TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
November 17, 2022 – 3:30 o'clock p.m.

In accordance with California Government Code Section 54953 teleconferencing will be used by the Board members and appropriate staff members during this meeting. Members of the public will also be able to participate by telephone, using the following dial in information:

Dial in #: (669-900-6833) To Listen and Address the Board when called upon: Meeting ID: 878 6799 8894; Passcode: 939181

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	Roll Call / Pledge of Allegiance		
3	Approval of agenda	2 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	Reports – Information Only a) Foundation Report – Jennifer Paroly b) Chief Nurse Executive – Candice Parras	 10 min. 10 min.	 Foundation President CNE
6	September 2022 Financial Statement Results	10 min.	CFO
7	New Business a) Board Swearing in Ceremony	 5 min.	 Chair
8	Old Business – None	-	-
9	Chief of Staff – *No Credentials this month*	-	-

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
10	Consideration of Consent Calendar ***Requested items to be pulled <u>require a second</u>*** (1) Approval of Resolution 820, 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 an agreement with Dr. Richard Smith, Medical Director for Infection Control for a term of 36 months, beginning December 1, 2022 and ending November 30, 2025, at an hourly rate of $176 for an annual cost not to exceed $63,360 and a total 3-year term cost not to exceed $190,080. (3) Approval of an agreement with David Amory. MD, James Andry, MD, Erin Farrelly, MD, Andrew Hartman, MD, Serve Kaska, MD, Hannah Kirby, MD, Kyle Mombell, MD, Grant Seiden, MD, Morgan Silldorf, MD. and Erik Stark, MD. to provide ED On-Call Coverage Panel for Orthopedics-General and Foot & Ankle, for a term of 24 months, beginning November 1, 2022 and ending October 31, 2024, at an annual cost of $746,125 and a total term cost of $1,492,250. (4) Approval of an agreement with Yuan Lin, MD and Darrell Wu for second surgical assist services for registered TCMC hospital patients for Cardiovascular bypass procedures for a term of 22 months beginning November 1, 2022 and ending August 31, 2024 at a cost not to exceed $501,750.00. . (5) Administrative Committees **A. Policies** **1. Patient Care Services Policies & Procedures** a. Collection of a Blood Specimen by Skin Puncture Procedure b. Fall Risk Procedure Tool Procedure c. Newborn Screening Collection of Specimen Procedure d. Patient Complaints & Grievances e. Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition) f. Pronation Therapy for the Mechanically Ventilated Patient g. Pyxis Connect Scanner Procedure (DELETE) h. Safe Medical Device Act Tracking i. Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure j. Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient Policy k. Skin and Wound Care Policy l. Specimen Labeling Procedure **2. Administrative 200 District Operations** a. Cash Elective Surgical Procedures 263 b. Mandatory Reporting Requirements 236 c. Purchase of Budgeted Capital Assets 252 d. Self-Pay Billing Collections Policy **3. Administrative 500 District Operations**	10 min.	Standard

	Agenda Item	Time Allotted	Requestor
	a. Advanced Beneficiary Notification 503 b. Compliance Program Overview 532 c. Disclosure of Protected Health Information 513 d. Disposal of Confidential Records 510 e. Hiring and Employment: Duty to Report Suspected Misconduct Potential Compliance Irregularity 544 f. Education and Training; As-Needed Education and Training 549 g. HIPAA Mitigation 591 h. Monitoring Compliance – Auditing & Reporting – Annual Compliance Workplan 552 i. Pending Debarment, Criminal Charges or Adverse Action against Covered Contractors – 540 j. Rights to Request Privacy for Protected Health Information 526 k. Screening Covered Contractors – 539 l. Use and Disclosure of Protected Information for Fundraising 525 m. Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives 593 **4. Emergency Department** a. Culture Follow Up, Emergency Department **5. Emergency Operations Procedure (EOP) Manual** a. 4006-Influx of Infectious Patient Epidemic Influenza or other (DELETE) b. 4006 – IC-ED (DELETE) c. 4009 Traffic Control in the Event of a Disaster Security (DELETE) d. 4010 Disaster Procedure for Earthquake (DELETE) e. 4012 Employee Disaster Call Back Procedure-Hospital Wide f. 4013 Bomb Threat g. 4023 Communications Department Specific h. 4026 Code Orange Disaster Plan-Emergency Department Specific (DELETE) i. 4036 Plan-Food and Nutrition Department (DELETE) j. 4061 Staffing Resource Department Specific (DELETE) k. 4065 Radiation Accidents l. 4068 Mitigation, Preparation, Response and Recovery Plan – Emergency Department Specific (DELETE) m. 4071 Disaster Plan Activation Hospital Wide (DELETE) n. 4072 HEICS Command Structure-Hospital Wide (DELETE) o. 4073 Introduction to Disaster HEICS – An Overview Hospital Wide (DELETE) p. 4078 Chemical Disaster Emergency Department Specific q. Authorization for Volunteer Caregivers During Disasters r. Chemical Exposure Plan s. Clean Zone t. Damage Assessment u. Disruption of Service v. Hazardous Substance Flowchart (DELETE) w. Location of Disaster Work Station 4003 x. Patients that Require Decon y. Personnel Expectations		

