Discharge to a Skilled Nursing Facility
   f. Case Manager or another nurse transferring care to another nurse or discipline
3. Key Transfer/Discharge information for patient care will include, but is not limited to, the following:
   a. Diagnosis
   b. Referral sheet
   c. Reason for discharge
   d. Vital Signs
   e. Physical/Psychosocial status

f. Current Functional status
g. Care/Intervention summary
h. Specific discharge instructions given
i. Goals not met and reason
j. Continuing symptom management needs (pain, dyspnea, nausea, vomiting, catheter, IV)
k. Resource information provided to patient for continuing needs
l. Outcomes
m. Resources ongoing
n. Living arrangement at discharge
o. Allergies
p. Medication profile
q. Current lab results if appropriate ~~with in~~**within** 72 hours
r. A fax cover sheet allowing for questions if needed
s. A communication note shall be included for patients being transferred to another agency or facility with an active infection. The type of infection and medications ordered will be addressed.

4. Discharge to the Primary Physician, Hospital and Skilled Nursing Facility and Hospice will include, but may not be limited to, the following:
~~t.~~**a.** The Transfer/Discharge Summary
~~u.~~**b.** Medication Profile
~~v.~~**c.** Current Lab results
~~w.~~**d.** Any other communication relevant to current patient status including any infectious disease currently being treated

~~A.~~**5.** Hand off from or to a case manager for total or immediate care will include, but is not limited to, the following:
~~1.~~**a.** Patient name
~~2.~~**b.** Copy of referral sheet if appropriate
~~3.~~**c.** Diagnosis
~~4.~~**d.** Medication problems if appropriate
~~5.~~**e.** Any psych/social problems affecting care and recovery
~~6.~~**f.** Ongoing treatments
g. Other aspects of the plan of care including goals and interventions
~~7.~~**h. Visit schedule frequency and duration**
~~x.~~**i.** Hand off to the case manager must be done by the end of the working day ~~so~~ **or** sooner if needed. Hand off by the clinician or case manager may be done via computer, face to face or voice mail.

~~4.~~**6. Transfer to Hospital**
a. Occasionally, the Agency is not immediately informed when a patient is taken to the hospital.
b. The Agency will fax the key patient information as soon as it becomes aware of admission to the hospital or skilled nursing facility, unless patient is already discharged from that facility. The agency will be available for questions.

Tri-City Health Care District	Home Health Care
PROCEDURE:	**HOME TOTAL PARENTERAL NUTRTION (TPN)**
Purpose:	To provide total energy and nutrient requirements in amounts sufficient to maintain a proper metabolic state and positive nitrogen balance intravenously
Supportive Data:	When a patient requires TPN accurate, safe and consistent measures must be implemented to reduce risk of infection, metabolic complications and maintain integrity of the central venous catheter. Proper monitoring allows for the assessment of the patient's tolerance of the nutritional support. 1. Dressing Changes (See long-term venous catheters procedure) 2. Initiating Home TPN (Continuous/Cyclic Infusion) Proper initiation of TPN per guidelines reduces the risk of metabolic complications, i.e. hyperglycemia, fluid overload
Equipment:	• Non-sterile gloves • Alcohol prep pads (3) • Chloroprep swabs • 12ml syringe with needleless syringe cannula filled with 10ml of normal saline • Vitamins/additives already have been added to TPN solution bag – Remove from refrigerator approximately 30-60 minutes before infusing • Normal Saline • IV poles • Infusion pump • TPN tubing • 1.2 micron filter • Isopropyl alcohol • Paper towel • Trash can • Needle discard container • Micropore tape – 1"
Issue Date:	11/97

A. **HOME TOTAL PARENTERAL NUTRTION (TPN):**

1. **Perform** Hand Hygiene.
2. Verify label on TPN solution with TPN profile from pharmacy.
3. Inspect solution and container for integrity, i.e. punctured bag, contaminates or precipitates.
4. Clean working area thoroughly with an approved disinfectant, such as sani-cloth and isopropyl alcohol.
5. Remove protective cap from TPN bag.
6. Open tubing package, close roller clamp/slit clamp. Remove protective cap from spike and insert spike into bag port.
7. Attach 1.2 micron filter to tubing prn.
8. Invert bag and hang on IV pole.
9. Follow instructions for pump, prime tubing via pump.
10. Cleanse injection cap on end of catheter with 3 alcohol pads.
11. Release clamp on extension set/central venous catheter.
12. Flush catheter with 10cc of N.S. If immediately hanging a new TPN bag, may flush catheter with 5 ml of NS.
13. Connect tubing to injection cap on catheter.
14. Administer TPN as ordered. Tapering up and down. Check pump for program accuracy.
15. IV Pump and tubing have built in safeguards to prevent bolus infusions.
16. IV tubing, filter and solutions changed every 24 hours.
17. Monitoring guidelines per MD-Pharmacy order: i.e. weights.
18. The patient/caregiver will receive education regarding TPN.
~~18.~~**19. Document procedure in patient's record.**

B. **REFERENCES:**

1. Perry, et.al. Clinical Nursing Skills and Techniques.Mosby, Inc.: St. Louis, 2006

Review	Revised	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/97, 09/00, 06/06,08,09, **05/22**	06/03, 06/06, 08/12, 06/20	07/20, **07/22**	08/20, **0722**	09/20, **08/22**	n/a	97,03,06, 09/20

2. Gorski, et.al. Policies and Procedures for Infusion Therapy, Infusion Nurses Society, Inc., MA 2016
3. Gorski, et.al. Journal of Infusion Nursing. Infusion Therapy Standards of Practice, Infusion Nurses Society, Inc., MA 2016

Tri-City Medical Center	~~Distribution: Nursing~~ Home Health Care
PROCEDURE:	**HYPOGLYCEMIC (SYMPTOMATIC) MANAGEMENT**
Purpose:	Management Of The Adult Patient With Symptomatic Hypoglycemia
~~Supportive Data:~~	
~~Equipment:~~	
Issue Date:	07/07

A. **DEFINITION:**

1. Hypoglycemia is a term used to describe the symptomatic patient (with diabetes mellitus in the majority of cases) with a blood glucose of less than or equal to 70mg/dl obtained by either blood glucose meter or lab.

B. **DATA BASE:**

1. Subjective: Patient complains of nausea, anxiety, dizziness, shakiness.
2. Objective: decreased level of consciousness, sweating, tachycardia, slurred speech, confusion, progressing to unresponsiveness, blood glucose less than 70mg/dl.
3. Diagnosis: Hypoglycemia

C. **PLAN:**

1. Blood Glucose below 60-70
2. Cause: Too little food (CHO), too much exercise or too much insulin or Diabetes meds.
3. Onset is sudden and can cause unconsciousness.
4. The 15-15-15 Rule
   a. Give 15 Gms of CHO (carbohydrates)
   b. Wait 15 minutes and retest, if still low give additional 15 Gms of CHO
   c. (15 Gms of CHO should increase the Blood Sugar about 20-30 mg/dl)
5. Follow with a meal or snack within ½ to 1 hour
6. Patients on the pump: suspend the pump for 15 minutes
7. Treatment of symptoms:
   a. 50-70: shaky…..give 15Gm CHO
   b. 30-50: sweaty, confused…..give 30 Gm CHO
   c. Less than 30: incoherent, weak, possibly unconscious
   d. Give 45 Gm CHO ~~may need Glucogon~~

Fast acting CHO		**15 Gms**	**30 Gms**
	~~Glucose tabs~~	~~3-4~~	~~6-8~~
	Orange juice	4oz	8oz
	Regular soda	4oz	9oz
	Milk	8oz	16oz
	Life savers	5-6	10-12
	Honey	1 T	2T
	Sugar Packets	3-4	6-8

~~8. Requirement For Skilled Nurse Initiating Procedure~~

~~a. Education and training on performing blood glucose analysis with the blood glucose monitoring device. Review of policy regarding intervention.~~

~~b. Experience: The nurse must be observed correctly performing a blood glucose measurement with the blood glucose monitoring device glucometer.~~

~~c. Initial evaluation: Orientation period.~~

Home Health Care Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/07, 07,09, 08/12, 01/13	**07/22**	**07/22**	**08/22**	**n/a**	03/13

d. Ongoing evaluation: Annual blood glucose monitoring device review with return demonstration.

9. All Skilled Nurses who have fulfilled above requirements are authorized to direct and perform Hypoglycemia Management.

10.8. **The physician will be notified of blood sugar range as necessary per physician orders.**

Issued	Reviewed	Revised	Approved
	7/07, 7/09, 8/12, 1/13	9/07, 8/12, 1/13	3/13

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Health~~	~~Distribution: Clinical Staff~~
~~POLICIES:~~	~~INFLUX OF INFECTIOUS PATIENTS~~
~~Policy Number:~~	~~315~~

ISSUE DATE: 11/04

SUBJECT: Influx of Infectious Patients

REVISION DATE: 04/05, 11/07, 04/08, 02/10, 09/11, 03/13

POLICY NUMBER: 315

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/13

A. **PURPOSE:**

1. To delineate an effective response in the event of an epidemic**, pandemic,** or infectious disease process requiring possible expansion or limitations of services.

B. **POLICY:**

1. It is the policy of the Agency to prepare for the potential influx of patients due to an increase of an infectious disease process in the community.

C. **PROCESS:**

1. Admission
   a. The agency's Admission to Service policy addresses the criteria for admission of ALL patients, irrespective of diagnosis. Patients are not admitted to service unless these criteria are met.
   b. The Agency will not accept referrals when safe delivery of care cannot be guaranteed. Limitation will be placed on admissions when staffing cannot meet the demands of an increased census. Safe delivery of care involves appropriate staff ratio to patient census.
   ~~c.~~ Patients who meet the Home Health criteria are accepted on a first come, first serve basis. When an influx of infectious patients becomes apparent, the Agency will accept infectious patients up to 5% of the average daily census, if safety and staffing permit. This percentage will remain in effect if the influx is ongoing unless re-evaluation is needed and change is agreed upon by **Home Health Director, and Home Health Medical Director** ~~**and home health management team**~~**leader**~~.~~
   d. If the potential influx is noted in the media, the Infection Control Preventionist at Tri-City Healthcare District will alert Home Health **Director or designee** ~~Leadership~~ of the potential influx. Home Health staff and the Home Health Medical Director will be informed of the situation.
2. Staffing & Management
   a. When possible, staffing visits for the infectious population will be done by one Home Health team to minimize exposure.

b. Staff with similar symptoms to the infectious process will not be allowed to work and will follow the Healthcare District's policy for return to work.
c. All staff caring for the infected population will be provided with the necessary protective equipment. N95 respirators will be worn by visiting staff for airborne diseases such as TB, SARS (Coronavirus) and NORO viruses. The Agency maintains additional protective equipment that is ten (10) times greater than the monthly usage when there is an influx of infectious patients.
d. The designated Home Health team will continue care if the disease process is prolonged. Additional nurses will be assigned if necessary.

D. **EDUCATION**

1. ~~Leadership~~ **Home Health staff** is informed of national infectious trends by the Infection Control Practitioner.
2. Resources for timely information of infectious diagnosis include, but are not limited to:
   a. TCMC Infectious Disease Physician Specialist
   b. TCMC Infection Preventionist
   c. Local Public Health Department
   d. Center for Disease Control

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 01/99	**SUBJECT: Infusion Program**
REVISION DATE(S): 10/04, 4/05, 11/07, 8/08, 2/10, 01/12, 09/20	**POLICY NUMBER: 314**

Home Health Care Approval:	~~06/20~~05/22
Pharmacy and Therapeutics Approval:	~~07/20~~07/22
Medical Executive Committee Approval:	~~08/20~~07/22
Administration Approval:	~~09/20~~08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/20

A. **POLICY:**
1. It is the policy of the Agency to ensure that patients are properly assessed and screened prior to acceptance for home intravenous therapy, using a defined set of criteria. Medical and psychosocial evaluations are equally important in determining the efficacy and safety of parenteral fluid and medication administration in the home.

B. **PURPOSE:**
1. To provide Intravenous services within the parameters defined by Home Health Best Practices

C. **PROCEDURE:**
1. Tri-City Home Health will only provide infusion therapies for which appropriate procedures have been written. Services provided are also dictated by the fact that infusion therapies must be administered by an RN who has completed the educational and performance objectives for Intravenous Therapy Administration.
2. Examples of therapies that may be administered in the home by Tri-City Home Health are:
   a. Pain Management, including PCA
   b. Antibiotic Administration * (See first dose antibiotic administration criteria)
   c. Antiviral and Antifungal Therapy on a case-to-case basis, after consultation with pharmacist
   d. Hydration
   e. Total Parenteral Nutrition (TPN) Central
   f. Specified IV Push Medications
      i. Diphenhydramine hydrochloride (Benadryl)
      ii. Furosemide (Lasix)
      iii. Metoclopramide (Reglan)
      iv. Methylprednisolone (Solu-Medrol)
      v. Nalaxone (Narcan)
   g. Hydrocortisone (Solu-cortef)
3. Therapies **not** to be administered in the home by Tri-City Home Care:
   a. IV cardiac drugs
   b. IV aminophylline
   c. IV calcium
   d. IV pitocin
   e. IV cancer chemotherapy
   f. IV phenothiazine derivatives
   g. IV mercurial derivatives
   h. IV heparin drips
   i. IV insulin drip

j. IV potassium bolus
k. Any experimental medications
l. Blood or blood products to include: Whole blood, packed RBC's, saline washed RBC's, frogen-deglycerolixed RBC's, fresh frozen plasma, all types of Platelets, Granulocytes, Cryoprecipitates-factorVIII, Factor VIII concentrates, Factor 1x concentrates, Albumin, Immune Serum Globulin (IgG) nonspecific, IgG RH immune globutin (IgG anti-D) IgG hepatitis B immune globulin.

D. **ADMISSION CRITERIA**

1. General admission criteria for admission to Home Care services must be met in order to qualify for admission to, and retention in the Home Infusion Program.
2. The physician who is primarily responsible for the patient's IV fluid regimen at home has ordered appropriate fluids, evaluated the patient, and determined that IV fluids are medically necessary. He or she will also monitor and evaluate the course of therapy.
3. The infectious disease diagnosis has been established and is supported by results of cultures whenever possible.
4. The patient's medical condition is stable, and all care needs can be met at home and meet the Home Care criteria for admission. He or she has no other medical problem necessitating continued hospitalization.
5. The patient or caregiver (or both) has willingly agreed to participate in home therapy .
6. The patient and/or caregiver shall be competent, motivated, and compliant individuals who are willing to undergo training and assume responsibility for home infusion therapy
7. The patient or caregiver (or both) is capable of learning and performing all required procedures.
8. The patient's home environment is adequate for the requirements for the patient's specific IV therapy. Some medications will require freezer or refrigerator storage. Telephone access must be available.
9. The patient and or caregivers psychosocial status has been assessed and is judged to be appropriate for home therapy with regard to the following:
   a. Availability of support person or caregiver if needed.
   b. Sufficient level of motor skills (especially with regard to ambulation and manual dexterity) when required.
   c. Compliance with established policies.
   d. Functional mental status (especially with regard to long and short-term memory, absence of depression, ability to concentrate).
   e. Ability to follow written instructions.
   f. Stability and safety of home setting.
10. Eligibility for reimbursement for home infusion therapy has been assessed, and the patient or responsible party has been advised of results of the assessment and is willing to assume financial responsibility when appropriate.
11. Geographic areas need to be identified as safe for home visitation by agency personnel, prior to admission to the program.
12. The preferred time for skilled nursing visits to be made is between the hours of 7:30 to 21:00, although the patient and/or caregiver will have access to a home care registered nurse 24 hours per day.
13. Consideration for home therapy will be cancelled or not accepted if one or more of the following conditions is present:
    a. Unstable medical condition
    b. Care needs in excess of home care capabilities
    c. Psychosocial instability (poor compliance or motivation, improper home environment)
    d. Known recent or currently active IV drug abusers.
14. The first dose of antibiotic <u>may</u> need to be given in the physician's office, hospital setting or under the supervision of a physician or his/her designee, based on information received from the first dose antibiotic checklist and consultation with RN, MD and Pharmacist.

E. **ADMISSION/INITIAL HOME VISIT**

1. Clinician Taking Referral:
   a. Schedule visit time in close proximity to delivery of medication and equipment by pharmacy. Timing is to be coordinated by intake clinician and/or hospital Case Manager with pharmacy and admitting RN.
   b. It is policy that anaphylaxis kits are ordered for the home of patients receiving first dose IV antibiotics. The following is the first dose antibiotic administration and appropriate treatment for anaphylaxis:
      i. Prior to IV medication administration check the first dose antibiotic administration criteria checklist carefully. Obtain baseline nursing assessment and vital signs. Have anaphylaxis kit within reach.
      ii. During IV administration, observe for anaphylactic response. If response occurs stop the flow of the drug and call 911 immediately. Administer anaphylactic kit medications as ordered by physician. Monitor patient until the arrival of paramedics checking vital signs and patency of airway. Initiate CPR if necessary. The physician is notified when patient is stable. All interventions are documented and an unusual occurrence form submitted.
   c. All orders for IV medications and solutions must include the name of the medication solution, dosage, dilution, route, frequency of administration, and rate of infusion.
   d. Laboratory work as indicated for each medication or solution shall be ordered by the physician.
2. RN Doing Skilled Nursing Visit:
   a. Orders for IV medications and solutions, intradermal anesthesia with lidocaine 1% without epinephrine, and orders for anaphylaxis must be obtained before the RN can perform IV administration of medications and solutions.
   b. Case by case evaluation will occur to determine the type of IV line patient will need to have in place based on the medications and solutions to be administered.
   c. Medications and solutions prepared by the pharmacy should arrive in the home as expected and shall be properly labeled with the patient's name, name of drug, dosage, diluent, date of preparation, expiration date, initials of preparer, and any special instructions. Emergency medications/supplies must be replaced by the pharmacy and sent to the home as soon as possible after their use.
   d. Complete standard admission assessment and paperwork as required for all home health patients. Assess and document specific information as needed for successful home infusion.
   e. Assess the patient's/caregiver's physical ability to perform intravenous administration procedures, as necessary.
   f. Assess environment for minimal necessities to perform intravenous procedures (electrical, refrigeration, plumbing, phone).
   g. Assess the patient's and/or caregiver's ability to comprehend instruction of intravenous administration procedure. The components of education will include aseptic technique, catheter care, infusion pump set-up and use of alarms, administration of parenteral medications, metabolic complications, catheter complications, TPN and disposal of used equipment.
   h. Initiate ~~basic~~ instruction in administration of intravenous therapy in the home and document instruction provided, return demo and level of **patient and/or patient caregiver** understanding in the ~~patient~~ medical record.
   i. Develop individual patient treatment plan for administration of intravenous therapy in the home, documenting responses, interaction, patient physical status and all pertinent information including need for follow up RN visit(s) to provide additional instruction and verify patient/caregiver satisfactory return demonstration.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**10/05**	**SUBJECT:**	**Interruption Of Services**
REVISION DATE:	**10/05, 01/06, 02/07, 10/08, 10/08, 12/10, 03/11, 06/12, 02/13**	**POLICY NUMBER:**	**113**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 8/05~~
~~REVISION DATE: 1/06, 10/08, 12/10, 3/11 7/12~~
~~REVIEW DATE: 10/05, 2/07, 10/08, 3/11, 6/12~~
~~SUBJECT: INTERRUPTION OF SERVICES~~
~~POLICT NUMBER: 113~~
~~APPROVAL: 10/05, 2/07, 10/08, 3/11, 2/13~~

A. **PURPOSE**:
1. To delineate the steps taken to provide ordered services to the Home Health patient when adequate staffing is compromised *or the patient requested individual is unavailable.*

B. **POLICY**:
1. It is the policy of the Agency to provide all services ordered by the physician according to Home Health regulations.

C. **PROCEDURE**:
1. In the event that a Home Health Service such as Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Services or Certified Home Health Aide would be delayed due to clinician illness, injury or accident, the process is as follows:
2. The ~~Nursing Supervisor~~ **Clinical Manager or Rehab Supervisor** is to be informed immediately when the physician's order for any treatment, frequency or duration of treatment cannot be completed.
3. The ~~Nursing Supervisor~~ **Clinical Manager or Rehab Supervisor** will call the patient to explain the situation and offer the following options pending MD approval:
   a. Transfer the patient to another agency for all services to be provided
   b. Place the specifically delayed discipline on hold. *This will also apply when the*
      i. *Patient requested individual is unavailable and the patient does not want a replacement.*
4. The ~~Nursing Supervisor~~ **Clinical Manager or Rehab Supervisor** will call the physician and the physician will determine if his/her order can be modified to the extent not to impede the progress of the patient. If no changes can be made to the existing order, and the physician does not accept the patient request to hold the discipline, the Agency will obtain the physician's approval to transfer the patient to another Home **Health** Care Agency.
5. The ~~Nursing Supervisor~~ **Clinical Manager or Rehab Supervisor** will call the patient and advise the patient of the physician's decision regarding an altered order changing the Plan of Care, or the transfer to another agency.
6. Recording of all conversations will be documented in ~~communication~~ **coordination** notes. In the event of a changed physician order, a Supplemental Physician Order will be sent to the physician for signature.

Tri-City Home Health	Distribution: RN's	DELETE — follow Elsevier Skills Intravenous Therapy Short Peripheral Catheter Insertion and Maintenance and Dressing Change
PROCEDURE: **INTRAVENOUS THERAPY, PERIPHERAL**		

Purpose: To Outline The Nursing Management Of Home Health Adult Patients Who Have Peripheral IV, IV Therapy And Saline Locks.

Supportive Data:

Equipment: Non-sterile gloves, 2% Chlorhexidine Gluconate/Isopropyl alcohol 70% (Chloraprep), Transparent dressing, IV equipment as appropriate

ISSUE DATE:	**SUBJECT:**
REVISION DATE:	**POLICY NUMBER:**
Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**07/22**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/13**

~~**A. Assessment**~~

~~1. Assess each visit; instruct patient caregiver to check 4x/day dressing / needle / catherer / tubing stability.~~

- ~~a) Solution and additives correct + labeled~~
- ~~b) Solution is infusing at proper rate~~
- ~~c) Tubing / extensions correct~~
- ~~d) Extremity properly supported / secured~~
- ~~e) Pump properly in use~~
- ~~f) Site for redness / swelling / tenderness~~
- ~~g) Dressing / needle / catheter stability~~
- ~~h) Presence / absence redness / swelling / tenderness~~
- ~~i) Assess for patency before administering all medications~~

~~2. Assess patient each visit~~

- ~~a) Vital signs (as defined by unit performance standards of dominant protocols in use)~~
- ~~b) Skin turgor / mucous membranes for adequate hydration~~
- ~~c) Anterior / posterior chest auscultation for congestion~~
- ~~d) Edema in dependent body parts~~
- ~~e) Behavioral changes~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
	~~4/90, 3/98, 3/00, 3/05, 6/06, 8/09, 1/13~~	~~11/96, 3/98, 4/00, 7/02, 3/04, 3/05, 5/09, 9/09, 8/12, 1/13~~	

B. Standard Precautions

1. Use Standard Precaution aseptic technique in all IV activities. Ensure that all needles and sharps contaminated by blood are disposed of in puncture-resistant containers with lids, for example, hard plastic detergent containers, coffee cans, sharps container. Provide patient with drop-off centers for disposal in their area.

C. Maintenance

1. Rotate site every 3 days. Eliminate site rotation when there is limited vein access; stretch time as long as possible; observe carefully next day. (Need physician order for IV extension over 4 days).

2. If unable to rotate site after 3 days, call MD for order. Change transparent dressings every 4 days. Clean site with Chloraprep swabs at that time (if not allergic). Label dressing with date of IV insertion.