	Agenda Item	Time Allotted	Requestor
	z. Procedure for Decon Tent aa. Purpose and Authority (DELETE) bb. Response to Wild Fires cc. Scope of Response (DELETE) dd. Triage Disaster Box (Delete) ee. Utility Mgmt Response Reference ff. Victim Tracking **6. Environment of Care Manual** a. 1135 Waiver, Requesting Policy b. Environmental and Waste Management for Ebola Virus Disease Procedure (DELETE) c. Hazardous Material Waste Training Procedures **7. Food & Nutrition** a. Clinical Nutrition Dietitian Staffing Policy b. Emergency Preparedness – Meals for all Nutricopia Policy c. Emergency Preparedness Food & Nutrition Disaster Plan Policy d. Nutritional Care and Assessment for Infants Admitted to NICU Policy **8. Home Care** a. Anticoagulation Therapy b. Central Venous Access Devices Procedure c. Emergency Preparedness Management Disaster Plan d. Medication Management **9. Outpatient Infusion Center** a. Age Specific Guidelines b. Data Management c. Diagnostic Tests d. Disseminating Medical Information e. Emergency Evacuation f. Environment of Care g. Fire Alarm – Evacuation Plan h. History and Physical i. Medical Emergencies j. Patient Discharge k. Patient Instructions l. Patient Record Content m. Physician/AHP Orders and Request for Service Orders Policy (DELETE) n. Scope of Services o. Staffing Plan p. Standards of Care **10. Patient Care Management** a. Utilization Management Plan Policy **11. Progressive Care unit** a. Admission Process for Progressive Care Unit (PCU) b. Hunger Strike, CDCR **12. Pulmonary Rehab** a. Emergency Response Plan b. Patient Enrollment		

	Agenda Item	Time Allotted	Requestor

c. Patient Referral

13. Radiology
a. Screening for Pregnancy in Patients Scheduled for Diagnostic Radiology Procedures

14. Rehabilitation
a. Behavior Management/Supervision Technique
b. Community Out-Reach Groups 800
c. Job Site Assessment 609
d. Occupational Therapy Assistant Supervision 707
e. Occupational Therapy Policy – 702
f. Supervision of Patient, OP 1106 Policy

15. Security
a. Code Adam – Infant Abduction 503
b. Code Red – Security Department Response 504
c. High Risk Patient or Visitor 509
d. Psychiatric Patient Escorts 216
e. Security Department Reports – 111

16. Women & Newborn Services
a. Cord Gas Collection
b. Group eta Streptococcal (GBS) Prevention and Treatment in Labor ad Newborn Follow-up
c. Hearing Screening Program: Newborn and Infants
d. Neonatal Delivery Room Attendance Policy
e. Newborn Hearing Screening: Inpatient and Outpatient Hearing Screening of Newborn and Infants Using Biological Equipment (DELETE)
f. Newborn Hearing Screening: State of California Reporting (DELETE)
g. Pitocin Administration for Induction/Augmentation
h. Preclampsia Care Guidelines

17. Wound Care
a. Adverse Reaction to Meds (DELETE)
b. Age-Specific Guidelines
c. Continuum of Care
d. Diagnosis Specific Guidelines
e. Diagnostic Tests
f. Environment of Care
g. History & Physical
h. Hospital Admission from the Center
i. Hypo-Hyperglycemia Management
j. Medical Emergencies
k. Medical Record Review
l. Minor Debridement
m. Nutritional Screening
n. Scope of Services
o. Standards of Care
p. Standards of Care – 1
q. Vascular Screen

(6) Minutes
a) September 29, 2022 – Regular Meeting
b) September 29, 2022 – Special Meeting
c) October 12, 2022 – Special Meeting

	Agenda Item	Time Allotted	Requestor
	(7) Meetings and Conferences – None (8) Dues and Memberships – a) 2023 California Special Districts Association (CSDA) Membership Renewal - $8,810.00 (9) Reports a) Lease Report – (September, 2022) b) Reimbursement Disclosure Report – (September, 2022)		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Chief Executive Officer	5 min.	Standard
14	Board Communications (three minutes per Board member)	18 min.	Standard
15	Report from Chairperson	3 min.	Standard
16	Total Time Budgeted for Open Session	1.5 hours	
17	Adjournment		

RESOLUTION NO. 820

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 November 17, 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: November 17, 2022
NAME OF AGREEMENT: Medical Director Agreement for Infection Control

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

Physician's Name: Richard Smith, M.D.

Area of Service: Infection Control

Term of Agreement: 36 months, Beginning December 1, 2022- Ending Nov 30, 2025

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

Rate/Hour	Hours per Month Not to Exceed	Hours per Year Not to Exceed	Monthly Cost Not to Exceed	Annual Cost Not to Exceed	36 Month Term Cost Not to Exceed
$176	30	360	$5,280	$63,360	$190,080

Description of Services/Supplies:

- Provide infectious disease clinical consultation as requested by medical staff
- Develop, implement and evaluate an infection control plan to mitigate inappropriate prescribing of antibiotics based on evidence-based, best practices in the contemporary practice of infectious disease
- Assure quality of preventative measures and risk aversion
- Establish and evaluate policies and procedures for medical and nursing care, including new treatment modalities, drug information and management protocols
- Recommend, develop and implement new services related to infection control and prevention
- Identify equipment and supply needs, and coordinate standardization of instrumentation/equipment for patient care as it relates to infection prevention
- Co-lead Infection Control meetings and attend other Hospital and Medical Staff meetings in order to accomplish the duties of this role

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 the agreement with Dr. Richard Smith as Medical Director of Infection Control for a term of 36 months, beginning December 1, 2022 and ending November 30, 2025, at an hourly rate of $176, for an annual cost not to exceed $63,360, and a total 3-year term cost not to exceed $190,080.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: November 17, 2022
NAME OF AGREEMENT: ED ON-CALL COVERAGE – ORTHOPEDICS- General, Foot & Ankle

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

Physician's Name: David Amory, M.D., James Andry, M.D., Erin Farrelly, M.D., Andrew Hartman, M.D., Serge Kaska, M.D., Hannah Kirby, M.D., Kyle Mombell, M.D., Grant Seiden, M.D., Morgan Silldorff, M.D., Erik Stark, M.D.

Area of Service: Emergency Department On-Call: Orthopedics

Term of Agreement: 24 months, Beginning November 1, 2022 – Ending October 31, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Shared Call agreement with Entire ED call panel for Orthopedic Surgery

Service	Rate/Day	Panel Days During Term	Panel Annual Cost
General	Mon-Fri: $1,750 Sat/Sun/Holidays: $1,800	515 days 215 days	$901,250 $387,000
Foot & Ankle	Mon-Fri: $250 Sat/Sun/Holidays: $350	515 days 215 days	$128,750 $75,250
		Total Term Cost	**$1,492,250**

Description of Services/Supplies:

- 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:		Yes	X	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 authorize the agreement with David Amory, M.D., James Andry, M.D., Erin Farrelly, M.D., Andrew Hartman, M.D., Serge Kaska, M.D., Hannah Kirby, M.D., Kyle Mombell, M.D., Grant Seiden, M.D., Morgan Silldorff, M.D., and Erik Stark, M.D. to provide ED On-Call Coverage Panel for Orthopedics-General and Foot & Ankle, for a term of 24 months, beginning November 1, 2022 and ending October 31, 2024, at an annual cost of $746,125 and a total term cost of $1,492,250.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: November 17, 2022
ED Call Agreement

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

Physicians Name: Yuan Lin, M.D./Dr. Darrell Wu, M.D.

Area of Service: Emergency Department On-Call: CVT Surgery Assist

Term of Agreement: 22 months, Beginning, Nov. 1, 2022 – Ending, Aug. 31, 2024

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

Rate/Day	Days per Year	Annual Cost	Total Term Cost
$750	Year 1: 365 days Year 2: 304 days	$274,500	$501,750

Position Responsibilities:

- Provide 24/7 patient coverage for CVT Surgery Assist services to the primary CVT surgeon taking call 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	

Person responsible for oversight of agreement: Johnathan Gonzales, Manager, Medical Staff, Gene Ma, M.D., Chief Medical Officer

Motion:
I move to approve the ED call agreement with a Yuan Lin, M.D. and Dr. Darrell Wu, MD. for second surgical assist services for registered TCMC hospital patients for Cardiovascular bypass procedures for a term of 22 months beginning November 1, 2022 and ending August 31, 2024 at a cost not to exceed $501,750.