3. Restart if not patient or site symptomatic.

4. Change hydration tubing and label with date every 3 days. Try to coordinate with bottle change.
   a) Change secondary tubing every 3 days.
   b) Change intermittent tubing every 3 days.
   c) Change IV pump cassette tubing per pharmacy protocol.

5. Change solution as recommended by pharmacy and ordered by physician. Label with date, time medications added, and initial.

6. Maintain constant flow rate to insure hydration. Do not allow containers to run dry; change at last 50ml (it is not necessary to subtract this amount as most containers have this reserve).
   a) Use electronic infusion devices on all continuous medication infusions
   b) Use flow regulator on all fluid restricted patients

D. Site Care

1. Swab with Chloroprep (unless allergic) to clean site and allow to dry.

2. Insert clinically appropriate IV cath.

3. Dress with transparent dressing. Insure dressing is labeled with date.

4. Wrap site with gauze if patient confused or if patient has tendency to hit or disturb site due to needle location.

5. Support all peripheral sites, if needed, (over antecubital, joint areas) with appropriate size padded arm board. Secure tight enough to immobilize joint + cannula. Maintain hand in a functional position. Validate that tissue perfusion or IV flow is not compromised.

E. Maintaining Lines

1. Instruct patient caregiver to flush every 24 hours with 1ml heparinized saline 1:100 solution.

2. Maintain all Keep Vein Open (KVO) lines at 0.2 ml/hr to 0.4 ml/hr for hydration therapy per manufacture's recommendations, or as ordered by physician.

F. Patient / Significant Other Instructions

1. Review with patient / significant other:
   a) Purpose of IV fluids
   b) Not to manipulate equipment / IV sites
   c) To report discomfort, shortness of breath, bleeding, leakage, swelling, or malfunctioning machines

G. Complications

1. Monitor for complications at all assessment intervals and notify physician as appropriate:
   a) Observe for phlebitis (red / warm / tender site)
   b) Observe for infiltration (pain / edema)
   c) Observe for evidence of systemic infection (fever / chills)
   d) Determine under-hydration (dry mucous membrane, thirst, poor skin turgor)
   e) Determine over-hydration (pulmonary congestion, excessive output)
   f) Monitor for catheter breakage, especially if cannula is over joint or catheter inside needle device is used; inspect cannula at skin entrance site; restart immediately if bent / cracked
   g) Determine if any allergic or toxic symptoms are exhibited by the patient
   h) Determine if repeated difficulty occurs in establishing a peripheral line
   i) If anaphylaxis medication / protocol is administered to patient
   j) Extravasation with titrated meds – stop infusion
   k) Complete RL solution for anaphylaxis, catheter breakage and extravasation
   l) Notify physician for serious complication of over hydration / under hydration:

OVER-hydration
- Rales
- Periorbital edema
- Pitting edema

UNDER-hydration
- Poor skin turgor
- Dry mucous membranes
- Sunken eyeballs
- Tachycardia
- Tacypnea
- Weight loss
- No tears

H. Phlebitis

1. Change needle / catheter location if phlebitis or infiltration occurs; try to change not only veins but extremity, if possible, to give area a rest.

2. Document degree of phlebitis in Patient Care Record as follows:
- 1+ Pain at site, erythema and/or edema, NO streak formation. NO palpable cord.
- 2+ Pain at site, erythema and/or edema, streak formation. NO palpable cord.
- 3+ Pain at site, erythema and/or edema, streak formation and palpable cord.

3. Apply warm, moist heat to area of infiltration of phlebitis until signs / symptoms diminish. Do not apply heat to infiltrated sites involving "Extravasation".

I. Trouble-Shooting Slow Flow

1. If infusion slows, do the following:
    a) Check tubing for kinks.
    b) Reposition extremity.
    c) Stabilize after effective repositioning.
    d) Gently aspirate for blood / fluid.
    e) Never open flow clamps completely without controller.
    f) Never rely on repositioning entirely – if IV is not reliable, restart.

J. Documentation

1. Instruct patient / caregiver.

2. Document abnormal assessment findings.

3. Record patient IV site assessment.

K. Reference

MOSBY ON LINE 2009

Tri-City Medical Center	Home Health Care
PROCEDURE:	**KCI WOUND VAC THERAPY CLINICAL GUIDELINES**
Purpose:	For use with difficult draining wounds not responding to conventional therapy
Supportive Data:	Why are we not using Mosby's Nursing Skills for this procedure?
Equipment:	KCI Wound VAC Therapy Clinical guidelines~~, P & P 1/07~~
Issue Date:	

A. **DRESSING CHANGE**:

1. **Instruct patient or caregiver to pre-medicate** ~~Pre-medicate patient~~ as needed 60 minutes prior to dressing change.
2. May instruct c/g to stop vac pump 60 minutes prior to scheduled visit.
3. Gather supplies for dressing change:
   a. Package of correct foam in unopened package
   b. Scissors
   c. Wound cleanser spray **or Normal Saline**
   d. Skin prep (no sting)
   e. Drape
   f. Gloves and eye protector if needed
4. Perform hand hygiene and don gloves.
5. Clamp tubing and remove old dressing and dispose of in double bag system along with canister, if indicated to be changed:
   a. If there is difficulty removing drape use adhesive remover or lubricant
   b. If foam adheres to wound, saturate~~d~~ the foam with normal saline or cut tubing close to trac pad and instill normal saline into tubing to saturate foam and loosen from wound bed.
   c. **If wound** is extremely painful and foam is difficult to remove, place one layer of adaptic (no xeroform) in ~~would~~ **wound** bed prior to foam placement. Cut holes in the adaptic to allow drainage through to foam. Obtain order from MD.
6. Remove gloves, wash hands and **don** gloves.
7. Cleanse wound with wound cleanser spray or NS – clean aggressively enough to remove any loose debris.
8. Measure wound weekly using wound ~~flow sheet~~ **measurement.**
9. Apply skin barrier (No-sting~~-3M~~) to peri-wound.
10. Apply drape as barrier, if able, all around intact skin surrounding wound.
11. Cut foam to size of wound, best to use 1 piece, do not pack into wound:
    a. If using more than 1 piece all foams must be in contact with each other
    b. Drape must be on any intact skin before placing foam on skin
    c. Foam may be cut thinner for shallow wounds
    d. Fill all dead spaces with foam but do not pack tight
12. Place drape over foam in wound allowing for a 3-5cm border.
13. Cut a 1-2cm hole into the drape.
14. Apply trac pad opening directly over the hole in the drape.
15. Connect ~~dressing~~ tubing to canister and open both clamps.
16. Remove gloves and wash hands.
17. Turn on pump~~ by pressing square in upper left corner~~.
18. Default setting is 125-mmHG continuous for black foam, set 150 mmHg for white foam. (versafoam) **unless specific parameters ordered from physician.**~~.~~
19. Foam dressing should depress and surface should have an uneven surface, like a "raisin."
20. If little or no depression of foam, there may be a small air leak, attempt to find and drape over, gently press around foam with fingertips to seal.

B. **CANISTER CHANGE**:

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/14, 05/22	n/a	06/22	08/22	n/a	

1. VAC canister should be changed weekly, when alarms, or when almost full
2. Turn off pump, close clamps
3. Remove from pump and dispose by double bagging
4. Insert new canister, connect tubing and open clamps
5. Resume pump, it will default to setting. VAC pump should not be off longer than 2 hours in a 24 hour period
6. If stopping pump and disconnecting tubing for short period, cover ends of tubing with gloves, alcohol swabs or gauze

C. **TROUBLESHOOTING:**

1. Alarms
   a. Canister is full, change canister even if it doesn't look full
   b. Difficulty maintaining suction, check/listen for leaks, reinforce with drape as needed
   c. Tubing blocked, check tubing for closed clamps or kinks
   d. Caregiver and patient should be instructed and returned demonstration for trouble shooting (i.e. changing canister, reinforce drape, checking tubing) Caregiver and patient should be instructed that if the wound vac is dislodged after hours and the drainage is small-moderate, a dry dressing should be placed over the wound until a nurse can come the next day.
   e. If all of the above has been tried w/o success, the Home Care Agency or KCI should be called.

D. **DOCUMENTATION:**

1. Description of wound
2. Cleansing of wound
3. Measure **wound** first visit of week, use wound ~~flow sheet~~ **measurement**
4. Type of foam used
5. Additional dressings (adaptic)
6. Skin barrier
7. Pump setting (i.e. ~~125~~ **100** mmhg continuous)
8. **Patient's response or tolerance to wound care**

E. **DISCONTINUING VAC THERAPY:**

1. Vac therapy needs an MD order to discontinue, but KCI recommends the therapy be stopped if:
   a. There is no progress for 1-2 weeks and potential solutions have failed.
   b. Minimal change in **wound** dimensions for 1-2 consecutive weeks and patient compliance and technique are not the cause.
2. Reassess for rapid deterioration of the wound. Assess for infection, patient compliance (check hour meter for actual number of therapy hours), clean **wound** more aggressively, assess for osteomyelitis, increase frequency of dressing change to every 48 hours.
3. Reassess for changes in the wound to dark discoloration or white maceration.

F. **REFERENCES**:

1. KCI Wound V.A.C. Therapy Clinical Guidelines
2. ~~V.A.C. policy and procedure 1-07~~

~~Reviewed/revised 09 CP~~
~~S:\homecare\Procedures Home Care Current\KCI Wound VAC Therapy Clinical Guidelines.doc~~
~~8/20/12:gam~~

Tri-City Medical Center
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT: Late Entry Documentation**
REVISION DATE~~(S)~~: 05/04, 11/07, 08/08, 03/11	**POLICY NUMBER: 405**
Home Health Care Approval:	**~~06/20~~05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/20~~07/22**
Administration Approval:	**~~08/20~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**
1. To define acceptable late documentation in the medical record.

B. **POLICY:**
1. It is the policy of the Agency to accept late documentation regarding pertinent patient information when all criteria are met.

C. **PROCEDURE:**
1. A late entry for additional information regarding a patient on **the same day or** a certain date **after the original date** is acceptable with the following conditions:
   a. All late entries must be headed as "late entry" and ~~dated with date of the late entry~~.
   b. ~~The late entry~~ ~~must be~~ **must be appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.**
   ~~b.c.~~ ~~signed by the clinician making the entry.~~
   ~~c.d.~~ ~~A late entry made on the same day must include the time the late entry is made.~~
   ~~d.~~e. A ~~continuation~~ **coordination or narrative** note may be used for a late entry but must reflect the date of the original visit date.
2. A late entry or change may never be recorded on a signed physician order.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE: 06/05	**SUBJECT: Pain /Symptom Management**
REVISION DATE~~(S)~~: 11/07, 08/08, 06/11	**POLICY NUMBER: 327**

Home Health Care Approval:	**~~06/20~~05/22**
Pharmacy and Therapeutics Approval:	**~~n/a~~07/22**
Medical Executive Committee Approval:	**~~n/a~~07/22**
Administration Approval:	**~~07/20~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **PURPOSE:**

1. To delineate the expectations and process for pain and symptom management in the Home Health setting.

B. **POLICY:**

1. It is the policy of the Agency to provide patients with assistance for pain and symptom management under the direction of the patient's physician.

C. **PROCEDURE:**

1. Management of patient's pain and symptoms are based on the initial and ongoing assessment of the **clinician** ~~nurse~~. Pain is managed according to standards of practice and the patient's level of desired relief.
2. The Home Health Team collaborates with the patient's primary physician regarding treatment and expected results of pain and symptom management.
3. Pain is assessed at every home care visit and communicated to the case manager and physician when needed. Pain level assessment is considered the "fifth" vital sign. Pain management is an interdisciplinary process. The patient's pain, symptoms and control of pain are reported at the team care conference when appropriate.
4. Documentation of pain is to be done at every ~~nursing~~ **clinician** visit. Documentation would include site, intensity, frequency and methods of relief. Type of pain medication and response would also be documented.
5. It is the expectation of the Agency to improve the patient's pain to the desired level with appropriate medication and non-pharmacologic alternatives.
6. Patient Teaching will be done regarding pain management:
   a. Discuss with the patient and family possible physiological causes of pain that might be specific to patient (e.g., mass pressing on nerve, tumor obstructing bowel, etc.)
   b. Teach the patient and family some non-invasive methods which might help prevent or alleviate pain (e.g., distraction, positioning, range of motion, music, meditation, guided imagery, massage therapy, etc.) Patient's cultural, ethnic, and religious beliefs, shall be considered.
   c. Discuss with the patient and family concepts of pain and pain management (e.g., reality of pain, variability and individuality of pain perception, etc.) teaching them to include self pain assessment, with ability to rate pain on a scale from 0-10, and identify location, aggravating factors and relieving factors.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

DELETE – follow Home Care Policy: Admission to Service

ISSUE DATE:	**SUBJECT: Patient Information Flow Process**
REVISION DATE:	**POLICY NUMBER: 404**
Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 5/10/04~~ ~~SUBJECT: Patient Information Flow Process~~

~~REVISION DATE: 7/04, 5/05, 10/06, 11/10~~ ~~POLICY NUMBER: 404~~

~~REVIEW DATE: 7/05, 10/06, 3/11, 6/12~~ ~~APPROVAL: 7/04, 11/06, 7/08, 3/11, 2/13~~

~~A. PURPOSE~~

~~To define the requirements, responsibility and steps necessary to process the admission and recertification paperwork through the office.~~

~~B. POLICY~~

~~The policy of the Agency is to expedite the start of care and recertification documentation process, to allow pertinent information to be delivered in a timely manner to all clinicians and the primary physician involved in the patient's care.~~

~~C. PROCEDURE~~

~~1. All staff will enter their computer documentation/paperwork no later than 10 am of the second day after start of care. Friday admission paperwork may be submitted on Monday.~~

~~2. The paperwork will be picked up by data entry.~~

~~3. The Medical Records Clerk will:~~

~~a) Assure all required items are present with the DAR and signature page~~

~~b) Create the original medical record chart that all of the original paperwork will stay in through the whole process.~~

~~c) A copy of the face sheet and the original funding form is given to the Patient Account Representative.~~

~~d) A copy of the face sheet is sent to the Intake Office for the on-call book.~~

~~e) Make copy of medication sheet for data entry~~

~~4. The Medical Records Technician will:~~

~~a) Hold the Medical Record for corrections, by the clinician Sends out correction notice to clinician.~~

~~b) Corrections forwarded to supervisor after three (3) working days for supervisor to follow up on correction.~~

~~c) Verifies that the corrections were completed.~~

~~d) Files chart~~

~~5. The Coder will:~~

~~a) Code the Oasis diagnosis~~

b) If any other discipline evaluated and created their plan of care on the start of care date, their information will be typed into the 485

c) Forwards the medical record to Clinical Supervisor

6. The Clinical Supervisor will:

a) Review the start of care, recertification or resume documentation

b) Email the clinician of missing documentation

c) Complete 485, print and give to front office personnel for sending to physician

7. Front office personnel will:

a) Make two (2) two copies of the 485 with one copy going to medical records and one copy to the Case Manager

b) Fax the original 485 to the physician

8. The front office personnel upon the return of the signed 485 will:

a) Log the database

b) Send the signed 485 to the Medical Record Technician

9. The Medical Records Technician will:

a) Remove and shred the unsigned copy of the 485 from the medical record

b) File the signed, original 485 in the medical record.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**03/06**	**SUBJECT:**	**Patient Safety**
REVISION DATE:	**07/07, 12/08, 02/09, 05/10, 11/11, 01/12, 02/13**	**POLICY NUMBER:**	

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 3/06~~	~~SUBJECT: PATIENT SAFETY~~
~~REVISION DATE: 1/07, 6/07, 12/08, 3/10~~	~~POLICY NUMBER: 305~~
~~REVIEW DATE: 5/07, 12/08, 3/10, 11/11, 6/12~~	~~APPROVAL: 7/07, 2/09, 5/10, 1/12, 2/13~~

A. ~~POLICY~~**PURPORSE:**
1. ~~It is t~~The ~~policy of the~~ Agency **will:**
   a. ~~to~~ Recognize patient safety issues and intervene when necessary.
   b. **Identify potential safety and security risk for patients and Home Health Care agency staff.**

B. **POLICY:** ~~PROCEDURE~~
1. **Patient safety risk include but are not limited to the following:**
2. Medication **Error Reduction:**
   a. ~~:~~ A complete medication profile will be obtained at the start of care, resumption and recertification for all Home Health patients.
   b. All medications and prescriptions will be reconciled with discharge instructions for patients discharged from Tri-City Medical Center **(TCMC).**
   ~~1.~~**c.** ~~-~~For patients admitted from other venues, a current medication list will be requested, **reviewed, reconciled, and available in patient's home.**
3. **Infection Prevention and Control:**
   a. **Hand Hygiene**
      i. All staff will practice ~~the CDC guidelines for~~ hand hygiene before and after the patient visit and **when appropriate during visits per the Centers for Disease Prevention and Control (CDC)**
      ~~2.~~**ii. Education regarding hand hygiene shall be given to the patient/family**
   b. **Personal Protective Equipment**
      i. **Staff will assess and will use the appropriate personal protective equipment during visits** ~~when appropriate during the visit. Education regarding hand hygiene shall be given to the patient/family~~.
4. Communication **B**~~b~~etween ~~c~~**C**aregivers**:**
   a. **Caregivers will follow policy for** ~~will follow Joint Commission guidelines for~~ reporting **and/**or receiving critical test results, transferring care to another domain, read back of all orders from a physician or designee.
   b. All staff **will use**~~using~~ **TCMC's posted** ~~the~~ standardized list of approved abbreviations. **Standardized abbreviations** ~~will~~ enhance communication via the written word.

~~3.~~c. **All lab draws, medication administration, and treatments, patients will be identified using two identifiers~~ways. For example~~, name and date of birth. Specimen tubes and containers will be labeled in the patient's presence**

5. **Oxygen Storage and Use**

~~4.~~a. All visiting staff of the Agency will address and educate the patient and family on the safety concerns regarding oxygen use in the home including storage, signage, smoke detectors, fire extinguishers and prevention of fires in the home.

6. Fall R~~r~~isk A~~a~~ssessments

a. **A fall risk assessment** will be **completed**~~done~~ on all patients using a standardized tool. **Patients and their caregivers will be provided** ~~and~~ **education on the appropriate** actions **to implement** ~~will be~~ **to** ~~pevent~~**prevent falls for high-risk patients.**

b. **Actions to identify potential fall risk within patient's home include but are not limited to the following:**

i. **Location o~~r~~f rugs, furniture**, adequate lighting

ii. **P~~p~~atient's mobility status**

~~taken to prevent falls in high risk patients.~~

~~5. For all lab draws, medication administration, and treatments, patients will be identified using two ways. For example, name and date of birth. Specimen tubes and containers will be labeled in the patient's presence.~~

~~1. The Agency will conduct a Fatal Mode Effects Analysis (FMEA) every 18 months or sooner if patient issues become a concern.~~

~~6. The Manager of Quality and Outcomes will be an active member of the TCMC Patient Safety Committee~~

C. REFERENCES:

~~2.~~1. **The Joint Commission Home Care Accreditation Requirements E-Edition – Infection Prevention and Control (IC.01.03.01)**

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**12/98**	**SUBJECT:**	**Physician Orders**
REVISION DATE:	**07/05, 04/07, 08/08, 08/09, 05/10, 06/11, 02/13**	**POLICY NUMBER:**	**408**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**07/22**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~Tri-City Home Health~~	~~Distribution:~~
~~Policies:~~	~~UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~
~~Subject:~~	~~PHYSICIAN ORDERS~~
~~Policy Number:~~	~~403~~

~~SSUE DATE:12/98~~
~~REVISION DATE: 7/04, 1/05, 12/05, 4/07, 5/08, 5/09, 3/10, 6/13~~
~~REVIEW DATE: 1/05, 7/05, 2/06, 4/07, 5/08, 5/09 4/09, 3/10, 3/11, 6/12~~

~~SUBJECT: PHYSICIAN ORDERS~~
~~POLICY NUMBER: 403~~
~~APPROVAL: 7/19/05, 4/23/07, 8/05/08, 8/09, 5/10, 6/11, 2/13~~

A. **PURPOSE**:
1. To clarify the use and content of physician orders

B. **POLICY**:
1. It is the policy of the Agency to delineate the requirements surrounding physician orders for compliance and patient safety. **Drugs, services, and treatments are administered only as ordered by a physician, dentist, podiatrist or other licensed and legally authorized practitioner to give such order within his or her scope of practice.**

C. **DEFINITION:**
1. Telephone or Verbal Order is defined as an order communicated from the physician or licensed **and legally authorized practitioner within his or her scope of practice.** ~~to authorize personnel.~~
2. Telephone or Verbal orders are faxed or mailed to the physician for signature.
3. Standardized Procedure Order is written for medication or intervention as a result of implementation of a standardized procedure prior to physician signature.

D. **PROCEDURE**
~~1.~~ All **verbal** physician orders will be **received only by a licensed nurse or any other person lawfully authorized to receive such orders as appropriate to their specialty areas. All telephone orders will be** read back & written at the time taken from the physician and **must be documented in the patient's clinical record and signed with date and time taken.** ~~will include the written order, interventions, and goals.~~
~~2. Copies of the **signed** physician's orders will be given to Medical Records **to**for **scan**inclusion in the patient's **electronic** medical **record**file.~~

2. **When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or servicing the ordered services, in accordance with state law and the Agency's policies, must document the orders in the patient's clinical record.** ~~Physician orders will be written by those clinicians receiving the order from the physician and report the new order to the case manager.~~
3. **Copies of signed physician orders will be given to Medical Records to scan in the patient's electronic medical record.**
4. If there are multiple physicians writing orders for a patient, the primary physician who initiated the Home **Health** ~~Care~~ plan of care will be notified of the changes made in the plan of care by another physician.
5. All physician orders are to be signed and returned to the agency within thirty (30) calendar days according to State Regulations as outlined in Title 22. Physicians may not use a signature stamp but may use electronic signatures.

~~1. Any addition or change of the Plan of Care requires physician notification, subsequent order from the physician and documentation of same. If no response from the physician with in 2-3 working days, the case manager will be responsible for follow up. Examples are including but not limited to:~~

~~1. Unexpected Emergency Room visit~~
~~2. New or exacerbated symptoms including wounds, edema or vital signs~~
~~3. Medications obtained from another source i.e. another MD, herbals, etc.~~

6. ~~If changes or additions to the Plan of Care impacting the physical or psychosocial well being of the patient are required the physician will be notified immediately.~~ Any delay of physician ordered medications, treatments or other interventions, for any reason including insurance coverage or inability to pay for medications, will be reported to the physician and documented as such.
7. Orders may be written by the following clinicians:
   a. RN
   b. LVN ~~(must be co-signed by an RN)~~
   c. P.T.
   d. PTA ~~(must be co-signed by RN or PT)~~
   e. O.T.
   f. SPT
   g. LCSW, MSW
   h. MS or BS ~~(must be co-signed by MSW or LCSW)~~
   i. RD
8. To make a change in the physician who is overseeing the plan of care as a whole:
   a. An order will be taken from the current physician to change oversight of the patient plan of care to the new physician.
   b. An order with a copy of the 485 plan of care and updated plan of care orders will be sent to the new physician assuming oversight of the plan of care.

E. **MEDICATION ORDERS:**

1. Medication orders will include:
   a. Name of medication
   b. Dose
   c. Frequency
   d. Route
   e. Duration if indicated
   f. Name of physician ordering medication
   g. Name and title of clinician receiving order
   h. Exact amount of dose decrease or increase with each dosing interval for taper orders.

i. Orders in which the dose or dosing interval varies dependent on the status of the patient must be clear, defined and consistent.

j. Indication for use is included when the order is PRN

~~a. Documentation of verbal read-back when taken from a physician or designee~~

k. Incomplete, illegible or unclear faxed orders will be clarified by the case manager.

l. There is no need to send a supplemental physician order for a medication obtained by the patient via a MD visit when the primary physician' name appears on the medication bottle. However, if the ordering physician is different from the primary physician, the primary physician needs to be notified and a communication note written.

~~2. New medication profiles are required for all Start of Care, Resumptions of Care, Recertifications and at Discharge. A final medication list will be faxed to the MD.~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~12/98~~	~~1/05, 7/05, 2/06, 4/07, 5/08, 5/09, 3/10, 3/11, 6/12~~	~~7/04, 1/05, 12/05, 4/07, 5/08, 5/09, 3/10, **2/13,** 6/13~~	~~7/05, 7/07, 8/08, 8/09, 5/10, 6/11, 2/13, **7/13**~~

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~Tri-City Home Health~~
~~Distribution:~~
~~Policies: UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~
~~Subject: PLAN OF CARE~~
~~Policy Number: 402~~

ISSUE DATE: 06/04 **SUBJECT:** Plan of Care

REVISION DATE: 01/05, 04/07, 08/08, 12/08, 08/09, 05/10, 06/11, 02/13, 07/13, 08/15, 8/16, 8/17, 8/18, 8/19, 8/20 **POLICY NUMBER: 402**

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	06/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**
1. To define the process for individualized plan of care development

B. **POLICY:**
1. A written plan of treatment or plan of care shall be established for each patient whose care requires medical orders.

C. **PROCESS:**
1. A plan of treatment or plan of care for patients requiring medical orders shall be:
   a. Signed and returned within 30 calendar days by the attending physician, dentist, podiatrist or other licensed and legally authorized practitioner within his or her scope of practice. ~~The Agency cannot accept orders signed by a physician assistant or nurse practitioner under current Medicare Conditions of Participation.~~
   b. Developed in consultation with other disciplines on the team.
   c. Modified and added to only with approval of the attending physician, dentist, podiatrist or other licensed and legally authorized practitioner within his or her scope of practice.
   d. Reviewed and updated by the attending physician in consultation with the agency health professional personnel as frequently as the patient's condition warrants or at least every 60 days.
2. The plan of treatment or plan of care for patients requiring medical orders shall include, but not be limited to the following pertinent information:
   a. Diagnoses: all pertinent to the Plan of Care
   b. Types of services, **supplies**, and equipment required
   c. Statement of treatment goals
   d. Medications and treatments
   e. Prognosis
   ~~e.~~**f.** Functional limitations
   ~~f.~~**g.** Mental, **psychosocial, and cognitive** status
   ~~g.~~**h.** Activities permitted
   ~~h.~~**i.** Nutritional requirements/assessments
   ~~i.~~**j.** Rehabilitation potential

~~j.~~**k.** Any safety measures required to protect against injury to the patient
~~k.~~**l.** Proposed frequency and duration of services
~~l.~~**m.** Discharge and referral plan
~~m.~~**n.** Instructions to patient and family
~~n.~~**o.** Food or drug allergies
~~o.~~**p.** Fall and Safety Assessments
q. Risk for emergency department visit and hospital readmission, and all necessary interventions to address the underlying risk factors
r. Patient-specific interventions and education
s. Measurable outcomes and goals identified by the organization and patient
t. Patient and caregiver education and training to facilitate timely discharge
u. Advance Directives
v. Identification of the disciplines involved in providing care
w. Any other relevant items, including additions, revisions, and deletions that the home health agency, physician, or allowed practitioner may choose to include

3. The initial assessment visit will be conducted by an RN or Physical Therapist if nursing is not involved in the case. The initial assessment visit will determine the immediate care and support needs of the patient; and for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status.
4. The Admitting RN or PT will call the primary care physician and provide a brief summary of evaluation and plan of care, including frequency and duration. A narrative note will be completed in ~~HCHB~~ **medical record** to identify the MD office contracted and the name of the person the information was communicated with.
5. If after the evaluation visit, it is determined that the initial plan of treatment or plan of care for patients requiring medical orders does not meet the patient's needs, the attending physician shall be consulted to approve additions or modifications to the original plan.
6. The professional person responsible for any specific treatment shall notify the attending physician and responsible agency staff of significant changes in the patient's condition.
7. Assessments completed within 5 days of admission will have their plan of care included on the ~~485~~ **Home Health Certification and Plan of Care** to be signed by the physician.
8. All discipline services started after 5 days will be entered as an add on discipline with a signed physician order. Their initial visit will be completed with a phone call to the primary MD and their POC to include problems, interventions, and **measurable** goals and a statement continuing the original plan of care created by the admitting clinician.

~~ISSUED:~~	~~REVIEWED:~~	~~REVISED:~~	~~APPROVED:~~
~~6/04~~	~~1/05, 2/06, 4/07, 5/08, 4/09, 3/10, 3/11, 6/12, 7/15, 8/16, 8/17, 8/18, 8/19, 8/20~~	~~7/04, 4/07, 5/08, 12/08, 3/10, 7/13, 8/15~~	~~1/05, 4/07, 08/08, 12/08, 8/09, 5/10, 6/11, 2/13, 7/13, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20~~

Tri-City Medical Center	Home Health Care
PROCEDURE:	**PROCEDURE FOR USE OF THE HOME CARE VISIT BAG**
Purpose:	To prevent cross contamination in the field
Equipment:	Visit bag and its contents
Issue Date:	09/96

A. **DEFINITIONS**:

1. To prevent and control the transmission of pathogenic micro-organisms through the management and usage of the visit bag referred to as "Bag Technique". The principles of "Bag Technique" minimally include the following: Hand hygiene, bag placement, and bag placement during interim storage, cleaning the interior and exterior surfaces of the bag, maintenance of equipment and supplies stored in the bag and management of equipment and supplies removed from the bag.

B. **PROCEDURE**:

1. Select a visibly, clean dry, flat surface when possible avoiding upholstered furniture or patient's bed. Place non-wheeled visit bag on chosen surface that will give you ample space for your supplies using the disposable water-resistant surface barrier under the bag or hang it on a doorknob or on a hanger over a door.
2. When a wheeled rolling bag is used, the bag should remain on the floor. If the bag has a large front flap, it should be opened in a manner that does not permit the front flap to have direct contact with the floor.
3. The visit bag should be placed on a visibly clean, dry surface inside the vehicle during transport to and from patients.
4. To protect supplies inside the bag from contamination and for ease of access, keep hand hygiene products and supplies stored in the outer pocket of the visit bag.
5. Hand hygiene is the most important infection prevention activity when implementing "Bag Technique". Perform hand hygiene before entering the visit bag.
6. Remove items which will be needed during the visit and place them on a visibly clean, dry, flat surface.
7. Do not re-enter the visit bag without performing hand hygiene. If gloves are worn, perform hand hygiene and then re-enter the visit bag. Never go back into the visit bag with "used" gloves.
8. Close the visit bag and keep closed during the visit. If additional supplies are needed during the visit, perform hand hygiene before removing supplies from the bag and/or re-entering the bag.
9. Clean any supplies which will be placed back into clean zippered area of the visit bag with a low level disinfectant: i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipe provided by agency.
10. Clean droid/tablet with low level disinfectant" i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipes provided by agency.
11. The visit bag should not be taken into patient's home when the patient is known to be colonized or infected with a multidrug-resistant organism (e.g., Methicillin-resistant S. Aureus or C. difficile), the patient is on transmission-based precautions the patient's home is infected with bedbugs, pests or grossly contaminated with human or pet excrement and/or at the staff member's discretion.
12. When the visit bag is not brought into the patient home, the items needed for the encounter should be placed in a disposable double bag and these items should be placed on the disposable, water-resistant surface barrier in the home. The outer disposable bag should be left in the patient's home, and the equipment carried out after being cleaned and disinfected in the inner disposable bag.
13. Wipe bag when visibly soiled with a low level disinfectant: i.e.: 70% alcohol, germicidal/sani-cloth wipes. May use PDI Germicidal wipes provided by agency. Wash visit bag minimally on a monthly basis in the wash machine and dry in the dryer on high heat for a full cycle.

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/96, 8/98;7/99, 7/00, 03/04, 01/06, 03/08, 08/12, 04/19, 06/20, 05/22	n/a	07/20, 07/22	08/20, 08/22	n/a	08/20

14. All dated supplies should be checked and replaced if needed.
15. All visit bags used for Tri City Home Care will be provided by the agency.

Tri-City Health Care Distr
Oceanside, California

DELETE - do not use restraints in Home Health Care

HOME HEALTH CARE

ISSUE DATE:	**SUBJECT: Restraints**
REVISION DATE:	**POLICY NUMBER: 325**
Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~TRI-CITY Healthcare District~~
~~Oceanside, California~~
~~UNIT SPECIFIC POLICY MANUAL~~
~~HOME HEALTH~~

~~ISSUE DATE: 10/05~~	~~SUBJECT: RESTRAINTS~~
~~REVISION DATE: 1/06~~	~~POLICY NUMBER: 325~~
~~REVIEW DATE: 10/05, 9/07, 3/09, 12/11~~	~~APPROVAL: 10/05, 11/07, 5/09, 1/12~~

~~PURPOSE:~~

~~To define the position of Tri-City Home Health regarding the use of restraints for the Home Health patient.~~

~~POLICY:~~

~~It is the policy of Tri-City Home Health not to engage in the use of restraints unless ordered specifically by a physician to prevent patient injury. Efforts are made to find alternatives to using restraints whenever possible. (see attached addendum) The ultimate goal is to minimize the use of restraints and achieve a restraint free home environment.~~

~~PROCEDURE:~~

~~**CHEMICAL RESTRAINTS**~~

~~Patients requiring chemical restraints to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical condition, are not used in the homecare setting. Medications used for anxiety or agitation are not considered a chemical restraint.~~
~~Family/caregivers will be educated on safe use of these medications.~~

~~**PHYSICAL RESTRAINTS**~~

~~Physical restraints will not be used unless ordered by the physician for the safety of the patient.~~
~~The orders must be clear regarding purpose, type of restraint, criteria for release, and contributing diagnosis.~~
~~Education given to the family/caregiver will be in writing and stress the safety aspects of any physical restraint used. Restraining of a patient in the prone position may predispose the patient to suffocation and is prohibited.~~
~~In the event the caregiver used restraints without the physician's order or advice, the clinician will inform the physician and educate the caregiver in alternatives to using restraints and safe use of restraints in the home setting.~~
~~All field staff will have education and proficiency testing for competency in restraint safety.~~

ALTERNATIVES TO RESTRAINT

A. Psychosocial Alternatives

- ☐ Diversion activities such as: TV, music, books, puzzles, or folding washcloths
- ☐ Family interaction
- ☐ Frequent orientation to day, time and surroundings
- ☐ Pastoral visit
- ☐ Reassurance if anxious
- ☐ Reading
- ☐ Relaxation techniques
- ☐ One-on-one discussion
- ☐ Encourage verbalization of feelings
- ☐ Validate patient's feelings
- ☐ Respect patient's need for personal space
- ☐ Decreased stimulation
- ☐ Change in environment
- ☐ Re-establishing communication
- ☐ Setting limits
- ☐ Use de-escalation and verbal redirection techniques
- ☐ Increase supervision, don't leave patient alone.

B. Environmental Alternatives

- ☐ Commode at bedside
- ☐ Decreased noise and stimulation
- ☐ Soft Music
- ☐ Night light
- ☐ Place personal items within reach
- ☐ Keep bed in low position
- ☐ Sensory aids available (glasses, hearing aid)
- ☐ Use of intercom or baby monitors
- ☐ Providing small safe quiet area
- ☐ Physical activity
- ☐ Install electronic alarms, signals which alert caregiver of doors opening

C. Physiological Alternatives

- ☐ Frequent Toileting
- ☐ Address hygiene needs and comfort measures
- ☐ Fluids/nutrition/snack
- ☐ Re-positioning and Positional devices
- ☐ Pain intervention
- ☐ Assisted ambulation
- ☐ Rest/sleep
- ☐ Additional warmth
- ☐ Room temperature at comfort level
- ☐ Medication Evaluation
- ☐ Check lab values

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT: Resumption of Care**
REVISION DATE: 07/05, 02/08, 01/12	**POLICY NUMBER: 308**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**07/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/12**

~~ISSUE DATE: 5/10/04~~	~~SUBJECT: Resumption of Care~~
~~REVISION DATE: 6/05, 1/08~~	~~POLICY NUMBER: 308~~
~~REVIEW DATE: 7/05, 1/08, 11/11~~	~~APPROVAL: 7/05, 2/08, 1/12~~

A. **PURPOSE**:
1. To define the requirements, responsibility and steps necessary for resumption of care for patients

B. **POLICY**:
1. The policy of the agency is for all Home Health patients who are hospitalized or in a Skilled Nursing Facility greater than 24 hours to be resumed with Home Health ~~if the Physician gives an order.~~ **The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status but not less frequently than within 48 hours of the patient's return to home if the Physician gives an order.**

C. **PROCEDURE**:
1. A physician's order to resume the patient must be obtained prior to the **update of the** comprehensive assessment being performed.
2. The assessment and resumption of care orders will be completed within 24-48 hours of receiving the physician order to resume.
3. Each discipline will complete their assessment and physician order when multiple disciplines are ordered for resumption of care.
4. Medications, doses and frequency are addressed for each resumption of care. A new medication **profile** ~~sheet~~ is created and **entered into** ~~copies are distributed to~~ the patient**'s** ~~and the~~ medical record **and a written copy left in the home with the patient.**
5. For patients resumed to Home Health during the last 5 days of the certification period and are to be recertified, ~~follow~~ **complete** the following **documentation** ~~information~~:
   a. Medicare/Medi-Cal patients:
      i. Complete the Resumption of Care (ROC) OASIS
      ii. Complete all documentation required for recertification
      iii. Complete a Recertification order
   b. Non-Medicare/Medi-Cal patients:
      i. Complete the Routine Visit (non-OASIS)
      ii. Complete all documentation required for recertification
      iii. Complete a Recertification **order**
      ~~iv. Resumption of status report~~

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE: 05/04	**SUBJECT:** Significant Change in Condition (SCIC) & Revision of the Plan of Care
REVISION DATE: 05/04, 07/12, 02/13	**POLICY NUMBER:** 308

Home Health Care Approval:	05/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	07/22
Administration Approval:	08/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/13

~~ISSUE DATE: 5/10/04~~
~~REVISION DATE: 6/12~~
~~REVIEW DATE: 7/12~~
~~SUBJECT: Significant Change in Condition (SCIC)~~
~~POLICY NUMBER: 308~~
~~APPROVAL: 5/04, 2/13~~

A. **PURPOSE**:

1. To identify when a significant change in condition (SCIC) occurs **and revision of the plan of care is needed for a** ~~in the Medicare/Medi-Cal~~ Home **Health** Care patient and to describe the appropriate documentation and follow up.

B. **POLICY**:

1. It is the Agency policy for the disciplines involved in the care of a ~~Medicare/Medi-Cal~~ patient to appropriately identify when there is a significant change in condition and follow the established procedures.

C. **PROCEDURE**:

1. All significant changes in **a patient's** condition **or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered** are reported **promptly** to the ~~primary~~ **relevant** physician**(s), dentist, podiatrist or other health professionals and responsible agency staff** ~~and the case manager~~.
2. The significant change in the patient's condition will be recorded on the clinicians visit note the day the staff member observes the change.
3. ~~3.~~ **The comprehensive assessment must be updated and revised (including administration of the OASIS) as frequently as the patient's condition warrants. A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the Agency and patient in the plan of care.** ~~OASIS follow-up (SCIC) requires all three of the following criteria~~:
   - ~~**The last 5 days of every 60 days beginning with the start-of-care date, unless the following occurs:**~~
     - ~~**Beneficiary elected transfer;**~~
     - ~~**Significant change in condition; or**~~
     - ~~**Discharge and return to the same HHA during the 60-day episode.**~~
   - ~~i. The patient significantly improves/declines in condition.~~
   - ~~b. There is no anticipation of change in condition at the start of care.~~
   - ~~c. The significant change of condition necessitates a signed physician's order that changes the plan of care.~~

4. **Revisions to the plan of care must be communicated as follows:**
   a. **Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the patient plan of care.**
   ~~4.~~b. **Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the patient plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the agency (if any).**~~Significant changes in condition will require completion of a follow-up OASIS when the condition change occurs in the home and the patient is not hospitalized.~~

~~5. Hospitalized patients who return to Home Care and are readmitted during the sixty day episode will have the resumption of care OASIS completed, rather than a follow-up OASIS. If the hospitalized patient returns to Home Care within the 56-60 day of the certification period, the resumption of care OASIS and the recertification OASIS must both be completed. If the patient is hospitalized and not readmitted as a Home Care patient until after the end of the sixty day episode, admit the patient as a new patient with a new start of care OASIS completed. The prior episode chart will close by completion of the discharge summary.~~

~~6. Examples of situations requiring a SCIC OASIS include, but are not limited to the following:~~

~~a. Addition of another discipline in the case due to a decline in the patient's condition.~~

~~b. Significant functional decline after admission that require the addition of a Home Health Aide~~

~~c. Unanticipated significant functional improvement in a patient.~~

~~7. Examples of situations not requiring a SCIC OASIS include, but are not limited to the following:~~

~~a. The patient anticipated to improve at the start of care and does so.~~

~~b. The patient anticipated to have potential to decline at the start of care and then does so.~~

~~c. The patient whose condition changes but the physician changes no orders.~~

Tri-City Health Care District	Home H

DELETE — follow Home Care Policy: Medication Management and Elsevier Skill: Continuous and Intermittent Subcutaneous Infusion

PROCEDURE:	SUBCUTANEOUS CATHETERS
Purpose:	Subcutaneous access is utilized to adminis small volume infusion into the subcutaneou through both adipose and connective tissue.
Equipment:	General Supplies • Gloves • Alcohol prep pads • Sharps container • Syringe Site Dressing • Gauze • Transparent semipermeable membrane (TSM) • Tape Subcutaneous Infusion Equipment • Subcutaneous needle 25-27 gauge, ½ inch • 10% providone-iodine swabs • Subcutaneous access infusion kit • Extension tubing, if necessary • Prefilled medication container or cassette • Infusion pump
Issue Date:	03/04

A. **SUBCUTANEOUS CATHETERS:**

1. Patient Assessment and Education
a. Verify patient's identity.
b. Obtain and verify physician's order.
c. Provide patient/ CG with educational material/information regarding procedure.
d. Obtain patient's consent.
e. Assess patient.
f. Place patient in reclining position.
2. Prior to Beginning Procedure
a. Wash hands.
b. Don mask and gloves.
c. Use aseptic technique and observe Standard Precautions throughout procedure.
3. Insertion Site and Device Selection
a. Select insertion site with adequate subcutaneous tissue: a fat fold of at lease 1 inch (2.5 cm) when thumb and forefinger are pinched together. Site selection is also based on patient's anticipated mobility and comfort. Sites may include:
i. Supraclavicular area
ii. Anterior chest wall
iii. Lower abdomen
iv. Outer aspects of the arms and thigh
b. Avoid areas that are:
i. Scarred
ii. Infected
iii. Irritated
iv. Edematous
v. Bony
vi. Highly vascularized

Review	Revision	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 07/12, **05/22**	08/12, 06/20	07/20, **07/22**	08/20, **07/22**	09/20, **08/22**	n/a	03/04, 09/20

vii. Near the waistline
c. Select access device with a 25-27 gauge, ½ inch steel needle or catheter.
4. Insertion Site Preparation
a. Wash insertion site with antiseptic soap and water if necessary.
b. Remove excess hair from insertion site via clipping if necessary.
c. Disinfect insertion site (see Chapter 5, Policy on Site disinfection). Chlorprep.
5. Device Placement and Therapy Initiation
a. Follow manufacturer's guidelines for access device placement.
b. Inspect access device for defects.
6. For Continuous Subcutaneous Infusion:
a. Prepare equipment and medication to be administered.
b. Lift skin up into small mound between thumb and index finger.
c. Insert primed subcutaneous infusion system with attached access device into the skin.
d. Stabilize access device.
e. Secure connection junctions.
f. Dress access site using transparent dressing to allow for site observation and palpation.
g. Initiate therapy.
7. For Subcutaneous Injection:
a. Use syringe with 25-27 gauge, ½ inch disposable needle containing medication to be administered.
b. Grasp skin firmly to elevate subcutaneous tissue.
c. Position needle bevel up and insert at a 90 degree angle.
d. Release grasp on skin once needle is inserted.
e. Pull back slightly on the plunger to aspirate; if blood appears, withdraw needle. Prepare second access site and repeat procedure.
f. Slowly inject medication. (Note: Only medications recommended for subcutaneous administration may be given.)
g. After injection is complete, gently but rapidly remove access device and discard in appropriate container.
h. Apply pressure to injection site and dress with sterile gauze.
8. Site Care and Maintenance
a. Inspect access site and equipment:
i. Observe site for bleeding, bruising, inflammation, drainage, edema, or cellulites
ii. Monitor patient for complaints regarding burning or itching at site
iii. Observe old sites for signs of irritation or infection
b. Change administration set immediately upon suspected contamination; otherwise, change administration set, including add-on devices and tubing, every 3-5 days as long as a closed system is maintained.
c. Change access site dressing immediately upon suspected contamination; otherwise, change transparent semipermeable membrane (TSM) dressing every 3-5 days during site rotation.
d. Rotate access site every 3-5 days. Select new site at least 1 inch from previous site, preferably dependent on patient comfort.
9. Post-Insertion
a. Do not flush subcutaneous access device.
b. Discard used equipment and supplies.
c. Remove gloves.
d. Wash hands.
e. Document in patient's medical record.

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**01/05**	**SUBJECT:**	**Transfers**
REVISION DATE:	**07/05, 02/08, 09/09, 11/11, 01/12**	**POLICY NUMBER:**	**316**
Home Health Care Approval:		**05/22**	
Pharmacy and Therapeutics Approval:		**n/a**	
Medical Executive Committee Approval:		**06/22**	
Administration Approval:		**08/22**	
Professional Affairs Committee Approval:		**n/a**	
Board of Directors Approval:		**01/12**	

~~ISSUE DATE: 1/05~~	~~SUBJECT: TRANSFERS~~
~~REVISION DATE: 7/05, 1/08, 9/09, 7/12~~	~~POLICY NUMBER: 316~~
~~REVIEW DATE: 4/05, 1/08, 9/09, 11/11~~	~~APPROVAL: 7/05, 2/08, 1/12~~

A. **PURPOSE**:
1. To delineate the policy and procedure for informing ~~patient~~ **of** transfer to ~~a health facility~~ another health care provider.

B. **POLICY**:
1. It is the policy of the Agency to provide pertinent patient information upon transfer ~~or admit~~ of a patient to another **health care provider** ~~medical facility~~. Other ~~medical facilities~~ may include hospitals, skilled nursing facilities or inpatient rehabilitation. **the patient and representative (if any),**
2. **Transfer from the agency may occur for the following reasons:**
   a. **The transfer is necessary for the patient's welfare because the Agency and the physician who is responsible for the home health plan of care agree that the Agency can no longer meet the patient's needs, based on the patient's acuity. The Agency must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the Agency's capabilities;**
   b. **The patient or payer will no longer pay for the services provided by the Agency;**
   c. **The physician who is responsible for the home health plan of care and the Agency agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the Agency and the physician who is responsible for the home health plan of care agree that the patient no longer needs the Agency's services;**
   d. **The patient refuses services, or elects to be transferred;**

C. **PROCEDURE**:
1. When the discipline managing the case becomes aware of the need for transfer or, a transfer has already occurred, the process is:
~~2. Patients experiencing hospitalization or other medical facilities for less than 24 hours are not considered transferred and no documentation is required.~~
~~3.~~**2.** Coordinate with MD if necessary preceding transfer.
   a. Notify MD if transfer has already occurred.
   b. The clinician will obtain an order from the MD to place the patient on hold for Home Health.
   c. The clinician will complete the OASIS Transfer Summary.

d. The Transfer Summary, medication profile and pertinent information will be forwarded to the receiving organization.
e. The clinician will notify all disciplines involved on the case of the patient transfer.
f. The ~~facility~~ **health care provider** the patient has been transferred to~~, or received from,~~ will be informed of any infections requiring care or special precautions.