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Collection of a Blood Specimen by Skin Puncture Procedure	2 year review, practice change	Forward to BOD for Approval
2. Fall Risk Procedure and Score Tool Procedure	2 year review, practice change	Forward to BOD for Approval
3. Newborn Screening Collection of Specimen Procedure	2 year review, practice change	Forward to BOD for Approval
4. Patient Complaints & Grievances	3 year review, practice change	Forward to BOD for Approval
5. Perinatal Death (Miscarriage, Stillbirth and Neonatal Death Care and Disposition)	2 year review, practice change	Forward to BOD for Approval
6. Pronation Therapy for the Mechanically Ventilated Patient	NEW	Forward to BOD for Approval
7. Pyxis Connect Scanner Procedure	DELETE	Forward to BOD for Approval
8. Safe Medical Device Act Tracking	3 year review, practice change	Forward to BOD for Approval
9. Sedation/ Analgesia Used During Therapeutic or Diagnostic Procedure	2 year review, practice change	Forward to BOD for Approval
10. Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient Policy	3 year review, practice change	Forward to BOD for Approval
11. Skin and Wound Care Policy	3 year review, practice change	Forward to BOD for Approval
12. Specimen Labeling Procedure	2 year review, practice change	Forward to BOD for Approval
Administrative 200 District Operations		
1. Cash Elective Surgical Procedures 263	3 year review, practice change	Forward to BOD for Approval
2. Mandatory Reporting Requirements 236	3 year review, practice change	Forward to BOD for Approval
3. Purchase of Budgeted Capital Assets 252	3 year review	Forward to BOD for Approval
4. Self-Pay Billing Collections Policy	NEW	Forward to BOD for Approval
Administrative 500 Compliance		
1. Advanced Beneficiary Notification 503	3 year review	Forward to BOD for Approval
2. Compliance Program Overview 532	3yr review, practice change	Forward to BOD for Approval
3. Disclosure of Protected Health Information 513	3 year review, practice change	Forward to BOD for Approval
4. Disposal of Confidential Records 510	3 year review, practice change	Forward to BOD for Approval
5. Hiring and Employment; Duty to Report Suspected Misconduct Potential Compliance Irregularity 544	3 year review, practice change	Forward to BOD for Approval
6. Education and Training; As-Needed Education and Training 549	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
7. HIPAA Mitigation 591	3 year review, practice change	Forward to BOD for Approval
8. Monitoring Compliance - Auditing & Reporting - Annual Compliance Workplan 552	3 year review, practice change	Forward to BOD for Approval
9. Pending Debarment, Criminal Charges or Adverse Action against Covered Contractors - 540	3 year review, practice change	Forward to BOD for Approval
10. Rights to Request Privacy for Protected Health Information 526	3 year review, practice change	Forward to BOD for Approval
11. Screening Covered Contractors - 539	3 year review, practice change	Forward to BOD for Approval
12. Use and Disclosure of Protected Information for Fundraising 525	3 year review, practice change	Forward to BOD for Approval
13. Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives 593	3 year review, practice change	Forward to BOD for Approval
Emergency Department		
1. Culture Follow Up, Emergency Department	3 year review, practice change	Forward to BOD for Approval
Emergency Operations Procedure (EOP) Manual		
1. 4006- Influx of Infectious Patient Epidemic Influenza or other	DELETE	Forward to BOD for Approval
2. 4006-IC-ED	DELETE	Forward to BOD for Approval
3. 4009 Traffic Control In The Event Of A Disaster Security	DELETE	Forward to BOD for Approval
4. 4010 Disaster Procedure for Earthquake	DELETE	Forward to BOD for Approval
5. 4012 Employee Disaster Call Back Procedure-Hospital Wide	3 year review	Forward to BOD for Approval
6. 4013 Bomb Threat	3 year review	Forward to BOD for Approval
7. 4015 Emergency Preparedness Management Disaster Plan Administration	DELETE	Forward to BOD for Approval
8. 4023 Communications Department Specific	3 year review, practice change	Forward to BOD for Approval
9. 4026 Code Orange Disaster Plan-Emergency Department Specific	DELETE	Forward to BOD for Approval
10. 4036 Plan-Food and NutritionDepartment	DELETE	Forward to BOD for Approval
11. 4061 Staffing Resource Department Specific	DELETE	Forward to BOD for Approval
12. 4065 Radiation Accidents	3 year review, practice change	Forward to BOD for Approval
13. 4068 Mitigation, Preparation, Response and recovery Plan-Emergency Department Sepcific	DELETE	Forward to BOD for Approval
14. 4071 Disaster Plan Activation Hospital Wide	DELETE	Forward to BOD for Approval
15. 4072 HEICS Command Structure-Hospital Wide	DELETE	Forward to BOD