Tri-City Medical Center	Home **Health** Care
PROCEDURE:	**UNNA BOOT APPLICATION**
Purpose:	For patients with chronic eczema and dermatitis requiring moderate compression for the treatment of venous insufficiency and/or venous leg ulcers.
Equipment:	Unna Boot wrap Gauze wrap Clean gloves Normal saline or wound cleaner Cast padding if needed Dressing supplies if needed
Issue Date:	2004

A. **DEFINITIONS:**

1. Unna Boot-an inelastic compression wrap impregnated with zinc oxide covered by gauze. Provides low compression therapy when ambulating.

B. **POLICY**

1. A physician order is required for an Unna boot application.
2. Patient must be assessed by the physician to rule out arterial disease prior to application of the Unna Boot.
3. Protect very thin legs/bony prominences from pressure by adding additional padding.
4. Promptly remove the wrap and notify the physician if the patient develops pain or pale, cool or numb tows and foot, or signs and symptoms of heart failure.
5. Discontinue if redness, itching or deterioration of the wound occurs and notify the physician.
6. Do not use for patients:
   a. With known sensitivity or allergy to zinc or other ingredients in bandage.
   b. With known active heart failure.
   c. In the presence of untreated lower limb skin or wound infection.

C. **PROCEDURE**:

1. **Perform hand hygiene.** Apply gloves and clean the wound with normal saline or wound cleanser.
2. Position the patient's leg in a slightly flexed position, with toes pulled toward shin.
3. Start at the base of the toes, using no tension and an overlap of 50%, loosely wrap the bandage around the foot, heel and ankle all the way up just below the knee using a spiraling method. Ensure that all areas are covered. Do not spiral back downward
4. If needed, wrap the foot and leg with cast padding in a loose spiral; ensuring that all bony prominences are protected.
5. Wrap with gauze and secure with tape.
6. If needed, apply a non-compression type stocking for further securement of the boot.
7. The Una boot may be changed 1-2 times a week or per MD order.
   a. If slippage occurs it may be changed sooner.
8. Instruct patient to remove the wrap and notify the agency if the following occur:
   a. Shortness of breath.
   b. Wrap slippage.
   c. Pain, numbness, tingling, **unable to move toes,** discoloration or swelling of toes.

D. **REFERENCES:**

1. British Columbia Provincial Nursing Skin & Wound Committee (2016). *Guideline: Application of Compression Therapy to Manage Venous Insufficiency and Mixed Venous/Arterial Insufficiency.*

Department Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/06, 02/20, **05/22**	n/a	04/20, **06/22**	05/20, **08/22**	n/a	05/20

Tri-City Health Care District
Oceanside, California

~~UNIT SPECIFIC POLICY MANUAL~~
HOME HEALTH CARE

ISSUE DATE:	**05/04**	**SUBJECT:**	**Wound Assessment**
REVISION DATE:	**05/04, 04/07, 10/08, 01/12, 02/13**	**POLICY NUMBER:**	**312**

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 5/04~~	~~SUBJECT: Wound Assessment~~
~~REVISION DATE: 4/07, 8/08~~	~~POLICY NUMBER: 312~~
~~REVIEW DATE: 4/07, 8/08, 11/11, 6/12~~	~~APPROVAL: 5/04, 4/07, 10/08, 1/12, 2/13~~

A. **PURPOSE**:
1. To define the Agency standards regarding wound assessment and documentation.

B. **POLICY**:
1. It is the policy of the Agency to comprehensively assess and document all wounds in a consistent manner.

C. **PROCEDURE**:
1. All wounds are measured at the start of care and every week, **preferably the first visit of the week,** until resolution of the wound is complete. Measurement is also done when there is any significant change in size. All wound measurements and treatments are to be documented on the ~~"Wound Care Flow Sheet."~~ **Wound Record Summary**. Cellulitis and rashes are also measured weekly and changes reported to the MD.
2. Wounds, cellulitis and rashes should be assessed every visit. Assessment includes but is not limited to:
   a. etiology of wound, factors that prevent healing, location, size, color, drainage color, odor and amount, and presence of granulation~~. As an adjunct to a narrative description, photographs should be taken at start of care to ensure that a wound is accurately described. Photographs are also useful for documenting a wound's status before and after debridement or if there has been a significant change.~~
3. Consideration of factors that prevent healing such as poor hygiene, incontinence, positioning and nutritional status are to be included in a complete wound assessment.
4. Any unexpected changes, such as size, color, increase of drainage, peri-wound redness, irritation, disruption of prior intact skin or new changes in the environment that effect promotion of healing shall be reported to the physician and case manager on the day the change is noted. All information shall be documented **in the patient's medical record** on the day change is identified.
5. Wound Care orders are closely followed and the type of irrigation, wound care products and secondary dressings used during the dressing change are documented appropriately. A ~~good~~ **detailed** description of the dressing change assists in the treatment of the wound. If the wound is not healing **according to plan of care goals,** the physician needs to be called for possible new treatment orders or a change in the plan of care.
6. Wounds that are manageable by a competent caregiver will be monitored with documentation weekly or appropriate visitation for the type, size and severity of the wound following

documented education of the caregiver. A return demonstration of wound care taught to the caregiver and verification of the timeliness the wound care being given as directed and is documented in the ~~clinical note~~ **patient's medical record**.

7. An annual wound care skills lab is ~~developed by the Clinical Educator~~ **conducted** and attendance is mandatory for all nursing staff. There are also ongoing wound care in-services and educational opportunities offered throughout the year.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/88**	**SUBJECT:**	**Computer Downtime/Printer Malfunction**
REVISION DATE(S):	**01/91, 01/94, 07/97, 10/99, 01/03, 12/03, 01/06, 09/08, 01/09, 03/12, 05/12**		

Department Approval:	**~~12/15~~08/22**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval;	**08/22**
Professional Affairs Committee Approval:	**~~01/18~~ n/a**
Board of Directors Approval:	**01/18**

A. **POLICY:**

1. Occupational therapy, Physical Therapy and Speech- Language Pathology is accountable through the Leadership Structure of Rehabilitation Services to follow Patient Care Services Policy: Cerner Downtime. When the computer system is unavailable for use, therapy orders will be faxed or telephoned to the department by the Unit Secretary/appropriate hospital staff responsible for transcribing physician orders.

B. **PROCEDURE:**

1. All therapy orders must be initiated via a physician's order and be faxed (x4007) or telephoned (x7272) to the Rehabilitation Services Department by the appropriate hospital staff.
2. Department personnel will check the fax server or answer the phone calls and record the order and relay order to the appropriate therapist.
3. When computer/printer is functioning properly, the ordering department personnel will input any received orders into the current computer system. The Rehabilitation Services assigned staff will verify orders received with the orders already recorded.
4. In the event of downtime for the current computer billing system, Rehabilitation Services staff will bill when the system is operational to update billing for past services.

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

1. Patient Care Services Policy: Cerner Downtime

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**09/15**	**SUBJECT:**	**Mission Statement, Goals and Objectives**

REVISION DATE(S): 09/15

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/18~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/18**

A. **POLICY:**

1. Tri-City Healthcare District Rehabilitation Services is dedicated to providing comprehensive, individualized and high quality healthcare to maximize the function and quality of life for all patients and members of our community.
2. Goals and Objectives:
   a. To render high quality rehabilitation services to assist each patient in reaching their maximum potential so they may assume their rightful place in society, while learning to live within the limits of their capabilities.
   b. To alleviate pain, restore function, and improve quality of life by using accepted and current techniques & approaches in physical, occupational, speech, audiology and therapeutic recreation. These include tests, measurements, procedures, modalities, treatment programs, and wellness education. Caregivers and family members are integrated into the treatment programs whenever possible. Therapeutic equipment is provided as appropriate.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 7/91 **SUBJECT: Service Locations**

REVISION DATE(S): 01/94, 04/97, 10/00, 01/09, 03/12, 09/15

Rehabilitation Services Department Approval:	10/18
Department of Medicine Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	12/18
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. **POLICY:**

1. This Policy / Procedure applies to the following Rehabilitation Services' locations:
   a. Rehabilitation Services is located in 1 North wing of Tri-City Medical Center.
   b. ~~Outpatient Rehabilitation Services is located at 2124 El Camino Real Suite 100~~**Tri-City Medical Center OP Rehab 4002 Vista Way**, Oceanside, CA ~~92054~~**92056**.
   c. Tri-City Wellness Center is located at 6250 El Camino Real, Carlsbad, CA 92009.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 01/09	**SUBJECT:** Rehabilitation Dress and Appearance Policy
	~~POLICY NUMBER: 1710~~
REVISION DATE~~(S)~~: 05/12	
Department Approval:	08/2207/15
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	08/22
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **POLICY:**

1. Occupational therapy, Physical Therapy and Speech-Language Pathology is accountable through the Leadership Structure of Rehabilitation Services to demonstrate professionalism, competency and respect by adhering to the mandated dress code as per Administrative Policy: Dress and Appearance Philosophy Policy 415.

B. **PROCEDURE:**

1. Employee Attire:
   a. The department manager and/or designee will review the dress code with new staff.
2. Employees are required to wear the designated department uniform.
   a. Black scrub top, preferably with Tri-City Medical Center Rehabilitation Services logo.
   b. Solid earth toned scrub bottoms, slacks, or dress pants only (i.e. khaki, grey, muted green, black).
3. Staff providing treatment in pool will wear:
   a. Conservative one (1) piece bathing suit with or without shorts/neat T-shirt
   b. When out of pool between treatments or when off duty, staff will wear cover-ups for brief trips out of pool area, but when not providing treatment in pool, must adhere to department dress code.

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

1. Administrative Policy: Dress and Appearance Philosophy 415

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/88**	**SUBJECT:**	**Staff Rotations**
REVISION DATE~~(S)~~:	**01/91, 11/94, 05/97, 01/00, 01/06 01/09, 04/12, 09/15**	**~~POLICY NUMBER:~~**	**~~615~~**

Department Approval:	**~~03/18~~08/22**
Department of Medicine Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~05/18~~ n/a**
Board of Directors Approval:	**05/18**

A. **POLICY:**

1. Occupational Therapy, Physical Therapy and Speech Language Pathology is accountable through Leadership Structure of Rehabilitation Services to promote a varied clinical experience, through the change in their primary work area, while maintaining a system of continuity of care in each work area.

B. **PROCEDURE:**

1. A minimum of one therapy staff member will be the primary therapy provider in each designated area which includes but is not limited to:
   a. Outpatient services
      i. Orthopedics
      ii. Neurologic
      iii. Lymphedema
      iv. Hands
      v. Aquatics
      vi. Swallow Studies
      vii. Pediatrics
      viii. Other Specialties based on current practice
   b. Inpatient services
      i. Medical/Surgical
      ii. Acute Rehabilitation
      iii. Orthopedics
2. Upon request, the staff may be given the option of rotating to another primary work area, or as deemed appropriate by the Leadership Structure of Rehabilitation Services.
3. Rotations will proceed with the following considerations:
   a. Each area must maintain a minimum of one staff member or as indicated based on patient care needs
   b. Staff will orient to the work area
   c. Staff will be notified of upcoming rotations as appropriate/applicable

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**6/88**	**SUBJECT:**	**Statement of Accountability**
REVISION DATE~~(S)~~:	**01/94, 04/97, 10/99, 10/00, 02/03, 01/09, 11/09, 03/12, 09/15**		

Rehabilitation Department Approval:	**~~05/18~~08/22**
Department of Medicine Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~10/18~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**11/18**

A. **POLICY:**

1. The Director of Rehabilitation Services is responsible to the Senior Director and the Rehabilitation Services Staff for the overall direction and supervision of the department and the administrative direction of Rehabilitation Services.
2. In the event of the absence of the Director, an appropriate designee will be assigned, which may include the Senior Director, a therapy supervisor, a vice president, a supervisor of another department, or other designee.

Tri-City Medical Center
Oceanside, California

Women and Newborn Services (WNS)

ISSUE DATE: 06/14 SUBJECT: Elective Delivery Under 39 Weeks

REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	05/22~~12/16~~
Department of OB/GYN Approval ~~Date(s)~~:	~~02/17~~06/22
Department of Pediatrics Approval ~~Date(s)~~:	n/a
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	~~03/17~~06/22
Administration Approval:	08/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~04/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	04/17

A. **PURPOSE:**

1. The purpose of this policy is to eliminate non-medically indicated ~~(elective)~~ deliveries prior to 39 weeks Estimated Gestational Age (EGA).

B. **POLICY:**

~~1. Non-medically elective Cesarean Section (C-Section) or induction of labor prior to 39 weeks EGA requires approval of the Obstetrics and Gynecology Department Chairperson or Designee.~~

~~2. Amniocentesis and documentation of fetal lung maturity is NOT an indication to deliver a less than 39 week EGA pregnancy.~~

1. Medical ~~and/or obstetric~~ indications that **indicate** ~~may require~~ delivery before 39 weeks ~~, via C-Section or induction which DO NOT require approval from the OB/GYN Department Chair or designee~~ include **but are not limited to:**

- **Abruption**
- **Antiphospholipid Syndrome**
- **Cardiovascular Disorders**
- **Cholestasis**
- **Diabetes (type 1 or 2)**
- **Fetal CNS Malformation**
- **Fetal Chromosomal Abnormality**
- **Fetal Demise (current or prior)**
- **Fetal Distress**
- **Fetal Malformation**
- **Fetal-Maternal Hemorrhage**
- **Gestational Diabetes (uncontrolled with insulin)**
- **HIV Infection**
- **Hypertensive Disorders of Pregnancy**
- **Isoimmunization**
- **IUGR**
- **Multiple Gestation**
- **Oligohydramnios**
- **Placenta Previa**
- **PROM**
- **Polyhydramnios**
- **Renal Disease**
- **Other (Perinatology Recommends Delivery)**

2. **The following indications do not meet criteria as medical indications for delivery prior to 39 weeks EGA:**

- **Suspected Macrosomia**
- **History of fast labors**
- **Advanced cervical dilation**
- **Previous maternal pelvic floor injury**
- **Partner leaving town**
- **Family in town**
- **Maternal exhaustion**
- **Lives far away**

a. **Suspected Macrosomia: cases where cesarean delivery is offered in order to avoid birth trauma should be limited to an ultrasound estimation of fetal weight of 5,000 grams, or 4,500 grams for diabetic women.**

~~3.~~

~~Medical and Obstetric Indications~~	
☐ ~~Abruption~~ ☐ ~~Coagulation Defects (Antiphospholipid Syndrome)~~ ☐ ~~Fetal Demise (Current)~~ ☐ ~~Fetal Distress/Abnormal FHR~~ ☐ ~~Fetal CNS Malformation or Chromosomal Abnormality, Suspected Damage to Fetus from Viral or other Diseases in Mother,, Drugs, Radiation~~ ☐ ~~Gestational Hypertension~~ ☐ ~~HIV Infection~~ ☐ ~~Isoimmunization/Fetal-Maternal Hemorrhage~~ ☐ ~~Multiple Gestation~~ ☐ ~~Placenta Previa~~ ☐ ~~Post Dates~~ ☐ ~~Unstable Lie~~	☐ ~~Chronic Hypertension~~ ☐ ~~Cardiovascular Disorders/Diseases~~ ☐ ~~Diabetes (Type I or II)~~ ☐ ~~Fetal Demise (Prior)~~ ☐ ~~Gestational Diabetes (GDM with Insulin)~~ ☐ ~~Heart Disease~~ ☐ ~~IUGR~~ ☐ ~~Liver Disease (Cholestasis of Pregnancy)~~ ☐ ~~Oligohydramnios~~ ☐ ~~Polyhydramnios~~ ☐ ~~Preeclampsia~~ ☐ ~~PROM~~ ☐ ~~Renal Disease~~ ☐ ~~Other _____ (Perinatology Consult Obtained/Agrees with Plan. Name: _____)~~

C. **PROCEDURE:**

1. Confirmation of Gestational Age: Gestational age needs to be confirmed using one of the American College of Obstetrics & Gynecology (ACOG) criteria:

   a. An ultrasound measurement at less than 20 weeks of gestation that supports an EGA of 39 weeks or greater.
   b. Fetal heart tones that have been documented as present for 30 weeks by Doppler ultrasonography.
   c. It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.
   d. ~~NOTE:~~ If the patient does not meet ACOG's criteria for confirmation of EGA, an amniocentesis to confirm lung maturity should be discussed.

2. Scheduling an Induction: When a provider or designee contacts the L&D charge nurse, these items will be provided:
   a. Woman's name, **date of birth and phone number** ~~and other patient identifiers, as necessary~~.
   b. Woman's due date, ~~and her~~ EGA at the time of the scheduled procedure and indication for the procedure ~~(induction or C-Section reason)~~.
   c. If the patient's EGA is greater than >39 weeks, the procedure is scheduled.
   d. If the patient's EGA is less than <39 weeks, the pre-screening form for induction and C-Section shall be **utilized.** ~~completed.~~
      i. The L&D charge nurse compares the indications to the pre-determined/approved list of medical and obstetric reasons for C-Section and induction. If the indication is on the list, the procedure is "medically indicated" and scheduled.
      ii. If the indication provided DOES NOT appear on the approved list, the L&D charge nurse will inform the provider/designee and offer an alternate date selection.
      ~~iii. If the provider continues to request that the non-medically indicated procedure be scheduled prior to 39 weeks, the L&D charge nurse will inform the provider that documented approval from the OB/GYN department chair or designee is required.~~

~~3. Scheduling a C-Section: When a provider or designee contacts the surgery scheduler, information is obtained based on the pre-operative questionnaire.~~

~~a. If the patient's EGA is greater than >39 weeks, the C-Section is scheduled.~~
~~b. If a patient's EGA is less than <39 weeks at the time of the desired surgery date, the surgery scheduler will contact the L&D charge nurse to complete and review the pre-screening request form for induction/C-Section BEFORE the surgery is scheduled.~~
~~i. The L&D charge nurse compares the indications to the pre-determined/approved list and if medically indicated, will notify the OR scheduler to schedule the C-Section.~~
~~ii. If the indication provided DOES NOT appear on the approved list, the L&D charge nurse will inform the OR scheduler the procedure CANNOT be scheduled and physician notification required.~~
~~iii. If the physician continues to request that the non-medically indicated procedure be scheduled, the OR scheduler will inform the provider that documented approval from the OB/GYN department chair or designee is required.~~

~~4.~~**3.** Informed Consent: Any woman with a scheduled ~~non-medically indicated (elective)~~ procedure (either by C-Section or induction) prior to 39 weeks EGA, will have an informed consent discussion documented in the medical record.

a. The informed consent will include **the** ~~the usual~~ discussion of risks and benefits of induction of labor/C-Section and also include a discussion of the risks to the baby being born ~~electively,prior~~**prior** to 39 weeks.

D. **FORM(S):**

1. Pre-Screening Form for Induction and (C-Section) Requests - Sample

E. **REFERENCES:**

1. ACOG, (201~~0~~9). Induction of Labor. American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 107. Obstetrics and Gynecology, 114(2), pp. 386-97.
2. Elimination of Non-Medically Indicated (Elective) Deliveries before 39 Weeks Gestational Age. www.marchofdimes.com, CMQCC.org.
~~2.~~**3. Smith H, Peterson N, Lagrew D, Main E. 2016. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative.**

Tri-City Medical Center ADVANCE

PRE-SCREENING FORM FOR INDUCTION AND CESAREAN SECTION (C-Section) REQUESTS
Call TCMC Labor & Delivery to Schedule (Induction/ C-Section): 760-940-7453
~~Call TCMC Surgery Scheduler to Schedule (C-Section): 760-940-3888~~

PATIENT/PROVIDER INFORMATION
Name: _____ Date of Birth: _____ Phone Number: _____

G/P_____ OB Provider: _____

Type of Procedure Planned: ☐ Induction ☐ C-Section Desired Date/ Time: _____

EDC: _____ Gestational Age at Date of Induction/ C-Section:_____

DATING CONFIRMED BY:
EDC Based on: ☐ ☐
-US @10-20 weeks
——Doppler w/ Fetal Heart Tones for 30 weeks

——☐——**Positive**~~(+)~~ hCG result fo☐36 weeks ~~Other dating criteria:~~ _____

Fetal Lung Maturity Test Results, **if**~~as~~ indicated: _____ Date: _____

INDICATIONS: Obstetric and Medical Conditions (If marked, OK to schedule if < 39 weeks EGA)

- **Abruption**
- **Antiphospholipid Syndrome**
- **Cardiovascular Disorders**
- **Cholestasis**
- **Diabetes (type 1 or 2)**
- **Fetal CNS Malformation**
- **Fetal Chromosomal Abnormality**
- **Fetal Demise (current or prior)**
- **Fetal Distress**
- **Fetal Malformation**
- **Fetal-Maternal Hemorrhage**
- **Gestational Diabetes (uncontrolled with insulin)**
- **HIV Infection**
- **Hypertensive Disorders of Pregnancy**
- **Isoimmunization**
- **IUGR**
- **Multiple Gestation**
- **Oligohydramnios**
- **Placenta Previa**
- **PROM**
- **Polyhydramnios**
- **Renal Disease**
- **Other (Perinatology Recommends Delivery**

- ☐ ~~Abruption~~
- ☐ ~~Coagulation Defects (Antiphospholipid Syndrome)~~
- ☐ ~~Fetal Demise (Current)~~
- ☐ ~~Fetal Distress/Abnormal FHR~~
- ☐ ~~Fetal CNS Malformation or Chromosomal abnormality, suspected damage to fetus from viral or other diseases in mother, drugs, radiation~~
- ☐ ~~Gestational Hypertension~~
- ☐ ~~HIV Infection~~
- ☐ ~~Isoimmunization/Fetal-Maternal Hemorrhage~~
- ☐ ~~Multiple Gestation~~
- ☐ ~~Placenta Previa~~
- ☐ ~~Post Dates~~
- ☐ ~~Unstable Lie~~

RESULTS:

- ☐ Procedure is Medically Indicated or EGA is > 39 weeks.
  Scheduled by_____
  Confirmed Date/ Time:_____
- ☐ ~~Procedure is NOT Scheduled Reason:~~ _____
- ☐ ~~Case referred to OB/GYN Department Chair: Date/ Time~~_____
  ~~Result:~~_____

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE:	**06/14**	**SUBJECT:**	**Infant Transport Intra-Facility**
REVISION DATE(~~S~~):	**07/17**		

Department Approval:	**~~01/17~~09/20**
Department of Pediatrics Approval:	**~~05/17~~04/22**
Department of OB/GYN Approval:	**~~06/17~~06/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/17~~06/22**
Administration Approval:	**08/22**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To outline the policy for infant transport within the medical facility.

~~1.~~2. **~~Special attention is required when transporting infants from one area of the hospital to another due to potential infection control and infant abduction concerns.~~ This policy is intended to provide guidelines ~~which ensures that all infants are transported safely.~~for safely transporting patients from Mother Baby Unit (MBU) and Labor & Delivery (LD). See Intrafacility Transport of the NICU Patient Policy for specific guidelines on transporting NICU patients.**

B. **POLICY:**

~~B.~~1. **Transports:**

~~1. Special attention is required when transporting infants from one area of the hospital to another due to potential infection control and infant abduction concerns. This policy is intended to provide~~ **guidelines** ~~a standard procedure which ensures that all infants are trans~~**ported**~~ferred safely.~~

~~2.~~a. Infants transported within the departments of Women and Newborn Services (WNS) which consists of (Labor and Delivery **(LD)**, Mother Baby Unit (MBU), **and Neonatal Intensive Care Services (NICU)** ~~MBU South, **Transitional** Nursery~~) will be escorted by a staff member **that has ~~either~~ a been certified as a Neonatal Resuscitation Provider (NRP)** ~~**Provider card or a Basic Life Saving card**. It is beneficial if the staff member is certified as a Neonatal Resuscitation Provider (NRP).~~

b. **Infants being transported outside of the WNS Departments will be**~~An infant who needs to be transported intra-facility (**such as** ex: radiology) will be~~ escorted by an assigned staff member **via bassinet or isolette with the nursery transport bag.**

~~3. **who will utilize the transport bag from the nursery during transport.**~~

c. **Banded individuals are encouraged to accompany the infant during transport.**

d. **All transports will be documented appropriately in the electronic medical record. If the infant is separated from the parent/caregiver during this time, the time and reason for separation will be documented.**

~~4.~~e. ~~In support of a patient and family centered care culture, parents/family members/~~**caregivers** ~~wearing the infant identification band are invited to accompany the infant when transported.~~

~~5. In emergent situations, **the** infant shall be transported in an open crib to the treatment area while lifesaving measures~~**, such as NRP,** ~~are initiated, as appropriate, and per~~ **~~the American of Pediatrics Neonatal Resuscitation (NRP) or per the Basic Life Support dependent on~~**

~~the job title of the person taking the infant to the treatment area. In most cases stimulation of the infant is started on the way to the treatment area, and the resuscitation is performed in the treatment room.~~WNS standardized procedure: Code Caleb.

2. Transfers:
   a. When the infant is ready for transfer, the primary nurse will provide report to the receiving nurse utilizing the appropriate hand-off communication and document the off unit/transfer form.
   b. Identification bands on the infant shall be verified against the parent/caregiver band before and after transfer. ~~See Intrafacility Transport of NICU Patient P&P~~
3. The infant will wear a hat, be swaddled in two blankets and be placed in supine position in an open crib for traveling. A bulb syringe will be placed at the head of the crib.
4. Vital signs (including temperature) and a brief assessment shall occur before and after transport/transfer.

~~C. DEFINITION(S):~~

~~1. Intra-facility- (internal transfer: Infants transferred from one area of the hospital to another area.~~
~~2. Transfer of a Neonate/Infant to the morgue: See the Miscarriages and Stillbirth Identification and Disposition procedure.~~

~~D. MODE OF TRANSFER:~~

~~1. All infants less than or equal to 32 weeks gestational age, and/or less than 1500 grams, **babies requiring oxygen, and/or who are hemodynamically unstable** will be transported in an incubator **with a pulse oxymeter (oxygen saturation monitor) in place**. (Please see Very Low Birth Weight Thermoregulation procedure and Transfer of Neonates and Infants policy).~~
~~2. All infants requiring oxygen and/or who are hemodynamically unstable will be transported in an incubator. (See Transfer of Neonates and Infants policy).~~
~~3. Infants who are thermodynamically and hemodynamically stable with normal vital signs, will be transferred **transported** in an open crib based on the nurse's evaluation of the patient's safety needs.~~
   ~~a. Infants with expected admissions to the Neonatal Intensive Care Unit (NICU) shall be transferred with a pulse ox (oxygen saturation monitor) in place.~~

~~E. DURING TRANSFER:~~

~~1. When the infant is ready for transfer, the primary nurse will provide report to the receiving nurse utilizing the appropriate hand-off communication **and document the**or off unit/transfer form.~~
   ~~a. If the infant is being transported to another area other than in the WNS for a procedure, a staff member will remain with the infant the entire time.~~
   ~~b. Identification bands on the infant shall be compared to the parent/caregiver, **and the** banded person before transfer and upon return. **If the infant is separated from the parent/caregiver during this time, the time and reason for separation will be documented.**~~
~~2. The infant will wear a hat, be swaddled in two blankets and be placed in supine position in an open crib in the flat position for traveling. A bulb syringe will be placed at the **head of the infantcrib.** foot of the crib.~~
~~3. Transport personnel shall be trained in Basic Life Support (BLS) and/or be a Neonatal Resuscitation Provider (NRP), as appropriate.~~
~~4. At a minimum, vital signs (including temperature) and a brief assessment shall occur before leaving the area and upon return, **or in the unit the infant is transported to.** to the sending area. The infant should **be in**have direct line observation during the transport in the open crib or **infant** transporter **warmer.**~~

~~F.~~**5.** ~~AT DISCHARGE:~~**At Discharge:**

~~1.~~**a.** Infants discharged from Tri-City ~~Healthcare District~~**Medical Center** (TC**MC**~~HD~~) shall be accompanied by a banded and/or properly identified parent/caregiver and a staff member/volunteer, to the designated hospital entrance.

~~2.~~**b.** Infants shall be transported off the unit in the arms of the mother/caregiver**/significant other**, who is seated in a wheelchair.

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

1. American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, ~~7~~**8**th Ed. Washington, DC: ACOG **and AAP**; 2017~~2~~; Elk Grove Village, IL~~: AAP; 2012.~~

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

ISSUE DATE:	**10/94**	**SUBJECT:**	**Partners in Care for Women and Newborn Services**
REVISION DATE~~(S)~~:	**01/00, 06/03, 08/09, 07/10, 06/14, 01/19**		

Women and Newborn Services Department Approval:	**~~11/18~~08/22**
Department of OB/GYN Approval:	**~~n/a~~08/22**
Perinatal Collaborative Approval:	**n/a**
Department of Pediatrics Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~01/19~~08/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**01/19**

A. **PURPOSE:**

1. **The healthcare team supports the presence of family and friends as "Partners in Care" and encourages their ongoing participation during their stay at Tri-City Medical Center (TCMC) to enjoy full and equal visitation privileges consistent with the wishes of the patient.** ~~The staff of Tri-City Medical Center (TCMC) for Women and Newborn Services (WNS) are committed to supporting the strength and integrity of families as they adapt to the physical and psycho/social changes brought about by childbirth. We promote a patient and family centered care philosophy that is a mutually beneficial partnership between healthcare providers, patients, and their families.~~ In order to address special circumstances, exceptions may be made by the Charge **Nurse** (RN), ~~and/or~~ the ~~Assistant Nurse~~ Manager on duty, **or delegeeesignee**. ~~The healthcare team supports the presence of family and friends as "Partners in Care" and encourages their ongoing participation during their stay at TCMC to enjoy full and equal visitation privileges consistent with the wishes of the patient. Visitation rights will not be denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.~~

B. **PROCEDURE:**

1. All Partners ~~in~~**in** Care:
   - **a.** Will be issued a visitation sticker for safety and security purposes **that must remain visible** ~~while in the hospital and when entering into the WNS area~~**at all times while in the hospital**.
     - **i.** The "~~patient will determine the~~**support person" (determined by the patient)** ~~that~~ **will receive the 2nd adult baby band in place of the visitation** ~~stickerwhich~~**sticker.** ~~which will and then the band will permit that person to enter the WNS area.~~
     - **ii.** ~~The 2nd adult baby band for the support person is not transferable~~**Once the support person has been banded, the band is non-transferable.**
     - **iii.** **The support person must be over the age of 18, unless the father is a minor.**
     - **iv.** **The support person is welcome at the bedside 24/7.**
   - ~~a.~~**b.** **Are welcome to visit between the hours of 8am and 8pm, except in labor and delivery.**

~~b.~~**c.** Will need to perform thorough hand hygiene prior to entering and exiting the patient room.

~~c. Will have a restriction of visitation for those children 14 and below during the influenza or **Respiratory syncytial virus** (RSV) season **or** as restricted throughout the community.~~

~~d. Children must be over the age of 1 one and need to be accompanied by an adult other than the patient when they are visiting.~~

~~i. They cannot be accommodated overnight.~~

~~ii. Strollers must be occupied.~~

~~Car seats are not allowed on the unit for safety reasons.~~

~~iii. Will need to wait in the waiting room if **visitation is restricted due to the need for privacy, clinical condition of the patient and/or baby, concerns for the patient(s) wellbeing, safety/security of other patients, and/or unusual activity in the department that temporarily is contrary to visitation.** an emergency occurs or if there is need for patient privacy.~~

~~e.~~**d.** ~~In order to provide a confidential environment for patients and a safe environment for everyone, waiting in the hallways is not permitted.~~**Will wait in the designated waiting area ~~not be permitted to linger in and not in~~ the hallways ~~in order to provide~~to ensure a confidential and safe environment for all.**

e. **Will be encouraged to take ~~S~~s**still photography of the **labor process,** baby, ~~and/or~~ mother, and family **(at the discretion of the staff and physicians), ~~, per their request,~~** but ~~not of the~~**Wwill not take videos or pictures during the** delivery or procedures. ~~In some situations, it may be requested that no photography is performed.~~

f. **Children over the age of 1 may visit but must be accompanied by an adult other than the patient when they are visiting.**

2. Exceptions to "~~Family Presence or Visitors~~**Partners in Care" presence at the bedside**:

a. **The patient may request restrictions to the support person's or** ~~Except when the patient, staff or provider chooses to restrict family and other "~~Partners in Care~~,"~~**'s presence at the bedside at any time.**

~~a.~~**b.** **I**~~i~~Limitations ~~on the presence~~**to the support person or Partners in Care** ~~of these individuals may be appropriate in exceptional circumstances~~**may be enforced in certain circumstances**, such as ~~when~~:

i. A legal reason (e.g., a restraining order, the patient is in legal custody, or a court order) ~~this will prohibit all visitors).~~**prohibiting visitors.**

~~i.~~**1)** **The patient will be registered as a "No Information" patient and staff will not ~~be able to~~ identify the patient's presence either via the phone or to an in-person visitor(s).**

ii. **When ~~B~~b**ehavior is disruptive to maintaining a therapeutic environment on the patient care unit.

iii. **When ~~A~~a** family member or visitor ~~who~~ is actively coughing, sneezing or has had a fever in the last 24 hours

~~iii.~~**iv.** **At the discretion of the health care team based on the patient's condition or unit activity.**~~is requested to not visit. This may jeopardize the patient's and baby's health.~~

3. Labor and Delivery **(LD)**:

a. "Partners in Care" are welcome in the patient's room~~,~~ 24 hours/day.~~, at the discretion of the patient. Visiting may be limited by the healthcare team if the patient's medical condition warrants. Waiting lounges are available during those occasions. The patient's spouse/significant other **who is over the age of 18, unless the significant other is a minor,** is encouraged to stay overnight while on the Labor and Delivery unit.~~

b. ~~To ensure their comfort and safety, c~~**C**hildren 14 and ~~below~~ **under** must be accompanied by an adult who is not the patient's primary support person while **the mother is in**~~in~~ labor.

~~b.~~**c.** **For the first hour after delivery, it is recommended that the mother, ~~significant other~~support person and baby are left alone to initiate skin to skin contact and**

promote bonding ~~. During this time, it is recommended that the other Partners of Care stay in the waiting area~~ unless the patient requests that ~~they~~all Partners in Care remain in the room.

~~c.~~4. Antenatal testing area~~/~~-/-triage:

~~i.~~a. The antenatal testing/triage is a semi-private area for testing and evaluating expecting mothers.

~~ii.~~b. In order to respect the privacy of our patients only ~~one~~ the support person is ~~recommended~~ allowed in the Triage room. ~~during this short term observation. They may be asked to step out of the Triage room for privacy per the patient or healthcare provider request~~.

~~Antepartum:~~

~~Partners in Care are welcome to visit between 8:00 a.m. to 8:00 p.m.~~

~~The spouse/significant other is encouraged to stay overnight. The support person must be over the age of 18, unless the father of the baby is a minor.~~

~~The number of visitors may be limited at the discretion of the healthcare team due to the medical condition of the patient.~~

~~d.~~5. Operating Room/PACU:

~~i.~~a. ~~One~~ The designated support person is welcome to attend a cesarean birth except in the event of an emergency. ~~Observation may be denied in the event of an emergency.~~

~~ii.~~b. ~~For Cesarean births, one visitor~~The support person ~~(usually the banded person)~~ will ~~be invited to the Recovery Room after initial stabilization of the patient~~escort the infant to the recovery room.

~~1) Other friends and family may wait comfortably in the waiting lounge.~~

~~4.~~6. ~~Postpartum~~Mother Baby Unit (MBU):

a. When transferring patients from LD to MBU Partners in Care will be left in the waiting room and only the support person will accompany the mother to the room. ~~When the transfer from Labor and Delivery to Mother Baby occurs, we ask that only the banded person come to the room, while the other Partners in Care wait in the waiting room. This will give staff time to check the Mother and Baby prior to visitors entering.~~

~~a. "Partners in Care" are welcome to visit between 9~~8 a.m. and ~~9~~8 p.m. The number of guests may be limited in semiprivate rooms.~~per the discretion of the patient/significant other and possibly the healthcare team should a medical or safety issue arise.~~

~~b. As long as the patient doesn't have a "suitemate", t~~The ~~support person~~ spouse/significant other is encouraged to stay overnight so they can participate in providing care and support to their new family.

~~i. The support person must be over the age of 18, unless the father of the baby is a minor.~~

~~ii.~~i. Chairs and recliners are provided for the support person.~~; the second bed is reserved for possible admission.~~

~~If the patient does have a "suitemate" then a~~All guests~~, children~~ and significant others ~~will~~ould need to ~~say goodbye~~ go home by ~~9~~8 p.m., when visiting hours ~~for the unit~~ are over, to ensure privacy ~~and rest~~ for all involved.

b. If the Mother remains inpatient following the baby's discharge, the Baby ~~needs to remain as a patient for additional medical treatment, and Baby is discharged, per protocol, Baby~~ will ~~then~~ be considered a "Visitor" and ~~require care by another adult over the age of 18 (not including the mother of the baby) unless the Father/Support person of the Baby is a minor~~must be accompanied by the support person at all times. The Baby cannot be left ~~unattended at any time.~~alone with the mother. ~~The parent(s)/~~patient/support ~~people~~person and the baby must keep their baby bands on the entire time that the mother is in the hospital in order to allow for visitation.

c. If the Baby ~~needs to remain as a patient for additional medical treatment, and the Mother is discharged, per protocol,~~remains inpatient following the mother's discharge, the baby will remain in MBU if the unit is able to accommodate the arrangement. One banded individual must remain with the infant at all times. ~~the Mother may be able to stay as a Visitor in a patient room with her Baby if the unit is able to accommodate the arrangement per the Charge Nurse discretion. If the unit~~MBU is unable to accommodate this, the baby will be transferred to the Neonatal Intensive Care Unit (NICU) for ~~care and that unit visitation policy will be utilized.~~ care. Refer to the NICU Visitation Policy for specifics. In either case the ~~parent(s)/significant other(s)~~banded individuals must keep their baby bands on the entire time the baby is in the hospital in order to visit the baby.

~~5. Transition Nursery:~~

~~At the discretion of the healthcare team the "banded" primary support person is welcome in the Transition Nursery during the short-term observation, if needed.~~

~~Together Time:~~

~~The unit will have a time for the Mother, significant other, and baby to bond that is considered a quiet time, if the patient wishes to observe this.~~

~~a. Neonatal Intensive Care Unit (NICU)-see the unit specific policy for details.~~

C. RELATED DOCUMENT(S):

1. WNS Visitation Letter (English)
2. WNS Visitation Letter (Spanish)
3. Extended Stay Mother (English)
4. Extended Stay Mother (Spanish)
5. Extended Stay Baby (English)
6. Extended Stay Baby (Spanish)
7. Neonatal Intensive Care Unit Visitation Policy

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

STANDARDS OF CARE – INTRAPARTUM

I. **PREAMBLE:**

A. Nursing practice in the care of Women's and Newborn's Services (WNS) is delivered in an environment that respects the goals, preferences, and patient rights of the family from admission, through the episode of care, to discharge. The WNS and nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN).

II. **DEFINITION(S):**

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

B. Scope of Nursing Practice: "Describes the who, what, where, when, why, and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010. "

C. Standards: "Authorative**Authoritative** statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2010, p. 67).
1. "Standards of care are Standards of Professional Nursing Practice."

D. Nursing Process: "The essential core of practice for the Registered Nurse (RN)is to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following:

E. Assessment: A systematic, dynamic way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors.. An assessment includes subjective and objective data.
1. Subjective-what the patient says.
2. Objective-observation based on assessment findings.

F. Diagnosis: A nurse's clinical judgment about the client's response to actual or potential health conditions or needs.

G. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short and long-range goals."

H. Planning: Care Plan i.e. Plan of Care: A comprehensive outline of care to be delivered to attain expected outcomes.

I. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care" from the patient during hospitalization and in preparation for discharge needs."

J. Evaluation: The process of determining both the "patient's status and the effectiveness of nursing care. It is a process that involves continuous evaluation of the patient and the modifications to the Plan of Care..

K. Patient: Recipient of nursing care.

L. Health Care Providers: Individuals with special expertise who provide health care services or assistance to clients

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/13, 11/16, 04/22	06/17, 06/22	n/a	n/a	06/17, 06/22	08/22	06/14, 07/17, n/a	06/14, 07/17

M. Significant Others: Family members and/or those significant to the client.
N. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.
O. "Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)..

II. WNS STANDARDS OF PRACTICE:

A. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
B. A comprehensive and dynamic data-base shall be maintained on all patients admitted to the hospital.
C. The patient can expect to have appropriate confidentiality maintained at all times.
D. The patient can expect that the RN shall ensure the optimal desired level of privacy.
E. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
F. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
G. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
H. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
I. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
J. An appropriate plan of care shall be formulated for each patient.
K. The plan of care will be implemented according to the priority of identified problems or needs.
L. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
M. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

III. NURSING PROCESS:

A. STANDARDS OF CARE: ASSESSMENT
   1. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
B. STANDARDS OF CARE: DIAGNOSIS
   1. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
C. STANDARDS OF CARE: OUTCOME IDENTIFICATION
   1. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
D. STANDARDS OF CARE: PLANNING
   1. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.
E. STANDARDS OF CARE: IMPLEMENTATION

~~1. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned tasks appropriately.~~

~~F. STANDARDS OF CARE: EVALUATION~~

~~1. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.~~

~~2. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.~~

~~3. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.~~

~~G. STANDARDS OF CARE: DOCUMENTATION~~

~~1. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided will be documented after completion of the care in a timely manner.~~

~~2. When it is not possible to document due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.~~

~~3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.~~

I. ADMISSION HISTORY

A. PATIENT HISTORY

1. All inpatients shall have the admission history completed and documented within 24 hours of admission to the unit.

B. MEDICATION HISTORY

1. All patients shall have a medication history documented upon admission to the unit per the Medication Reconciliation Policy.

C. HEIGHT AND WEIGHT/OTHER MEASUREMENTS

1. Height and weight can be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation allows, it is preferred that the patient be weighed upon admission.
   a. Weights shall be documented in kilograms (kg) and height in centimeters (cm).

D. ALLERGIES

1. Any known medication or food allergies will be documented on admission as follows:
   a. On the patient allergy band
   b. On the allergy sticker placed on the front of the chart
   c. In the patient's Electronic Health Record (EHR)

E. SOCIAL HISTORY

1. The following will be documented upon admission:
   a. History of tobacco use
   b. History of depression, suicide and domestic violence
   c. Substance use/abuse
      i. Toxicology urine specimen will be obtained if the patient has had a positive toxicology screen during the current pregnancy, a history of substance use in the last 5 years, has had less than or equal to three prenatal visits, suspicion of placental abruption, or per OB Provider request.
2. Social Service Needs
   a. Initiate a social service referral for the following (including, but not limited to)
      i. Adoptions

ii. Infants going into foster care
iii. Patients with no prenatal care
iv. Teen moms
v. Positive toxicology results
vi. Mothers of newborns in the Neonatal Intensive Care Unit (NICU) or in another facility
vii. All mothers and families experiencing Perinatal loss
viii. High risk mother or newborn, as defined by their provider

F. IMMUNIZATIONS
1. Patients will be screened for the Influenza vaccine during the designated hospital flu season.
a. If the patient meets requirements, the RN will administer the vaccine or document refusal of the vaccine prior to discharge.
2. Patients will be screened for the Tetanus Diphtheria Pertussis (Tdap) upon admission
a. If the patient meets the requirements, the RN will administer the vaccine or document refusal of the vaccine prior to discharge.

~~IV.~~II. GENERAL OB NURSING ASSESSMENT
A. ~~STANDARDS OF CARE:~~ VITAL SIGNS
1. Maternal Vital Signs (VS) include: Temperature, Heart Rate (HR), Blood Pressure (BP), Respiratory Rate (RR), Pain and Oxygenation level (when clinically indicated).
2. VS will be obtained on admission to the hospital, upon transfer to a new unit, within 1 hour prior to discharge and/or per provider orders.
3. Intrapartum VS (BP, HR and RR) will be recorded as follows:
a. Latent labor (<6cm), every four hours at minimum
b. Active labor and second stage (>6cm), every hour at minimum
4. Intrapartum temperature will be recorded as follows:
a. Every four hours
b. Rupture of membranes (ROM) every two hours or if febrile every hour
5. For patients with an Oxytocin infusion VS are as follows:
a. BP, HR and RR: every hour at minimum
b. Temperature: every four hours, if ROM every two hours or if febrile every hour
6. For patients with Cervidil and Cytotec VS are as follows:
a. BP, HR and RR: every 30 minutes x2 after placement, then every four hours
b. Temperature: every four hours, if ROM every two hours or if febrile every hour
7. For patients with a Magnesium Sulfate infusion see: Magnesium Sulfate, Administration in Obstetric Patients procedure
8. For patients with an epidural see: Epidural/Patient Controlled Epidural Anesthesia and Spinal Block Management procedure
9. Immediate vaginal delivery postpartum VS will be recorded as follows:
a. BP, HR and RR: every 15 minutes for the first hour, then every 30 minutes for the next hour unless abnormal findings are detected.
b. Temperature: every one hour for 2-hours (total of 2 temperatures)
10. Immediate cesarean section delivery recovery/postpartum VS will be recorded per the anesthesiologist orders
11. Notify the provider if:
a. Temperature is greater than 38°C or 100.4°F
b. HR is greater than 110 beats per minute
c. SBP is greater than 140 mmHg and/or DBP is greater than 90 mmHg

i. If known hypertension notify provider for SBP greater than 155 mmHg and/or DBP greater than 105 mmHg

d. RR is greater than 25 breaths per minute or less than 12 breaths per minute

B. PAIN ASSESSMENT

1. Refer to Patient Care Services: Pain Management, for the full standards of care
2. Patients will be assessed for pain upon admission to the unit, with routine VS and with each report of a new or different pain.
   a. A pain assessment will include the following
      i. Acceptable/target pain level
      ii. Current pain level
         1) Mild: pain level 1-3
         2) Moderate: pain level 4-7
         3) Severe: pain level 8-10
      iii. Pain scale used
      iv. Symptoms of pain which may include but are not limited to:
         1) Intensity, location, quality, curation, alleviating factors and/or aggravating factors
3. All patients will be assessed for sedation prior to the administration of opiates
4. A pain assessment will be documented with each patient report of a new or different pain
5. Assessment of pain level shall be performed with routine vital signs and as needed
6. Reassessment of pain level and relief shall be performed per the following:
   a. 30 minutes for intravenous medications
   b. 60 minutes for oral or intramuscular medications
   c. 15-60 minutes for non-pharmacological treatments
7. For patients with an epidural a pain assessment will be assessed and documented prior to the start of the procedure then 30 minutes after placement and every two hours there after
8. In the OB Post-Anesthesia Care Unit, when pain medication is ordered more frequently than 30-minute intervals (i.e., every five minutes) the nurse will document the effectiveness after the last dose given

C. INTAKE AND OUTPUT (I&O)

1. I&O will be monitored as follows:
   a. Every 8 hours, with 24-hour totals
   b. Patients with a Magnesium Sulfate infusion refer to the procedure: Magnesium Sulfate, Administration in Obstetric Patients.
   c. Patients with an epidural will have I&O assessed every four hours
   d. Notify the provider for any of the following:
      i. Patient is not voiding within 6 hours of foley catheter removal
      ii. Measured output is less than or equal to 30mL per hour, or less than or equal to 120mL in 4hours.
   e. Blood loss: refer to WNS procedure Obstetrical Hemorrhage

D. POSTPARTUM HEMORRHAGE RISK

1. The Postpartum Hemorrhage Risk Assessment will be performed on admission, each shift and prior to delivery (8-10cm dilated).