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
		for Approval
16. 4073 Introduction to DisasterHEICS An Overview Hospital Wide	DELETE	Forward to BOD for Approval
17. 4078 Chemical Disaster Emergency Department Specific	3 year review	Forward to BOD for Approval
18. Authorization for Volunteer Caregivers During Disasters	3 year review	Forward to BOD for Approval
19. Chemical Exposure Plan	3 year review, practice change	Forward to BOD for Approval
20. Clean_Zone	3 year review, practice change	Forward to BOD for Approval
21. Damage Assessment	3 year review	Forward to BOD for Approval
22. Disruption of Service	3 year review	Forward to BOD for Approval
23. Hazardous_Substance_Flowchart	DELETE	Forward to BOD for Approval
24. Location of Disaster Work Station 4003	3 year review	Forward to BOD for Approval
25. Patients_That_Require_Decon	3 year review, practice change	Forward to BOD for Approval
26. Personnel Expectations	3 year review	Forward to BOD for Approval
27. Procedure_for_Decon_Tent	3 year review, practice change	Forward to BOD for Approval
28. Purpose and Authority	DELETE	Forward to BOD for Approval
29. Response to Wild Fires	3 year review	Forward to BOD for Approval
30. Scope of Response	DELETE	Forward to BOD for Approval
31. Triage_Disaster_Box	DELETE	Forward to BOD for Approval
32. Unidentified_Patients	DELETE	Forward to BOD for Approval
33. Utility_Mgmt_Response_Ref	3 year review, practice change	Forward to BOD for Approval
34. Victim Tracking	3 year review	Forward to BOD for Approval
Environment of Care Manual		
1. 1135 Waiver, Requesting Policy	NEW	Forward to BOD for Approval
2. Environmental and Waste Management for Ebola Virus Disease Procedure	DELETE	Forward to BOD for Approval
3. Hazardous Material Waste Training Procedures	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

Food & Nutrition		
1. Clinical Nutrition Dietitian Staffing Policy	3 year review, practice change	Forward to BOD for Approval
2. Emergency Preparedness - Meals for All Nutricopia Policy	3 year review, practice change	Forward to BOD for Approval
3. Emergency Preparedness Food Nutrition Disaster Plan Policy	3 year review, practice change	Forward to BOD for Approval
4. Nutritional Care and Assessment for Infants Admitted to NICU Policy	3 year review, practice change	Forward to BOD for Approval
Home Care		
1. Anticoagulation Therapy	3 year review, practice change	Forward to BOD for Approval
2. Central Venous Access Devices Procedure	2 year review, practice change	Forward to BOD for Approval
3. Emergency Preparedness Management Disaster Plan	3 year review, practice change	Forward to BOD for Approval
4. Medication Management	3 year review, practice change	Forward to BOD for Approval
Outpatient Infusion Center		
1. Age-Specific Guidelines	3 year review	Forward to BOD for Approval
2. Data Management	3 year review	Forward to BOD for Approval
3. Diagnostic Tests	3 year review	Forward to BOD for Approval
4. Disseminating Medical Information	3 year review	Forward to BOD for Approval
5. Emergency Evacuation	3 year review, practice change	Forward to BOD for Approval
6. Environment of Care	3 year review	Forward to BOD for Approval
7. Fire Alarm_Evacuation Plan	3 year review	Forward to BOD for Approval
8. History and Physical	3 year review	Forward to BOD for Approval
9. Medical Emergencies	3 year review, practice change	Forward to BOD for Approval
10. Patient Discharge	3 year review	Forward to BOD for Approval
11. Patient Instructions	3 year review	Forward to BOD for Approval
12. Patient Record Content	3 year review	Forward to BOD for Approval
13. Physician/AHP Orders and Request for Services Orders Policy	DELETE	Forward to BOD for Approval
14. Scope of Services	3 year review	Forward to BOD for Approval
15. Staffing Plan	3 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