E. INFUSION THERAPY

1. Central venous lines, including PICC lines, shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed per the Standards of Care Adult policy.

~~A.~~

~~1. Maternal Vital Signs Shall include:~~

~~a. Temperature~~

~~b. Heart Rate~~

c. Blood Pressure
d. Respiratory Rate
e. Oxygenation Level
f. Pain Level

2. Vital signs shall be obtained on admission, transfer to a unit, at discharge (if discharged home undelivered) per Patient Care Services (PCS) procedure Discharge of Patients, per providers orders, and may be modified as follows:
3. Intrapartum:
   a. Hourly blood pressure, pulse and respirations, when in **latent** labor **(<6cm). Every 30 minutes while in active labor (>6cm)**
      i. If patient has an oxytocin or epidural infusion, vital signs **BP, HR and RR** may be q 15-30 minutes per provider orders.
      ii. Continuous pulse oximetry may be needed, once epidural is placed and/or with magnesium sulfate administration per procedure and provider order) or more frequently per patient condition.
   b. Maternal temperature every 4 hours or per provider orders and usually every 2 hours if membranes are ruptured, and every hour if febrile.
   c. Fetal Monitoring per Fetal Heart Rate Surveillance Procedure, induction procedure/policy or as ordered per provider

d. Immediate Postpartum/ Recovery after a , **Vaginal Delivery:**
   a. Vital signs: Pulse, BP, and RR every 15 minutes **X 2 hours**, x4, q 2 hr x 1, then q 6 hours for the first 24 hours,, then every shift until discharge and prn as clinically
e. indicated
f. **b.** Temperature shall be taken once during recovery and more frequently if febrile.
g. **For** Immediate Postpartum/ Recovery Post-Operative, **Cesarean Delivery: Refer to Surgical Services Peri-Anesthesia Nursing Services for further information**
      i. Recovery vital signs as ordered by anesthesiologist, and Medical system for measure of recover after anesthesia, Activity, RR, Color, Blood Circulation, consciousness usually Pulse, BP and RR every 5 minutes x3, then q 15 until a Modified Aldrete score of 8/10 or greater is achieved.
      ii. Pt shall be placed on Cardiac Monitor during recovery and have EKG rhythm strip printed x1 and placed in the medical record for capture validation.
      iii. Temperature shall be taken once during recovery and more frequently if febrile.
   h. Notify provider if:
      i. Temperature greater than or equal to 100.4° F or 38° C
      ii. Blood pressure greater than or equal to systolic 140 systolic and/or greater than or equal to 90 diastolic. **While keeping in mind patients baseline blood pressure**
      iii. Pulse greater than or equal to 120 bpm
      iv. Respirations greater than 28 or less than 12

B. STANDARDS OF CARE: PAIN ASSESSMENT
   1. Assessment: Pain per Pain Management Policy
      a. A general pain assessment shall consist of the following:
         i. Acceptable level of pain intensity
         ii. Pain scale
         iii. Current pain intensity
      b. If patient complains of pain, assess the following:
         i. Location, intensity, and duration/onset
         ii. Quality/type
         iii. Aggravating factors
         iv. Alleviating factors

~~2. Assess for presence of pain/discomfort with vital signs and PRN~~
~~3. Perform a pain assessment with each patient report of new or different pain.~~
~~4. Perform a pain reassessment as follows:~~
~~a. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention~~
~~b. One (1) hour after PO intervention~~

~~D. STANDARDS OF CARE: INTAKE AND OUTPUT~~
~~1. Intake and output shall be monitored as ordered and as follows:~~
~~c. Intrapartum:~~
~~i. I&O totals every shift with 24 hour totals~~
~~ii. Assess bladder every 4-6 hours, or as ordered by provider~~
~~iii. Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour, or less than or equal to 120 mL in 4 hours.~~
~~iv. Bleeding: **Refer to WNS procedure: Obstetrical Hemorrhage.**~~
~~1) Patients shall be screened for risk of obstetrical hemorrhage upon admission, and as part of the ongoing reassessment throughout antepartum and/or intrapartum admission.~~
~~2) Patients will be screened who present to labor and delivery with placenta previa, accreta and its variants, possible placental abruption with or without vaginal bleeding~~
~~a) Assess and document quantity (# of pads/chux, degree of saturation and/or weigh as needed.), color, associated symptoms and frequency of bleeding~~
~~b) Notify provider of active bleeding, and report above findings.~~

~~E. STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS~~
~~1. Height and weight can be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation allows, it is preferred that the patient be weighed upon admission.~~
~~c. Weights shall be documented in kilograms (kg) and height in centimeters (cm).~~
~~2. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.~~

~~F.~~**G.** ~~STANDARDS OF CARE:~~ ASPIRATION ASSESSMENT

1. Maintain aspiration precautions for maternal patients identified at risk.
   ~~c.~~**a.** Maintain head of bead (HOB) at 30 degrees at all times.
   ~~d. If eclamptic seizure occurs, lower head of bed, open airway, roll patient to side and suction secretions as necessary.~~
   ~~i. Avoid attempts to insert suctioning device when patient's teeth are clenched.~~
   ~~e.~~**b.** Maintain suction equipment at bedside at all times.

~~G.~~**H.** ~~STANDARDS OF CARE:~~ PATIENT SAFETY

1. The health care team shall provide measures to ensure patient safety ~~for the unique maternal-fetal dyad and/or mother baby couplet~~. This includes having the bed in the lowest position, wheels locked, and room free of clutter.

2. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

III. SYSTEM ASSESSMENT

~~1.~~

~~2. Patient safety shall be assessed per the following:~~
~~c. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures, and as needed.~~

~~d. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.~~
~~e. Allergies will be monitored and documented upon admission.~~
~~i. Any known medication or food allergy shall be documented as follows:~~
~~1) The patient allergy band~~
~~2) Allergy sticker placed on the front of the chart~~
~~3) In patient's Electronic Medical Record (EMR)~~
~~f. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders Policy.~~
~~g. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.~~
~~h. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.~~
~~i. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.~~
~~j. Patients shall be assessed for falls per PCS: Falls Risk Procedure.~~
~~k. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit specific hand-off policies.~~
~~l. Medication shall be reconciled per PCS: Medication Reconciliation Policy.~~
~~m. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.~~

~~VI. SYSTEM REVIEW~~

A. ~~All maternal patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.~~**All patients admitted to WNS shall be assessed by a Registered Nurse (RN) per the following:**

1. **Admission/Initial Shift Assessment:**
   a. **All patients admitted to the Labor and Delivery Unit will have a system assessment documented within 4 hours, dependent on the situation (stage of labor or urgency in which the patient is being seen)**
   b. **Initial shift system assessment will be performed within 2 hours of the start of shift and documented within 4 hours of the start of shift.**
2. **Transfer Assessment:**
   a. **A focused assessment will be performed when the patient arrives to the Postpartum unit with both the transferring RN and receiving RN**
      i. **A focused assessment will include but is not limited to:**
         1) **Recent VS including pain level**
         2) **Fundal height, position and tone**
         3) **Lochia color, amount and description**
         4) **Perineal description and interventions**
         5) **Bladder distention and/or voiding status**
         6) **Cesarean section incision and/or dressing**
         7) **Postpartum Hemorrhage Risk Assessment (PPH RA)**
      ii. **A system assessment will be performed within 2 hours of receiving the patient and documented within 4 hours.**
3. **Reassessment**
   a. **After the completion of an Admission/Initial shift assessment a focused assessment will be completed every four hours or sooner in response to treatment given or a change in the patient's condition.**

~~A.~~**4. If the patient refuses an assessment, document the refusal in the EHR**

~~B. STANDARD OF CARE I: ASSESSMENT~~
~~1. All patients admitted to WNS nursing units shall be assessed by a Registered Nurse per the following:~~

~~2. Admission and/or Transfer: Assessment~~
~~a. All patients admitted or transferred to a higher level of care shall have a focused assessment initiated as soon as possible. A detailed or disease specific assessment shall be document as needed.~~
~~b. The assessment shall be completed in a timely manner dependent on the situation (stage of labor or urgency in which the patient is being seen).~~
~~3. Admission Assessment- Patient History:~~
~~a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.~~
~~i. This assessment-patient history shall include an assessment for obstetric hemorrhage.~~
~~4. Medication Patient History Form~~
~~a. All patients shall have a Medication Patient History completed upon arrival to the unit per the Medication Reconciliation Policy.~~
~~5. Initial Shift Assessment~~
~~a. An RN shall initiate an ongoing head to toe assessment at the beginning of the shift.~~
~~6. Reassessment~~
~~a. After completion of an Admission / Initial shift assessment patients are reassessed prn and as clinically indicated.~~
~~i. If the patient refuses a reassessment, document refusal in the medical record.~~
~~b. System Specific/ Focus assessment shall be completed as follows:~~
~~i. When there is a change in patient's condition and when clinically indicated.~~
~~ii. In response to a treatment given to patient.~~

B. SYSTEMS:

~~C.~~**1.** ~~STANDARDS OF CARE 1.1: ASSESSMENT~~ NEUROLOGICAL ~~SYSTEM REVIEW~~
~~1. Neurological: System Review~~
a. Assess the following on admission **and on the initial**~~, transfer of care, once a~~ shift **assessment,** unless otherwise indicated more frequently (i.e. WNS procedure Magnesium Sulfate):
i. Level of consciousness
ii. Orientation
iii. Presence of:
1) Headache
2) Visual disturbances, e.g. blurred vision or scotoma
iv. Deep Tendon Reflexes
~~v.~~**1)** Patellar or brachial
~~vi.~~**v.** Clonus
~~vii.~~**vi.** Effects of epidural/regional anesthesia on lower extremities
1) Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
2) Assessment of epidural site, removal of catheter post-delivery per **the WNS P**procedure**: Epidural/Patient Controlled Epidural Anesthesia (PCEA) and Spinal Block Management** ~~(Reference: WNS procedure: "Epidural Medication Administration").~~

~~D.~~**2.** ~~STANDARDS OF CARE 1.2: ASSESSMENT~~ CARDIOVASCULAR ~~SYSTEM REVIEW~~
~~1. Cardiovascular System Review~~
a. Assess heart sounds,~~-i~~ note regular or irregular rhythm.
b. Check capillary refill
c. Check edema location and grade
d. Assess peripheral perfusion; skin warm and dry
e. Assess **calves bilaterally for the presence of tenderness and swelling** ~~Homan's sign for presence of thrombophlebitis.~~

~~E. STANDARDS OF CARE 1.3: ASSESSMENT~~ PULMONARY ~~SYSTEM REVIEW~~

~~1.~~**3.** ~~Pulmonary: System Review~~

a. Check oxygen delivery devices if applicable
b. Check amount oxygen flow if applicable
c. Assess of pulse oximetry as indicated
    i. Continuous monitoring post-epidural placement
    ii. Per orders or per PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"
d. Assess **for** respiratory ~~effort~~**symptoms, pattern, and rate of respirations**
e. Auscultate breath sounds all lobes
f. Assess sputum amount, color, and consistency if applicable
g. Assess for presence of cough
~~h. Assess for presence of artificial airway, tubes, and drains if applicable.~~
~~i.~~**h.** Assess chest expansion for symmetry

~~F. STANDARDS OF CARE~~1.4: ~~ASSESSMENT~~ GASTROINTESTINAL ~~(GI) SYSTEM REVIEW~~

~~1.~~**4.** ~~GI: System Review~~

a. Assess gravid abdomen:
    i. Round **or asymmetrical**~~, gravid, distention.~~
    ii. Soft, firm, distended, non-distended.
    iii. Pain upon palpation~~, right upper quadrant pain.~~
b. Assess for nausea and/or vomiting.
c. Auscultate for presence of bowel sounds in all four quadrants.
d. Assess bowel function including passing flatus **and**~~or~~ last stool.

~~G.~~**5.** ~~STANDARDS OF CARE 1.5: ASSESSMENT~~ GENITOUTINARY ~~SYSTEM REVIEW~~

~~1. Genitourinary (GU) System Review~~

a. Assess urine color and clarity, frequency and dysuria.
b. Assess for bladder distension.
    i. Assess external anatomy/perineum as applicable
    ii. Assess for leaking of amniotic fluid :
        1) Color, amount, and/or odor.
    iii. Assess vaginal discharge:
        1) Color, amount, and/or odor.

~~1) **Urinary Catheter, indwelling: see Elsevier Urinary Catheter: Straight and Indwelling (Foley) Catheter Insertion and Specimen Collection (Female)**~~

~~H.~~**6.** ~~STANDARDS OF CARE 1.6: ASSESSMENT~~ MUSCULOSKELETAL ~~SYSTEM REVIEW~~

~~1. Musculoskeletal System Review~~

a. Presence of assistive devices.
b. Presence of joint or musculoskeletal abnormalities.
c. Full range of motion ~~against gravity, some to full resistance of all extremities.~~
d. Mobility appropriate for age.

~~I.~~**7.** ~~STANDARDS OF CARE 1.7: ASSESSMENT~~ INTEGUMENTARY ~~SYSTEM REVIEW~~
(Refer to skin and wound care policy for further information)

~~1. Integumentary System Review, Maternal:~~

a. Assess mucous membranes and skin color~~; consistent with person's ethnicity.~~
b. Palpate skin for temperature and moisture.
c. Assess skin turgor.
d. Assess skin integrity~~, temperature, and condition of any dressings.~~
e. Complete Braden Scale~~- Predicting~~**Predicting** bed sore risk.
~~f. Assess for presence of specialty mattress/bed or overlays.~~
~~g. Assess for the presence of skin abnormalities.~~
~~h. Assess for the presence of pressure ulcers.~~

~~J.~~**8.** ~~STANDARDS OF CARE 1.8: ASSESSMENT~~ PSYCHO/SOCIAL

~~1. Psychosocial assessment shall consist of the following:~~
a. Coping
~~a.~~**i. Support/Coping Interventions**
b. Affect/Behavior
~~c. Social Service (SS) Referral Reason~~
~~d.~~**c.** Distress
d. Stressors

IV. RELATED DOCUMENTS:

A. Adult Standards of Care
B. Magnesium Sulfate, Administration in Obstetric Patients
C. WNS Procedure: Epidural/Patient Controlled Epidural Anesthesia (PCEA) and Spinal Block Management
D. Obstetrical Hemorrhage
E. Patient Care Services (PCS): Critical Results and Critical Test/Diagnostics
F. PCS: Identification, Patient
G. PCS: Physician/Allied Health Professionals (AHP) Inpatient Orders
H. PCS: Central Venous Access Devices
I. PCS: Specimen Handling
J. PCS: Medical Equipment Brought into the Facility
K. PCS: Fall Risk
L. PCS: Hand-off Communication
M. PCS: Medication Reconciliation
N. PCS: Pain Management

~~e.~~
~~Support/Coping Interventions~~
~~f. **Substance Use**~~
~~2. Psycho/Social: Nursing Interventions~~
~~a. In order to promote family centered care, the nurse shall:~~
~~i. Introduce bedside health care providers to the patient/family.~~
~~ii. Review visitation and unit policies to patient/family on admission and as needed.~~
~~iii. Assess and then verify with patient/family age appropriate needs.~~
~~iv. Assess and then verify patient/family's ability to understand and participate in the plan of care.~~
~~v. Encourage the family to have periods of uninterrupted sleep when appropriate~~
~~vi. Promote patient/family centered care~~
~~1) Discuss expectations and collaborate with patient/family~~
~~2) Encourage patient/family to ask questions **and participate in plan of care as appropriate**~~
~~vii. Promote patient independence in Activities of Daily Living (ADL)~~
~~viii. Promote **non-pharmacological** comfort measures (if ordered or request order) by:**Examples include** Music therapy, Therapeutic recreation, Spiritual comfort, Guided imagery, Reminiscence therapy, Encourage family/friends to visit, Arrange for a child's visitation, Arrange for pet therapy, Arrange for physical or occupational therapy.~~
~~ix. Patients shall be informed of their responsibilities upon admission and as necessary thereafter. **See TCMC Patient Handbook.**~~
~~1) These responsibilities include:~~
~~a) Providing information~~
~~b) Asking questions~~
~~c) Following instructions~~
~~d) Accepting consequences~~
~~e) Following rules and regulations~~
~~f) Showing respect and consideration~~
~~g) Meeting financial commitments.~~
~~i) See TCMC Patient Handbook.~~
~~x. Encourage patient and/or their family to participate in their plan of care.~~
~~Assess for history of **depression, suicide and** domestic violence/safety in home.~~

~~Assess for history of substance use/abuse~~

~~xi. Toxicology urine specimen will be obtained if the patient has had a positive toxicology screen during pregnancy, a history of substance use in the last 5 years, has had less than or equal to three prenatal visits, suspicion of placental abruption, or per OB Provider request.~~

~~xii. Request social services as appropriate.~~

~~1) Initiate social services referrals for the following (including, but not limited to):~~

~~a) Adoptions~~

~~b) Infants going to foster care~~

~~c) Patients with no prenatal care~~

~~d) Teen moms~~

~~e) Positive toxicology results~~

~~f) Mothers of infants in Neonatal Intensive Care or in another facility~~

~~g) All mothers and families experiencing Perinatal loss~~

~~h) High risk mother or newborn, as defined by their provider.~~

~~K. STANDARDS OF CARE: INFUSION THERAPY~~

~~1. Central venous lines, including PICC lines, shall be assessed per PCS Central Venous Access Devices Procedure~~

~~Note date of scheduled central dressing change, and change as indicated to occur every Saturday or if visibly soiled Peripheral IV See "Standards of Care for Adults".~~

~~Peripheral IV site shall be assessed: (Refer to Standards of Care Adult for further instructions)~~

~~At the initial shift assessment~~

~~prior to transfer~~

~~a. Maintenance or continuous infusion shall be assessed every 2 hours and PRN~~

~~VII.~~V. REFERENCES

A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2017~~2~~. *Guidelines for Perinatal Care* ~~*Eighth*~~*~~Seventh Edition~~**8th Edition***. Washington, DC

B. American Academy of Pediatrics (2010*). Policy Statement – Hospital Stay for Healthy Term Newborns*. Retrieved on 01/12/2011: http://aappolicy.aappublications.org/cgi/reprint/pediatrics;125/2/405.pdf

C. American Nurses Association (ANA). (2010). *Nursing scope and standards of practice*. Silver Spring, MD: Nursesbooks.org.

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E. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.

F. Mattson, S., & Smith, J.E. (Eds.) (2016~~4~~) *Core Curriculum for Maternal-Newborn Nursing (5~~4~~th Ed.)* Philadelphia, PA: Saunders

~~F.~~**G. Rice Simpson, K., Creehan, P.A.,O'Brien-Abel, N., Roth, C.K., Rohan, A.J. (2021) Perinatal Nursing (5th Ed.) Philadelphia, PA: Wolters Kluwer**

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

STANDARDS OF CARE – POSTPARTUM

I. GENERAL OB NURSING ASSESSMENT:

A. VITAL SIGNS:

1. Maternal Vital Signs (VS) include: Temperature (T), Heart Rate (HR), Blood Pressure (BP), Respiratory Rate (RR), Pain and Oxygenation level (when clinically indicated).
2. VS will be obtained on admission to the hospital, upon transfer to a new unit, within 1 hour prior to discharge and/or per provider orders.
3. For patients with a Magnesium Sulfate infusion see: Magnesium Sulfate, Administration in Obstetric Patients procedure.
4. Immediate vaginal delivery postpartum VS will be recorded as follows:
   a. BP, HR and RR: every 15 minutes for the first hour, then every 30 minutes for the next hour unless abnormal findings are detected.
   b. Temperature: every one hour for 2-hours (total of 2 temperatures)
5. Immediate Cesarean Section delivery recovery/postpartum VS will be recorded per the anesthesiologist orders.
6. After the immediate delivery VS are completed, VS will be recorded as follows:
   a. BP, HR, RR, and T: Every 4 hours until 24 hours post-delivery, then once per shift, as needed per patient condition and within 1 hour of discharge.
      i. After 12 hours the RN may defer an additional 4 hours if the patient is stable and sleeping.
7. Notify the provider if:
   a. Temperature is greater than 38°C or 100.4°F
   b. HR is greater than 110 beats per minute
   c. SBP is greater than 140 mmHg and/or DBP is greater than 90 mmHg
      i. If known hypertension notify provider for SBP greater than 155 mmHg and/or DBP greater than 105 mmHg
   d. RR is greater than 25 breaths per minute or less than 12 breaths per minute

B. POSTPARTUM ASSESSMENT:

1. Fundal: height, position, tone
2. Bladder distention
3. Lochia: color, amount, description
   a. If lochia amount is documented as moderate, heavy or excessive, pad weights are to be documented and delivery provider notified.
4. Perineal: description and interventions
5. Immediate vaginal delivery assessment every 15 minutes for the first hour, then every 30 minutes for the next hour unless abnormal findings are detected, then refer to the procedure Obstetrical Hemorrhage for frequency.
6. Immediate cesarean delivery assessment (when patient is moved into the recovery room) every 15 minutes for the first hour, then every 30 minutes until transfer unless abnormal findings are detected, then refer to the procedure Obstetrical Hemorrhage for frequency.

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/14, 06/16, 04/22	04/ 14, 12/16, 06/22	n/a	n/a	01/17, 06/22	08/22	06/14, 02/17, n/a	06/14, 02/17

7. After the immediate delivery assessments are complete, the postpartum assessment will be recorded as follows:
    a. Every 4 hours until 24 hours post-delivery, then once per shift and as needed per patient condition.
        i. After 12 hours the RN may defer an additional 4 hours if the patient is stable and sleeping.
8. A Postpartum Hemorrhage Risk Assessment will be performed per the procedure Obstetrical Hemorrhage.

C. PAIN ASSESSMENT:
1. Refer to Patient Care Services: Pain Management, for the full standards of care.
2. Patients will be assessed for pain upon transfer to the unit, with routine VS and with each report of a new or different pain.
    a. A pain assessment will include the following
        i. Acceptable/target pain level
        ii. Current pain level
            1) Mild: pain level 1-3
            2) Moderate: pain level 4-7
            3) Severe: pain level 8-10
        iii. Pain scale used
        iv. Symptoms of pain which may include but are not limited to:
            1) Intensity, location, quality, curation, alleviating factors and/or aggravating factors.
3. All patients will be assessed for sedation prior to the administration of opiates
4. Reassessment of pain level and relief shall be performed per the following:
    a. 30 minutes for intravenous medications
    b. 60 minutes for oral or intramuscular medications
    c. 15-60 minutes for non-pharmacological treatments
5. In the Post-Anesthesia Care Unit, when pain medication is ordered more frequently than 30-minute intervals (i.e., every five minutes) the nurse will document the effectiveness after the last dose given.