16. Standards of Care	3 year review	Forward to BOD for Approval
Patient Care Management		
1. Utilization Management Plan Policy	3 year review, practice change	Forward to BOD for Approval
Progressive Care Unit		
1. Admission Process For Progressive Care Unit (PCU)	NEW	Forward to BOD for Approval
2. Hunger Strike, CDCR	3 year review, practice change	Forward to BOD for Approval
Pulmonary Rehab		
1. Emergency Response System	3 year review, practice change	Forward to BOD for Approval
2. Patient Enrollment	3 year review, practice change	Forward to BOD for Approval
3. Patient Referral	3 year review	Forward to BOD for Approval
Radiology		
1. Screening for Pregnancy in Patients Scheduled for Diagnostic Radiology Procedures	NEW	Forward to BOD for Approval
Rehabilitation		
1. Behavior Management/ Supervision Technique	3 year review	Forward to BOD for Approval
2. Community Out-Reach Groups 800	3 year review	Forward to BOD for Approval
3. Job Site Assessment 609	3 year review, practice change	Forward to BOD for Approval
4. Occupational Therapy Assistant Supervision 707	3 year review	Forward to BOD for Approval
5. Occupational Therapy Policy - 702	3 year review	Forward to BOD for Approval
6. Supervision of Patient, OP 1106 Policy	3 year review	Forward to BOD for Approval
Security		
1. Code Adam - Infant Abduction 503	3 year review	Forward to BOD for Approval
2. Code Red - Security Department Response 504	3 year review, practice change	Forward to BOD for Approval
3. High Risk Patient or Visitor 509	3 year review	Forward to BOD for Approval
4. Psychiatric Patient Escorts 216	3 year review	Forward to BOD for Approval
5. Security Department Reports - 111	3 year review, practice change	Forward to BOD for Approval
Women & Newborn Services		
1. Cord Gas Collection	2 year review, practice change	Forward to BOD for Approval
2. Group Beta Streptococcal (GBS) Prevention and Treatment in Labor and Newborn Follow Up	2 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
November 7th, 2022

CONTACT: Candice Parras, CPCS

3. Hearing Screening Program: Newborn and Infants	3 year review, practice change	Forward to BOD for Approval
4. Neonatal Delivery Room Attendance Policy	3 year review, practice change	Forward to BOD for Approval
5. Newborn Hearing Screening: Inpatient and Outpatient Hearing Screening of Newborn and Infants Using Biological Equipment	DELETE	Forward to BOD for Approval
6. Newborn Hearing Screening: State of California Reporting	DELETE	Forward to BOD for Approval
7. Pitocin Administration for Induction/Augmentation	2 year review, practice change	Forward to BOD for Approval
8. Preeclampsia Care Guidelines	2 year review, practice change	Forward to BOD for Approval
Wound Care		
1. Adverse Reaction to Meds	DELETE	Forward to BOD for Approval
2. Age-Specific Guidelines	3 year review, practice change	Forward to BOD for Approval
3. Continuum of Care	3 year review	Forward to BOD for Approval
4. Diagnosis Specific Guidelines	3 year review, practice change	Forward to BOD for Approval
5. Diagnostic Tests	3 year review	Forward to BOD for Approval
6. Environment of Care	3 year review, practice change	Forward to BOD for Approval
7. History & Physical	3 year review, practice change	Forward to BOD for Approval
8. Hospital Admission from the Center	3 year review, practice change	Forward to BOD for Approval
9. Hypo-Hyperglycemia Management	3 year review, practice change	Forward to BOD for Approval
10. Medical Emergencies	3 year review, practice change	Forward to BOD for Approval
11. Medical Record Review	3 year review, practice change	Forward to BOD for Approval
12. Minor Debridement	3 year review, practice change	Forward to BOD for Approval
13. Nutritional Screening	3 year review, practice change	Forward to BOD for Approval
14. Scope of Services	3 year review, practice change	Forward to BOD for Approval
15. Standards of Care	3 year review, practice change	Forward to BOD for Approval
16. Standards of Care- 1	3 year review, practice change	Forward to BOD for Approval
17. Vascular Screen	3 year review, practice change	Forward to BOD for Approval