D. INTAKE AND OUTPUT (I&O):
1. I&O will be monitored as follows:
    a. Patients with a Magnesium Sulfate infusion refer to the procedure: Magnesium Sulfate, Administration in Obstetric Patients.
    b. OB PACU: assess and document patency of the foley catheter, amount, color and clarity of urine.
    c. Document foley catheter output every 4 hours with a shift total at 24 hours until it is discontinued.
    d. Notify the provider for any of the following:
        i. Patient is not voiding within 6 hours of a vaginal delivery or urinary catheter removal.
        ii. Measured output is less than or equal to 30mL per hour, or less than or equal to 120mL in 4hours.
    e. Blood loss: refer to WNS procedure Obstetrical Hemorrhage

E. POSTPARTUM HEMORRHAGE RISK ASSESSMENT:
1. The postpartum hemorrhage risk assessment will be performed on arrival to the unit and every shift for 24 hours.
    a. If the patient is high risk then continue to perform the postpartum hemorrhage risk assessment once a shift until discharge.

F. ASPIRATION ASSESSMENT:
1. Maintain aspiration precautions for maternal patients identified at risk.

a. Maintain head of bed (HOB) at 30 degrees at all times.
b. Maintain suction equipment at bedside at all times.

G. SOCIAL SERVICE:
1. Initiate social services referrals for the following (including, but not limited to):
a. Adoptions
b. Infants going into foster care
c. Patients with no prenatal care
d. Teen moms
e. Positive toxicology results
f. Mothers of infants in Neonatal Intensive Care Unit (NICU) or in another facility
g. All mothers and families experiencing Perinatal loss
h. High risk mother or newborn, as defined by their provider.

H. INFUSION THERAPY:
1. Central venous lines, including PICC lines, shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed per the Standards of Care Adult policy.

I. IMMUNIZATIONS:
1. Rhogam will be administered per provider order
2. MMR will be administered if patient is Rubella equivocal or non-immune
3. Patients will be screened for the Influenza vaccine during the designated hospital flu season.
a. If the patient meets requirements, the RN will administer the vaccine or document refusal of the vaccine.
4. Patients will be screened for Tetanus Diphtheria Pertussis (Tdap) and vaccination will be administered if indicated per Standardized Procedure: Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine Administration for Postpartum Patients.

J. PATIENT SAFETY:
1. The health care team shall provide measures to ensure patient safety for the mother baby couplet. This includes having the bed in the lowest position, wheels locked, and room free of clutter.
2. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

II. SYSTEM ASSESSMENT:
A. All maternal patients admitted to WNS nursing units shall be assessed by a Registered Nurse per the following:
1. Initial Shift System Assessment:
a. Initial shift system assessment performed within 2 hours of the start of shift and documented within 4 hours of the start of shift.
2. Transfer Assessment:
a. A focused assessment will be performed when the patient arrives to the Postpartum unit with both the transferring RN and receiving RN.
i. A focused assessment will include but is not limited to:
1) Recent VS including pain level
2) Fundal height, position and tone
3) Lochia color, amount and description
4) Perineal description and interventions
5) Bladder distention and/or voiding status
6) Cesarean Section incision and/or dressing
7) Post-birth postpartum hemorrhage risk assessment

ii. A system assessment will be performed within 2 hours of receiving the patient and documented within 4 hours.

3. Reassessment:
   a. After the completion of an initial shift system assessment, a focused assessment will be completed every 4 hours for 24 hours then PRN for condition changes.
4. If the patient refuses an assessment, document refusal in the EHR.

B. SYSTEMS:
1. NEUROLOGICAL
   a. Assess the following on the initial shift assessment, unless indicated more frequently (i.e. WNS procedure Magnesium Sulfate):
      i. Level of consciousness
      ii. Orientation
      iii. Presence of:
         1) Headache
         2) Visual disturbances, e.g. blurred vision or scotoma
      iv. Deep Tendon Reflexes
         1) Patellar or brachial
      v. Clonus
      vi. Assessment of epidural site per the WNS Procedure: Epidural/Patient Controlled Epidural Anesthesia (PCEA) and Spinal Block Management
         1) Ambulate patient post epidural/spinal with assist for the first two times.
2. CARDIOVASCULAR
   a. Assess heart sounds, note regular or irregular rhythm.
   b. Check capillary refill
   c. Check edema location and grade
   d. Assess peripheral perfusion; skin warm and dry
   e. Assess calves bilaterally for presence of tenderness and swelling.
3. PULMONARY
   a. Check oxygen delivery devices if applicable
   b. Check amount oxygen flow if applicable
   c. Assess pulse oximetry as indicated
      i. Per orders or PCS procedure: Magnesium Sulfate Administration in Obstetric Patients
   d. Assess for respiratory symptoms, pattern, and rate of respirations
   e. Auscultate breath sounds all lobes
   f. Assess sputum amount, color, and consistency if applicable
   g. Assess for presence of cough
   h. Assess chest expansion for symmetry
4. GASTROINTESTINAL
   a. Assess abdomen:
      i. Round or asymmetrical
      ii. Soft, firm, distended, non-distended.
      iii. Pain upon palpation
   b. Assess for nausea and/or vomiting.
   c. Auscultate for presence of bowel sounds in all four quadrants.
   d. Assess bowel function including passing flatus and last stool.
   e. Monitor for the presence of hemorrhoids
5. GENITOUTINARY

a. Assess urine color and clarity, frequency and dysuria.
b. Assess for bladder distension.
c. Assess external anatomy/perineum as applicable

6. MUSCULOSKELETAL
   a. Presence of assistive devices.
   b. Presence of joint or musculoskeletal abnormalities.
   c. Full range of motion.
   d. Mobility appropriate for age.
7. INTEGUMENTARY (Refer to skin and wound care policy for further information)
   a. Assess mucous membranes and skin color.
   b. Palpate skin for temperature and moisture.
   c. Assess skin turgor.
   d. Assess skin integrity
   e. Assess surgical incision
   f. Complete Braden Scale- Predicting bed sore risk.
8. PSYCHOSOCIAL:
   a. Coping
      i. Support/Coping Interventions
   b. Affect/Behavior
   c. Distress
   d. Stressors

III. RELATED DOCUMENTS:

A. Adult Standards of Care
B. Patient Care Services (PCS): Discharge of Patients and Discharge Against Medical Advice (AMA)
C. PCS: Identification, Patient
D. PCS: Physician/Allied Health Professionals (AHP) Inpatient Orders
E. PCS: Pain Management
F. PCS: Critical Results and Critical Test/Diagnostics
G. PCS: Specimen Handling
H. PCS: Medical Equipment Brought into the Facility
I. PCS: Fall Risk
J. PCS: Hand-off Communication
K. PCS: Medication Reconciliation

IV. REFERENCES:

A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2017. *Guidelines for Perinatal Care Eighth Edition.* Washington, DC
B. American Nurses Association (ANA). (2021). *Nursing scope and standards of practice.* Silver Spring, MD.
C. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns* (2019). Eighth Edition.
D. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (2021). 5th edition.
E. Mattson, S., & Smith, J.E. (Eds.) (2016) *Core Curriculum for Maternal-Newborn Nursing (5th Ed.)* Philadelphia, PA: Saunders

~~A. PREAMBLE:~~

~~1. Nursing practice in the care of Women and Newborns is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women's and Newborn's Services (WNS) nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and~~

guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN).Couplet care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices

B. **DEFINITIONS:**

1. Standards of Professional Nursing Practice: "Authoritative statements of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p. 2.
2. Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010 p. 67).
   a. "Standards of care are Standards of Professional Nursing Practice."
3. Nursing Process: The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient-focused care. The nursing process as outlined by the ANA (2016) includes the following
   a. Assessment: A systematic, dynamic way to collect and analyze data about a patient i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.
      i. Subjective-what the patient says
      ii. Objective-observation based on assessment findings
   b. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to: orientation, assessment, level of consciousness, affect/behavior, respiratory symptoms, respirations, respiratory pattern, skin color, skin temperature, fundal/lochia/cesarean section/tubal ligation assessment.
   c. Diagnosis: A nurses' clinical judgment about the patient's response to actual or potential health conditions or needs.
   d. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measureable and achieved short and long-range goals".
      i. Planning: Care Plan i.e. Plan of Care: A comprehensive outline of care to be delivered to attain expected outcomes.
   e. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care from the patient during hospitalization and in preparation for discharge needs".
      i.
   f. Evaluation: The process of determining both the "Patient's status and the effectiveness of nursing care. It is a process that involves continuous evaluation of the patient and the modifications to the Plan of Care."
4. Patient: Recipient of nursing care.
5. Health Care Providers: Individuals with special expertise who provide health care services or assistance to patients.
6. Significant Others: Family members and/or those significant to the patient.
7. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.
8. Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence-based practice to improve care (ANA, 2010)".

C. **WNS STANDARDS OF PRACTICE:**

1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic data base shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.
4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according to the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **NURSING PROCESS:**

1. **STANDARDS OF CARE: ASSESSMENT**
   a. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. **STANDARDS OF CARE: DIAGNOSIS**
   a. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
3. **STANDARDS OF CARE: OUTCOME IDENTIFICATION**
   a. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. **STANDARDS OF CARE: PLANNING**
   a. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.
5. **STANDARDS OF CARE: IMPLEMENTATION**
   a. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned tasks appropriately.
6. **STANDARDS OF CARE: EVALUATION**
   a. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.
   b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.
   c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.

E. **STANDARDS OF CARE: DOCUMENTATION:**

1. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.
2. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.
3. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.

GENERAL OB NURSING ASSESSMENT

A. **STANDARDS OF CARE: VITAL SIGNS:**
1. Maternal vital signs shall include:
   a. Temperature, documented in Celsius (preferred)
   b. Blood Pressure (BP)
   c. Heart Rate (HR)
   d. Respiratory Rate (RR)
   e. SpO2
   f. Pain Level
2. Vitals signs shall be obtained on admission, transfer to a unit, at discharge per Patient Care Services (PCS) procedure Discharge of Patients, per provider's orders and as follows:
   a. Postpartum, Vaginal Delivery:
      i. In Labor and delivery vital signs are obtained every 15 minutes x4, at 2 hours, upon admission to couplet care, then every 6 hours for the first 24 hours post-delivery, then every shift until discharge, prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients and prn as clinically indicated or ordered by provider. Patient's temperature is taken x 1 following delivery.
      ii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12
   b. Post-Operative, Cesarean Delivery:
      i. PACU vital signs as ordered by anesthesiologist/provider
      ii. Vital signs, including temperature, upon admission to couplet care, then every 6 hours for first 48 hours post-delivery, then every shift and prn as clinically indicated or ordered by provider and prior to discharge per Patient Care Services (PCS) procedure Discharge of Patients
         1) See anesthesia Power Plan for vital signs in the first 24 hours after cesarean section (generally includes respiratory rate every 1 hour times 12 hours then every 2 hours times 12 hours).
      iii. Notify provider if:
         1) Temperature greater than or equal to 100.4° F or 38° C
         2) Blood pressure greater than or equal to systolic 140 and/or diastolic 90; greater than or equal to systolic 160 and/or 110 diastolic if known preeclamptic
         3) Pulse greater than or equal to 120 bpm
         4) Respirations greater than 28 or less than 12

B. **STANDARDS OF CARE: PAIN ASSESSMENT:**
1. Assessment: Pain per Pain Management Policy
   a. A general pain assessment shall consist of the following:
   b. Acceptable pain

c. Pain scale
d. Current pain intensity
e. If patient complains of pain, assess the following:
   i. Location, intensity, and duration/onset
   ii. Quality/type
   iii. Aggravating factors
   iv. Alleviating factors
f. Assess for presence of pain/discomfort with vital signs and PRN
g. Perform a pain assessment with each patient report of new or different pain.
h. Perform a pain reassessment as follows:
   i. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention
   ii. One (1) hour after PO intervention

C. **STANDARDS OF CARE: INTAKE AND OUTPUT:**

1. Intake and output shall be monitored as ordered and as follows:
   a. Postpartum, Vaginal Delivery:
      i. Check if patient voiding without difficulty x 2 post-delivery.RN or designee to offer assistance as needed.
      ii. After delivery or after catheter removal goal is for patient to void spontaneously within 6 hours
         1) If patient on I/O or has an IV ordered, notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
      iii. Maintain IV access for 24 hrs. post epidural anesthesia unless ordered by provider.
      iv. Post-partum hemorrhage
         1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
         2) Monitor lochia- color, odor, amount, consistency, clots, steady stream or trickle
            a) Assess pads and saturation
            b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
            c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
            d) Refer to WNS Obstetrical Hemorrhage procedure.
   b. Postoperative, Cesarean Delivery:
      i. OB PACU: upon arrival from the OR and prior to transfer to couplet care:
         1) Assess and document the number of the IV fluid bag
         2) Assess and document patency of the Foley catheter with urine collection bag for amount, color and clarity of urine
      ii. I&O totals every shift with 24 hour totals for day of delivery, and post-op day.
         1) Notify provider if measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours
         2) IV converted to saline lock or discontinued on post-op day 1, or as ordered by provider
         3) Foley catheter discontinued on post-op day 1 or as ordered by provider
            a) Assess bladder/voiding difficulties prn
            b) Check voiding x2 post-removal of catheter. RN or designee to offer assistance as needed. After catheter removal goal is for patient to void spontaneously within 6 hours.
      iii. Post-operative cesarean hemorrhage:

1) Assess and review risk factors for obstetrical hemorrhage, and monitor patient's blood loss for baseline blood loss output
2) Monitor lochia- color, odor, amount, consistency, clots, steady stream or trickle
a) Assess pads and saturation
b) Weigh all blood saturated pads, chux, other soft/cloth materials for accurate assessment of blood loss
c) Document blood loss in medical record, including provider notification, interventions, blood replacement products, and medications given.
d) Refer to WNS Obstetrical Hemorrhage procedure.

iv. Assess for the presence of tubes and drains, if present, assess type and location
1) Confirmation of placement, and drainage description
2) Check tube placement for drainage and insertion site integrity

D. **STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENT:**

1. Height and weight will be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation permits, it is preferred that the patient be weighed upon admission to Labor and Delivery.
a. Weights shall be documented in kilograms (kg) and height in centimeters (cm)
b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.

E. **STANDARDS OF CARE: ASPIRATION ASSESSMENT:**

1. Maintain aspiration precautions for maternal patients identified at risk.
a. Maintain head of bed (HOB) at 30 degrees at all times
i. If eclamptic seizure, lower head of bed, open airway, roll patient to side and suction secretions as necessary
ii. Avoid attempts to insert suctioning device when patient's teeth are clenched
b. Maintain suction equipment at bedside at all times.

F. **STANDARDS OF CARE: PATIENT SAFETY:**

1. The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes the bed in the lowest position, wheels locked, and room free of clutter.
2. Patient safety shall be assessed per the following:
a. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures and as needed.
b. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
c. Allergies will be monitored and documented upon admission
i. Any known medication or food allergy shall be documented as follows:
1) The patient allergy band
2) Allergy sticker placed on the front of the chart
3) Medication Administration Record
ii. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders Policy.
d. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
e. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
f. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
g. Patients shall be assessed for falls per PCS: Falls Risk Procedure.

h. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit-specific hand-off policies.
i. Medication shall be reconciled per PCS: Medication Reconciliation Policy.
j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

SYSTEM REVIEW

A. All maternal patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

B. **STANDARD OF CARE 1: ASSESSMENT:**
1. All patients admitted to WNS nursing units shall be assessed by a Registered Nurse per the following:
2. Admission and/or Transfer: Assessment
3. Admission Assessment- Patient History:
   a. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
      i. This assessment-patient history shall include an assessment for obstetric hemorrhage
4. Medication Patient History Form
   a. All patients shall have a Medication Patient History completed as soon as possible upon arrival to the unit per the Medication Reconciliation Policy.
5. Initial Shift Assessment
   a. RN shall initiate an ongoing head to toe assessment as follows: within 3 hours of the start of the shift
6. Reassessment/focused assessment may be documented as no change since last assessment
   a. After completion of an Admission or an Initial shift Assessment, all patients shall have a:
      i. Focused reassessment (to usually include fundus, lochia, bladder incision if applicable) performed and documented in the EMR.
      ii. A more detailed assessment may be completed dependent on clinical condition or per PCS Magnesium Sulfate procedure.
      iii. If the patient refuses a reassessment, document their refusal in the medical record.
      iv. System Specific Assessment (Focus assessment/postpartum assessment) shall also be completed as follows:
         1) Change in patient's condition from the initial shift assessment or reassessment.
         2) Response to treatment provided to a patient
   b. Postpartum assessment and frequency:
      i. Uterine assessment (to include lochia assessment):
         1) Fundal height/relationship to umbilicus (-3, -2, -1, 0, +1, +2, +3)
         2) Location (midline (ML), right of ML, left of ML, displaced – bladder assessment)
         3) Consistency (firm, boggy - firms with massage, boggy)
         4) Time intervals, beginning post-delivery:
            a) Birth – 2 hrs.: every 15 minutes x4, then at 2hours
            b) 2hrs-6hrs: upon admission to MBU, then every 6 hrs. post-delivery
            c) Vaginal Delivery: 6- 24 Hrs. every 6 hrs. or sooner if clinically indicated times 24 hours, then q shift until discharge
            d) Cesarean Section: 6-48 hours: every 6 hours or sooner if clinical indicated times 24 hours then q shift until discharge.

ii. Evaluation of blood loss/lochia: include at the same time intervals for uterine assessment
1) Slight, Scant, Moderate, Heavy (with or without clots)
2) Rubra, serosa or other
3) Note presence of foul odor
4) Risk assessment for obstetric hemorrhage
a) Refer to WNS Obstetrical hemorrhage procedure.
iii. Perineal/hemorrhoid assessment as applicable.
1) Approximated
2) Color (presence or absence of ecchymosis)
3) Edema
4) Presence or absence of Hemorrhoids

C. **STANDARDS OF CARE 1.1: ASSESSMENT NEUROLOGICAL SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Neurological: System Review
a. Assess the following:
i. Level of consciousness
ii. Orientation
iii. Presence of Headache
iv. Visual disturbances, e.g. blurred vision or scotoma
v. Deep Tendon Reflexes
vi. Patellar or brachial
vii. Clonus
b. Effects of epidural/regional anesthesia on lower extremities
i. Progressive return to pre-anesthesia response, accompanied by increased voluntary movement of legs
ii. Assessment of epidural site, removal of catheter post-delivery per procedure (Reference: WNS procedure: "Epidural Medication Administration")

D. **STANDARDS OF CARE 1.2: ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Cardiovascular System Review
a. Assess heart sounds in all auscultatory areas; note regular or irregular
b. Check capillary refill
c. Check edema location and grade
d. Palpate bilateral peripheral pulses: radial and dorsalis pedis
e. Assess peripheral perfusion; skin warm and dry
f. Assess Homan's sign for presence of thrombophlebitis

E. **STANDARDS OF CARE 1.3: ASSESSMENT PULMONARY SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Pulmonary: System Review
a. Check oxygen delivery devices if applicable
b. Check amount oxygen flow if applicable
c. Assess pulse oximetry
i. For Magnesium Sulfate administration for preeclampsia/preterm labor see Reference: PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"
d. Assess respiratory effort
e. Auscultate breath sounds all lobes
f. Assess sputum amount, color, and consistency if applicable
g. Assess for presence of cough
h. Assess for presence of artificial airway, tubes, and drains if applicable
i. Assess chest expansion for symmetry

F. **STANDARDS OF CARE1.4: ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. GI: System Review
   a. Assess abdomen
      i. Round, distention
      ii. Soft, firm, distended, non-distended
   b. Assess for nausea and/or vomiting
   c. Auscultate for presence of bowel sounds in all four quadrants
   d. Assess bowel function including passing flatus or last stool

G. **STANDARDS OF CARE 1.5: ASSESSMENT GENITOUTINARY SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Genitourinary (GU) System Review
   a. Assess urine color and clarity, frequency and voiding difficulties/dysuria
   b. Assess for bladder distension

H. **STANDARDS OF CARE 1.6: ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Musculoskeletal System Review
   a. Presence of assistive devices
   b. Presence of joint or musculoskeletal abnormalities
   c. Full range of motion against gravity, some to full resistance of all extremities
   d. Mobility appropriate for age

I. **STANDARDS OF CARE 1.7: ASSESSMENT INTEGUMENTARY SYSTEM REVIEW ADMISSION ASSESSMENT:**
1. Integumentary System Review:
   a. Assess mucous membranes
   b. Skin color; consistent with person's ethnicity
   c. Palpate skin for temperature and moisture
   d. Assess skin turgor
   e. Assess skin integrity, temperature, and condition of any dressings
   f. Complete Braden Scale
   g. Assess for presence of specialty mattress/bed or overlay
   h. Assess for the presence of skin abnormalities
   i. Assess for the presence of pressure ulcers

J. **STANDARDS OF CARE 1.8: ASSESSMENT PSYCHO/SOCIAL ADMISSION ASSESSMENT:**
1. Psychosocial assessment shall consist of the following:
   a. Coping
   b. Affect/Behavior
   c. Social Service (SS) Referral Reason
   d. Distress
   e. Stressors
   f. Support/Coping Interventions
2. Psycho/Social: Nursing Interventions will be documented on initial admission assessment and prn if change occurs
   a. In ordered to promote family centered care, the nurse shall:
      i. Introduce bedside health care providers to the patient/family.
      ii. Review visitation and unit policies to patient/family on admission and as needed.
      iii. Assess and then verify with patient/family age appropriate needs.
      iv. Assess and then verify patient/family's ability to understand and participate in the plan of care.

v. Encourage the family to have periods of uninterrupted sleep/bonding when appropriate.
vi. Promote patient/family centered care
1) Discuss expectations and collaborate with patient/family
2) Encourage patient/family to ask questions
vii. Promote patient independence in Activities of Daily Living (ADL)
viii. Promote comfort measures (if ordered or request order) by:
1) Music therapy
2) Therapeutic recreation
3) Spiritual comfort
4) Guided imagery
5) Reminiscence therapy
6) Encourage family/friend to visit
7) Arrange for a child's visitation
8) Arrange for pet therapy
9) Arrange for physical and/or occupational therapy.
ix. Patients shall be informed of their responsibilities upon admission and as necessary thereafter.
1) These responsibilities include:
a) Providing information
b) Asking questions
c) Following instructions
d) Following rules and regulations
e) Showing respect and consideration
f) Meeting financial commitments.
i) See TCMC Patient Handbook.
x. Encourage patient and/or their family to participate in their plan of care.
xi. Observe bonding behaviors when applicable:
1) Eye contact
2) Holding infant
3) Talking to infant
4) Participating in care of infant – feeding, diaper changes, comforting
xii. Request social services as appropriate.
1) Initiate social services referrals for the following (including, but not limited to:
a) Adoptions; surrogates
b) Infants going to foster care
c) Patients with no prenatal care
d) Teen moms
e) Positive toxicology results
f) Mothers of infants in Neonatal Intensive Care or in another facility
g) All mothers and families experiencing Perinatal loss
h) Assistance with post-partum home care

K. **STANDARDS OF CARE: INFUSION THERAPY:**
1. Central venous lines shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed on admission, ongoing and transfer from other nursing unit.
a. The following shall be assessed:
i. IV insertion date
ii. IV access type
iii. IV site and condition
iv. Patency
v. Dressing type and condition
vi. Date infusion changed
vii. Date central venous dressing changed

3. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN.
4. Maintenance or continuous infusion shall be assessed every 2 hours and PRN
5. Infusion Therapy: Nursing Interventions
   a. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
   b. Document initials and date IV started directly on the dressing.
   c. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
   d. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site
   e. IV solutions and tubing shall be changed as follows:
      i. Change every 4 days
         1) All IV tubing
         2) Add-on devices (neutral displacement connector MicroClave), antireflux, extension set, etc.) and with tubing change
         3) Rotate IV insertion sites
         4) Commercially prepared solutions, if the bag is spiked once with initial start
         5) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback
      ii. Change every 24 hours
         1) All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours
         2) Lipids or lipid containing products
         3) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc.) and with tubing change
   f. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
   g. Label IV solutions with date and time IV solution hung and document in the EMR
   h. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site
   i. Infusion pumps shall be used per TCMC Infusion Pump Infusion System with Guardrails.
   j. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy.
   k. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
   l. Swab Cap
      i. When a Central Venous line injection port is not in use, place an Swab Cap on the unused port(s).
      ii. Apply a new Swab Cap
         1) Every time the cap is removed
         2) Every 8 hours with routine IV flushing
      iii. PRN IV flushing

L. **STANDARDS OF CARE: IMMUNIZATIONS/OTHER:**
1. Rhogam will be administered if indicated
2. Rubella will be administered if needed
3. During the flu season: patients will be screened for influenza and vaccination will be administered if indicated per Standardized Procedure Pneumococcal and Influenza Vaccine Screening and Administration
4. All patients will be screened for Tetanus, Diphtheria, Pertussis (Tdap) and vaccination will be administered if indicated per Standardized Procedure Tetanus, Diphtheria, and Pertussis (Tdap) Vaccine Administration for Postpartum Patients.

M. **REFERENCES:**

1. ~~American Academy of Pediatrics and American College of Obstetricians and Gynecologists 2012. *Guidelines for Perinatal Care Seventh Edition.* Washington, DC~~
2. ~~American Nurses Association (ANA). (2010). *Nursing scope and standards of practice.* Silver Spring, MD: Nursesbooks.org.~~
3. ~~American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org~~
4. ~~Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.~~
5. ~~Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (2014). 4th edition.~~
6. ~~California Board of Registered Nursing. (2010). Nursing practice act business and professions code. Chapter 6 Nursing: Section 2725. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
7. ~~California Board of Registered Nursing. (2010). Standards of competent performance, California code of regulations, title 16, section 1443.5. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
8. ~~California Board of Registered Nursing. (2010). California code of regulations, title 22, section 70125. Retrieved March 2010 from http://www.rn.ca.gov/regulations/rn.shtml~~
9. ~~Mattson, S., & Smith, J.E. (Eds.) (2011) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia, PA: Saunders~~

Tri-City Medical Center	~~Distribution:~~ **Women and Newborn Services**
PROCEDURE:	**VIBROACOUSTIC STIMULATION (VAS)**
Purpose:	To evaluate fetal acid base status and ~~to evaluate~~ fetal well-being during antepartum testing. ~~**and** or during intrapartum fetal heart rate monitoring.~~
Supportive Data:	This screening test is a method of evaluating fetal **acid base** status by observing fetal heart rate (FHR) response following **vibro**acoustic stimulation. A single startle response ~~**or**~~**and** acceleration of the FHR in response to VAS is associated with a functional brainstem ~~**and the absence of fetal acidosis,**~~ regardless of fetal age.~~. VAS should be performed when the FHR is within a normal baseline range.~~
Equipment:	1. Electronic fetal monitor 2. A**Vibroa**coustic stimulator

A. **INDICATIONS:**

1. VAS **is** ~~may be~~ considered **an indirect method for evaluation of** ~~as a method to evaluate~~ fetal well-being when:
   - **a.** A non-reactive~~,~~ non-stress test (NST) ~~**(see the WNS Non-Stress Test procedure in Elsevier)**~~ is observed after 20—40 minutes of monitoring.
     - **i. See Elsevier Online Skills: NST**

~~Absent or minimal FHR variability and absence of accelerations is noted **for longer than 40 minutes** during a 50-90 minute period of antepartum or intrapartum electronic fetal monitoring.~~

~~**To differentiate between normal sleep cycles versus insufficient fetal oxygenation, preexisting fetal neurologic insult or the presence of a major neurologic or cardiac congenital anomaly.**~~

~~a. Estimated Gestational Age (EGA) is **> 25 weeks**~~

B. **CONTRAINDICATIONS:**

1. VAS should NOT be performed during ~~episodes of~~ **possible stress such as**:
- **a. Vaginal exams**
- ~~1.~~**b. Uterine contractions**
- ~~a.~~**c.** FHR bradycardia
- ~~b.~~**d.** FHR tachycardia
- ~~c.~~**e.** FHR decelerations

C. **PROCEDURE:**

1. Explain the procedure to the patient.

2. **Perform Leopold maneuvers to determine fetal head position**
- ~~1.~~**a. See Elsevier Online Skills: Leopold Maneuvers**

~~2.~~**3.** Position/reposition the FHR and uterine monitors to obtain an interpretable/recordable tracing.

4. Position the VAS on the maternal abdomen near the fetal head ~~**(vertex or breech positions have been found to both be effective)**~~ and apply the ~~sound~~ stimulus for one to two seconds.
- **a. A FHR acceleration is a positive response to the VAS and a reassuring sign of fetal well-being.**
- **b. If, in response to VAS, the fetus elicits a prolonged acceleration or tachycardia, do not apply further stimulus.**
- **c. If NST remains nonreactive, VAS may be repeated up to three times, for progressively longer intervals lasting up to 3 seconds during each attempt.**
  - **i. If the NST is still nonreactive, following a total of 4 VAS attempts, notify the provider as alternate tests may need to be considered to assess for fetal well-being.**

Review/Revision Date	Department of OB/GYN	Division of Neonatology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
2/06, 12/12, 01/16, **01/22**	01/13, 01/16, **06/22**	n/a	n/a	05/13; 02/16, **06/22**	**08/22**	06/13; 03/16, **n/a**	06/13; 03/16

~~3.~~

~~a. If the FHR remains nNon-**Reactive**ractice, the VAS may be repeated at one minute intervals up to three times, progressing to a maximum stimulation duration of three seconds.~~

~~4. Do not apply stimulus during a contraction.~~

~~5. 8**This is reflective of a pH (absent of acidosis) greater than or equal to 7.19.**~~

~~a. For an EGA less than 32 weeks, a FHR acceleration **greater or equal to** ≥10 bpm above the baseline, lasting **greater or equal to** 10 seconds is considered a POSITIVE response. See WNS Fetal Heart Rate Surveillance Policy.~~

~~6. In the absence of a FHR acceleration:~~

~~a. The VAS may be repeated at one-minute intervals up to three times **as mentioned above**.~~

~~b. If FHR continues to have no accelerations, alternate tests may need to be considered to assess for fetal well-being. (A Contraction Stress Test or Biophysical Profile may be added per provider order.~~

D. **PROVIDER NOTIFICATION:**

~~1.~~ Notify the provider **of the fetal response to VAS.** ~~for the absence of an acceleration following VAS attempt.~~

1.

~~2.~~ **A change in FHR indicating a CAT II or CAT III tracing.** ~~Inform the provider for the presence of a Category II **fetal heart rate tracing progressing to a Category III** or a **Category** III FHR **tracing** pattern after VAS attempt.~~

2.

E. **DOCUMENTATION:**

1. Document procedure, **provider notification and fetal response in the electronic medical record.**~~, any provider notification, and fetal monitoring tracing and/or fetal monitoring response to VAS in the electronic medical record.~~

F. **RELATED DOCUMENTS:**

1. **Fetal Heart Rate (FHR) Surveillance/Monitoring policy**

G. **REFERENCES:**

1. **American Academy of Pediatrics. 2017. Guidelines for Perinatal Care, 8th ed.**
2. **Lyndon, A., Wisner, K. 2021. Fetal Heart Monitoring Principles and Practices, 6th ed. Washington, DC: Kendall Hunt.**

~~F.~~**3. Mattson, S., Smith, J. 2016. Core Curriculum for Maternal-Newborn Nursing, 5th ed. St. Louis, MI: Elsevier.**

~~1. Lyndon, A. & Ali, L.inda (2015)). Fetal Heart Monitoring Principles in Practices 5th Ed). Washing ton D.C.: Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN). Washington D. C., Kendall Hunt Publishing.~~

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
May 26, 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 May 26, 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
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
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 Younger to approve the agenda as presented. Director Chaya seconded the motion. The motion passed unanimously.

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 May 26, 2022 Regular Board of Directors Meeting Agenda.

5. Special Recognitions –

- 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: Rachel Herrera

Ms. Candice Parras, Chief of Patient Care Services stated a recognition ceremony was held on May 9th to recognize our Nurses and Support Staff of the Year for 2022, including Laura Lamour, Nurse of the Year (Day Shift), Dagmara Kolasa, Nurse of the Year (Night Shift), Rachael Herrea, Patient Support Staff of the Year and Karen Conyers (Above and Beyond). The winners were selected by their peers.

Kolasa Dagmara was present via Zoom and stated the award was one of her greatest accomplishments this year. She added that she felt supportive in her personal growth and feels blessed and grateful to be working with such great people.

On behalf of the Board of Directors, Chairperson Chavez congratulated the award recipients.

6. May, 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 – $287,224
- Operating Expense - $306,978
- EBITDA - $49
- EROE – (10,674)

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

- Average Daily Census – 161
- Adjusted Patient Days – 94,172
- Surgery Cases – 5,475
- ED Visits – 41,575

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

- Net Operating Revenue – $28,625
- Operating Expense - $31,722
- EBITDA – ($1,085)
- EROE – ($2,149)

Mr. Rivas explained for the first six months of this year we were performing better than budget. However, in January the COVID surge hit and it has been a struggle since as there is no Cares Act grant monies being disbursed or other governmental assistance. In addition, there was a labor shortage and we were forced to get contract labor which was costly.

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

- Average Daily Census – 148
- Adjusted Patient Days – 9,076
- Surgery Cases – 557
- ED Visits – 4,192

6. New Business

a) Consideration of proposed Board Committee Charters and Committee List.

Chairperson Chavez referred Board members to the Board Committee Charters and Committee assignments. There were no questions or comments.

It was moved by Director Chaya to approve the proposed Board Committee Charters and Committee List as presented. 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 of Board Sponsorship for Foundation Gala

Chairperson Chavez stated in 2021 the Board approved a $50,000 sponsorship to the annual Foundation Gala. Today's agenda item is to seek the Board's support for the 2022 Foundation Gala.

Ms. Jennifer Paroly, Foundation President stated the Foundation's goal is to support the hospital and the Board's monetary support is completely voluntary. Ms. Paroly stated the Foundation has spearheaded the Emergency Department remodel project with the help from the Copley Foundation and hope to completely fund that project. She reported the Foundation is also funding 50% of the new MRI, along with the hospital and have provided $100,000 to support the OB Initiative. Ms. Paroly expressed her appreciation to the Board for their support and solidarity with the Foundation Board.

It was moved by Director Gleason that the Board of Directors support the Foundation Gala with a sponsorship of $50,000. Director Chaya 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 May 2022 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on May 23, 2022.

Dr. Johnson presented the Medical Staff Credentials which included 9 Initial Appointments, 25 Reappointments, 1 Reinstatement, 1 Change of Status, 1 Update to Previous Reappointment, 1 Automatic Resignation, 10 Voluntary Resignations and 3 Proctoring Recommendations.

It was moved by Director Mizell to approve the May 2022 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on May 26, 2022. Director Gleason 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

Chairperson Chavez pulled the Outpatient Behavioral Health Services Admission and Eligibility Criteria policy.

It was moved by Director Gleason to approve the Consent Calendar minus the item pulled. 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**

10. Discussion of items pulled from Consent Calendar

Candice Parras, Chief of Patient Care Services provided information on the outpatient Behavioral Health Services program which provides day, evening and group sessions. Patients are safe and screened for suicidal tendencies as well as screen watched during their group sessions. The program will not take anyone younger than 14 years of age or those that are destructive.

Ms. Parras also commented on the Crisis Stabilization Unit which interfaces with Tri-City's outpatient program and is a great benefit to our community.

It was moved by Director Chavez to approve the Outpatient Behavioral Health Services Policy Admission and Eligibility Criteria. Director Chaya 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**

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 commented on the Outpatient Behavioral Health program as well, noting it is an intensive program and a key component in the services Tri-City provides. Mr. Dietlin also commented on the two Crisis Stabilization Units (CSU), one of which is in Vista and a second one in Oceanside. He stated he is optimistic that we will be able to break ground in the coming months on the 16-bed inpatient Psychiatric Health Facility in which we are partnering with the county.

Mr. Dietlin provided a brief COVID-19 update. Currently Tri-City's has 16 COVID-19 positive inpatients and county-wide there are 181. Mr. Dietlin stated the Tri-City team has been exemplary throughout the pandemic and the clinical outcomes have been fantastic. He expressed his appreciation to everyone for their efforts.

Mr. Dietlin congratulated the nurses and support staff for the awards received during Nurse's Week. Those individuals were chosen by their peers which is a great honor.

Mr. Dietlin reported the Joint Commission conducted their survey during Nurse's Week as well. He thanked everyone involved including Board members who participated for their collaboration and stellar performance.

Mr. Dietlin reported the Emergency Room remodel project is going out to bid. In addition, we are continuing to move forward with the MRI project and on target to get equipment installed by December.

Lastly, Mr. Dietlin reported Tri-City was recently awarded Business of the Year at the Carlsbad Business Awards luncheon. He congratulated Aaron Byzak, Chief External Awards officer and his team for being instrumental in the large number of awards Tri-City has received. The awards reflect the hospital's mission to advance the healthcare of our community.

13. Board Communications

Director Coulter stated he attended the Carlsbad Business Awards Luncheon and was thrilled to see Tri-City win the award.

Director Chaya congratulated the Nurse's Week award recipients. She also congratulated nurses, physicians and staff on a successful Joint Commission survey.

Director Mizell stated it is clear we are meeting our patient's needs. He congratulated the nurses and support staff on their awards and gave kudos to the patient mobility tech team. He noted every single person on the team is necessary and is vital to the success of the organization. Lastly, Mr. Mizell stated he is happy to be a member of the Board of Directors and being able to see how well this hospital operates.

Director Sanchez stated there is so much to celebrate this month. She congratulated the winners of the Nurse and Support Staff awards and recognized the 23 awards the organization has received with the help of Mr. Aaron Byzak and his team. Director Sanchez also reminded everyone of the Foundation Golf Tournament scheduled for June 13th.

Director Younger congratulated everyone on a successful Joint Commission Survey. She also congratulated the 2022 Nurses and Support Staff of the Year. Lastly, Director Younger congratulated Mr. Aaron Byzak, Chief External Affairs Officer and his team on the many awards Tri-City has received out in the community.

Director Gleason echoed her congratulations to all that were recognized at today's meeting and stated she is very proud to share the wonderful news reported today.

14. Report from Chairperson

Chairperson Chavez recognized the nurses for everything they do each and every day.

Chairperson Chavez commented on the upcoming General Election on November 8th and noted incumbents and candidates will have a short window to declare their candidacy beginning July 18th through August 12th.

Chairperson Chavez reminded everyone that Memorial Day is a day of recognition for those service members who have died for our country.

15. Move to adjourn

It was moved by Director Younger and seconded by Director Coulter to adjourn the meeting. The motion passed unanimously (7-0).

16. There being no further business Chairperson Chavez adjourned the meeting at 4:10 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

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

June 10, 2022 – 3:00 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:00 p.m. on June 10, 2022.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy Younger

Absent was Director Nina Chaya, M.D. *(due to conflict of interest)*

Also present via teleconference were:

Steve Dietlin, Chief Executive Officer
Gene Ma, M.D., Chief Medical Officer
Jeff Scott, Board Counsel
Barbara Hainsworth, Senior Administrative Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:02 p.m. via teleconference with attendance as listed above.

2. Approval of agenda

   It was moved by Director Coulter to approve the agenda as presented. Director Sanchez seconded the motion. The motion passed (6-0-0-1) with Director Chaya 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 June 10, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included a Report Involving Trade Secrets.

5. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Coulter to go into Closed Session at 3:05 p.m. The motion passed (6-0-0-1) with Director Chaya absent.

6. At 4:10 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 concerning Trade Secrets pursuant to Health & Safety Code Section 32016 and took no action.

8. New Business

a) Consideration to authorize negotiation and execution of an Anesthesia Services Agreement for Tri-City Medical Center.

It was moved by Director Coulter that the Tri-City Healthcare District Board of Directors authorize management to negotiate and execute an Anesthesia Coverage Agreement for Tri-City Medical Center.

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

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

8. Adjournment

It was moved by Director Coulter and seconded by Director Younger to adjourn the meeting at 4:16 p.m. The motion passed (6-0-0-1) with Director Chaya absent.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

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

June 29, 2022 – 3:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on June 29, 2022.

The following Directors constituting a quorum of the Board of Directors were present;

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy Younger

Also present were:

Steve Dietlin, Chief Executive Officer
Gene Ma, M.D., Chief Medical Officer
Candice Parras, Chief Patient Care Services
Ray Rivas, Chief Financial Officer
Jeremy Raimo, SVP, Business Development
Jeff Scott, Board Counsel

1. Chairperson Chavez called the meeting to order at 3:05 p.m. with attendance as listed.

2. Approval of Agenda.

   It was moved by Director Gleason, seconded by Director Coulter, and unanimously passed to approve the agenda as presented.

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

   Board Counsel Jeff Scott made an oral announcement of the items listed on the June 29, 2022, Special Board Meeting Agenda to be discussed during Closed Session.

5. Motion to go into Closed Session.

   It was moved by Director Younger, seconded by Director Gleason, and unanimously carried to go into Closed Session in accordance with the items listed on the June 29, 2022 agenda.

6. At 4:10 p.m. the Board returned to Open Session with attendance as previously noted.

7. Report After Closed Session.

   Board Counsel Scott reported that the Board in Closed Session heard a report and discussed trade secrets in accordance with Government Code Section 32106 and took no action.

8. New Business.

a) Review, discussion, and action regarding the Operating and Capital Budgets for Fiscal year 2023.

CFO Rivas reviewed the FY 2022 and the projected FY 2023 operations budgets. Key indicators were reviewed, including Average Daily Census, Average Lengths of Stay and Discharges. Mr. Rivas also reviewed the Financial Statements for FY 2022, the projected Financial Statements for FY 2023, Gross Revenues and Expenses as well as hospital Assets and Liabilities. Mr. Rivas also reviewed the proposed Capital Budget for FY 2023.

After Board discussion, it was moved by Director Mizell, seconded by Director Gleason, and unanimously carried to approve the Operating and Capital Budgets as presented for FY 2023.

b) Review, discussion, and consideration to extend the MidCap Financial Services Capital Management Credit Agreement.

CFO Rivas provided a report to the Board on extending the MidCap Financial Services Capital Credit Management Agreement.

After Board discussion, it was moved by Director Coulter, seconded by Director Younger, and unanimously carried to approve the extension of the MidCap Financial Services Capital Management Credit Agreement.

Director Younger left the meeting at 4:30 p.m.

10. Reconvene to Closed Session.

It was moved by Director Sanchez, seconded by Director Coulter, and unanimously carried *(with the absence of Director Younger)* to reconvene to Closed Session in accordance with the items listed on the June 29, 2022, agenda.

11. Report After Closed Session.

Counsel Scott reported that the Board met in Closed Session and heard a report involving Hospital Trade Secrets, potential litigation pursuant to Government Code 54956.9(d) 2, and Quality Assurance matters pursuant to Health & Safety Code 32155. The Board directed staff to take appropriate action concerning the potential litigation matter and took no action on the Hospital Trade Secret and Quality Assurance items.

12. Adjournment.

It was moved by Director Chaya, seconded by Director Sanchez, and unanimously carried to adjourn the meeting at 5:30 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
June 30, 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 June 30, 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
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs Officer
Dr. Gene Ma, Chief Medical Officer
Anna Aguilar, Vice President, Human Resources
Jeremy Raimo, SVP, Business Development
Susan Bond, General Counsel
Roger Cortez, Chief Compliance Officer
Jennifer Paroly, Foundation President
Eva England, Sr. Director, Ancillary Svcs.
Mark Albright, VP of IT
Dr. Jamie Johnson, Chief of Staff
Jeffrey Scott, Board Counsel
Karren Hertz, Sr. Admin. 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 Gleason seconded the motion. The motion passed unanimously.

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 June 30, 2022 Regular Board of Directors Meeting Agenda.

5. May 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 – $311,737
- Operating Expense – $341,081
- EBITDA – ($7,724)
- EROE ($19,497)

Mr. Rivas also reported on the fiscal year to date financials (Normalized – in Thousands) as follows:

- Net Operating Revenue – $319,737
- Operating Expense – $341,081
- EBITDA – $276
- EROE – ($11,497)

Mr. Rivas stated that the anticipated IGT (Intergovernmental Transfer) has not been recorded as of this period, thus reflecting an EROE Variance of ($21,622) versus an anticipated EROE Variance of ($13,622). Mr. Rivas commented on the Average Length of Stay which is currently at 5.81 and aiming for a 4.5 target.

Lastly, Mr. Rivas presented graphs which reflects TCMC's Average Daily Census (Excluding Newborns) and Acute Average Length of Stay (LOS).

6. New Business - None

7. Old Business - None

8. Chief of Staff

a) Consideration of the June 2022 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on June 27, 2022.

Dr. Johnson presented the Medical Staff Credentials which included 10 Initial Appointments, 27 Reappointments, 1 Reinstatement, 1 Automatic Resignation, 8 Voluntary Resignations, 2 Automatic Relinquishment of Privileges, 1 Additional Privilege Request and 2 Proctoring Recommendations.

It was moved by Director Chaya to approve the June 2022 Credentialing Actions Involving the Medical Staff as recommended by the Medical Executive Committee on June 27, 2022. Director Gleason 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 questioned the age requirement concerning elder abuse reporting. Ms. Candice Parras, Chief Patient Care Services explained Policy 8610-309 "Reporting Suspected Dependent Adult/Elder Abuse Neglect/Exploitation" has been modified as the State of California recently changed the age requirement for abuse reporting from 65 to 60 years of age.

It was moved by Director Coulter to approve the Consent Calendar. Director Gleason 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**

10. Discussion of items pulled from Consent Calendar

There were no items pulled from the Consent Calendar

11. Comments by Members of the Public

There were no comments by members of the public.

12. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO provided a brief update on current COVID-19 statistics. He also commented on today's financial report and plans to see an improved FY2023 with everyone working together.

Mr. Dietlin recognized the Oceanside Heroes of the Year award recipients Sarah Jayyousi, Jason Taua, Julia Montes and Jessica Shrader.

Mr. Dietlin reported the Auxiliary has presented the hospital with a check in the amount of $25,000. He expressed his appreciation to the Auxiliary for their support and dedication.

Lastly, Mr. Dietlin reported construction on the 16-bed stand-alone Psychiatric Health Facility (PHF) is still pending but moving forward in the right direction.

13. Board Communications

Board members expressed their gratitude towards the Auxiliary for not only their monetary support but their countless hours of hard work and dedication to the hospital.

Board members also commented on the Oceanside Heroes of the Year event in which staff were once again recognized for their community achievements.

14. Report from Chairperson

Chairperson Chavez acknowledged the generous support from the Auxiliary.

Chairperson Chavez requested a report from External Affairs at the next Regular Board meeting.

15. Move to adjourn

It was moved by Director Gleason 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 4:20 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending July 31, 2022

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	LeaseTerm 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)	54,884.88	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	Approx 10,218	$2.58	(a)	34,930.23	07/01/17	07/31/24	**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)	17,473.44	07/01/17	06/30/27	**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)	15,268.06	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)	13,247.41	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)	14,867.90	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	07/31/22	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**221,030.09**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending July 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	BEHAVIOR TRAINING	70722EDU	199.99	84122	SPRUEL CANDYCE
8740	YRAUMA CONFRENCE	71522EDU	200.00	84131	MORELLI CHRISTINA
8740	CERTIFIED TECHNICIAN CLASS	71522EDU	125.00	84132	CAMARGO DAVID
8740	NCC-RNC	70722EDU	200.00	56790	ROSENLOF, GLORIA
8740	NATIONAL TEACHING INSTITUTE	71522 EDU	200.00	80572	FLEMING, ELIZABETH
8740	SPINNIN BABIES	70722EDU	200.00	83316	TROESH, ROMINA

**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.