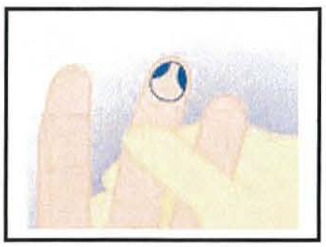
Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**COLLECTION OF BLOOD SPECIMEN BY SKIN PUNCTURE**
Purpose:	To outline the procedure for collection of blood specimen by skin puncture.
Supportive Data:	Skin puncture is applicable for: 1. Severely burned patients 2. Extremely obese patients 3. Patients with thrombotic tendencies 4. Patients with malignancies for whom venipuncture is reserved for therapeutic purposes 5. Geriatric patients or patients in whom superficial veins are not accessible or fragile 6. Patients performing tests at home (e.g. blood glucose) 7. Newborn/pediatric patients
Equipment:	1. Tenderfoot (NSY) and Preemie Tenderfoot (NICU) 2. Automatic lancet device 3. Heel warmer 4. Alcohol prep pad or Chlorhexidine Gluconate prep pad and Saline wipe 5. Capillary blood collection tubes 6. Gauze Pads 7. Spot Bandages

A. **PROCEDURE:**

1. Verify order for blood sampling.
2. Identify the patient per Patient Care Services Policy: Identification, Patient.
3. Ensure the blood specimen is collected from the individual designated on the specimen labels or requisition slip.
4. Choose the Puncture Site:
   a. Each patient should be assessed individually to choose the optimal blood-sampling method.
      i. Venipuncture should be performed in the event finger stick cannot be obtained.
   b. It is recommended greater than 2mL be drawn via venipuncture.
   c. Nonpharmacologic comfort measures should be considered for patients undergoing painful procedures such as skin puncture.
   d. Infant Heel Stick:
      i. Warm the infant's heel: Use a heel warmer according to manufacturer's instructions.
      ii. Registered Nurse may provide the patient with oral sucrose and pacifier per physician/Allied Healthcare Professional (AHP) order.
      iii. Provide developmental positioning (for example swaddling or holding).
      iv. Site of Puncture: The blood must be obtained from the infant's heel using the most medial or lateral portion of the plantar surface of the heel, where "medial" is defined as closest to the midline of the body, "lateral" is defined as away from the midline of the body, and "plantar surface" as the walking surface of the foot.

      v. Assess the sampling site and select an area without excessive previous punctures, hematomas, or infection.
      vi. Contraindications to performing heel sticks are bruising or hematoma on the feet; feet that are edematous, injured, or infected; and feet with anomalies upon which pressures should be avoided.
   e. Children and Adult Finger Stick:

Patient Care Service Content Expert	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
03/00; 05/12; 11/15; 03/17, **12/21**	06/12, 11/15, 05/17, **04/22**	06/12, 12/15, 05/17, **05/22**	03/16, 08/17, **08/22**	n/a	10/12, 04/16, 09/17, **09/22**	**11/22**	11/12, 05/16, 10/17, **n/a**	12/12, 05/16, 10/17



i. The puncture shall be on the palmar surface (pad) of the distal phalanx and not at the side or tip of the finger.
ii. Avoid puncturing the fifth finger if possible.
iii. The skin puncture site must be warm and not swollen (edematous).

5. Clean the Puncture Site:
   a. Disinfect the site for sample collection with alcohol pad and allow it to dry. Betadine or iodine shall not be used to clean and disinfect skin-puncture sites.
      i. For NICU infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU). Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for NICU infants.
6. Select Puncture Device:
   a. Infants: Use an automated heel lancing device that is appropriate size for the patient to perform the heel stick to ensure the proper depth.
   b. Finger Sticks: Use the appropriate automatic lancet device to ensure the proper depth.
7. Order of Draw: If multiple specimens are to be collected, including preservative (EDTA – Lavender Cap) specimens, the EDTA specimen is drawn first to assure adequate volume (at least to the bottom 250 uL line but not more than the 500 uL line) and accurate hematology test results. Recap and mix IMMEDIATELY. Other additive specimens (Green top) are collected next and clotted specimens (Red top) last.
8. Perform the puncture:

   a. Puncture the chosen site that has been prepared.
   b. Wipe the first drop of blood with dry gauze pad since it is most likely to contain excess tissue fluid.
   c. A second drop of blood will form over the puncture site. When a micro collection device touches this drop, blood will flow into the tubes by capillary action.
   d. During specimen collection, allow capillaries to refill (apply gentle pressure and then release) Avoid excessive squeezing of the heel). Fill specimen containers to the specified volume.
   e. Allow blood drops to fall freely into the tube (avoid scooping or scraping blood from the heel or finger).
   f. Fill specimen containers to the specified volume. Cap the tube when it is filled.
   g. Each additive tube must be mixed by gentle inversion 8-10 times immediately after collection.
9. Post Puncture Bleeding:
   a. Infant's Heel: Hold a gauze pad pressed against the puncture site until the bleeding stops.
   b. Finger Stick: Apply pressure with a clean gauze pad until bleeding stops. Place a bandage on the site, if necessary.
10. Dispose the automated lancing device in a sharps container.
11. Labeling Policy:
    a. Refer to Patient Care Services Specimen Labeling Procedure.

B. **REFERENCE(S):**

~~1. MacDonald, MG, and J Ramasethu. Folk LA. Capillary heel stick blood sampling. 4th ed. Philadelphia: Lippincott Williams and Wilkins, 2007. 93. Print.~~

~~2.~~**1.** Ohlsson, Shah VS A. "Venipuncture versus heel lance for blood sampling in term neonates." Cochrane Database System. 19 Apr. 2010. Web 24 May 2012. www.2.cochrane.org/reviews/en/ab001452.html.

~~3.~~**2.** Robbins, Meyers R. Pediatric Nutrition Practice Group. 2nd ed. Chicago: American Dietetic Association, 2011. Print.

~~4.~~**3.** **Heel Stick (Neonatal) Extended Text. (n.d.). Retrieved March 4th, 2022, from Point of Care Elsevier Performance Manager: https://point-of-**

care.elsevierperformancemanager.com/skills/1233/extended-text?skillId=NN_003&virtualname=tricity-caoceanside#scrollToTop

~~5. Walton, DM, MG MacDonald, and J Ramasethu. Atlas of procedures in neonatology. 4th ed. Philadelphia: Lippincott Williams and Wilkins, 2007. 84. Print.~~

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**FALL RISK PROCEDURE AND SCORE TOOL**
Purpose:	To provide a comprehensive fall risk assessment on all patients each shift and implement appropriate fall risk interventions based upon the patient's identified fall risk factors.
Supportive Data:	Requires a Registered Nurse (RN) to evaluate and identify risk factors for falls, develop an appropriate plan of care for prevention, perform a comprehensive evaluation of falls that occur, and revise the plan of care as appropriate for fall prevention.
Equipment:	Fall Risk Score Tool

A. **PROCEDURE:**

1. The registered nurse (RN) completes the Morse Fall Risk Assessment on every patient, including visually assessing and interviewing the patient, to determine the patient's fall risk score and secondary risk factors:
   a. Upon admission to the hospital
   b. Upon admission or transfer to another level of care
   c. Once a shift
   d. After any fall occurs
   e. When there is a change in the patient's status (physiological, functional, or cognitive)
2. Review the patient's medications for any that may alter the patient's ambulatory stability (see Medication Fall Alert Reference Text).
3. All patients receive the following Universal Fall Precautions as appropriate:
   a. Adequate lighting
   b. Assistive devices within easy reach
   c. Bed in low position
   d. Bed wheels and wheelchair brakes locked
   e. Assure call light and possessions are within easy reach
   f. Clean and dry surfaces
   g. Hand rails and grab bars accessible
   h. Hourly rounding
   i. Non-skid slippers or footwear are worn during ambulation
   j. Orient patients to their bed area, unit facilities, and how to get assistance
   k. Patient/family fall prevention education (uses the Patient and Family Guide and review Fall Prevention section)
   l. Review Partnering for Fall Prevention- My Safety Plan, with patient and their family. This is not a permanent part of the chart and shall remain at bedside in discharge folders.
      i. Excluding patients in Behavioral Health Services, Progressive Care Unit, ~~and~~ Women and Newborn Services**, and Surgical Services**
   m. Rooms free of clutter
   n. Side rails up times two (2)
4. The patient's primary RN shall implement an individual Interdisciplinary Plan of Care (IPOC) for **the** fall risks identified. Appropriate interventions based on the patient's fall risk score shall be selected and documented on the IPOC. These include but are not limited to:
   a. Low Risk Patients (equals 0 - 35 total score):
      i. Reinforce use of grab bars near toilets.
      ii. Reinforce possible medication side effects that could increase risk of falling.
      iii. Limit administration of combinations of medications that may increase fall risk when possible.
      iv. Select suitable chairs with armrests that are an appropriate height for rising and sitting.
      v. Encourage patient to move/change position slowly.
      vi. Place patients with urgency near toilets or use commodes.

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
6/06, 1/08, 6/09, 09/15, 04/16, 09/17, **05/22**	11/11, 10/15, 06/16, 03/18, **06/22**	11/11, 10/15, 7/16, 03/18, **07/22**	n/a	11/15, 11/16, 03/18, **09/22**	**11/22**	2/12, 01/16, 01/17, 04/18, **n/a**	2/12, 1/16, 01/17, 04/18

vii. Instruct male patients prone to dizziness to sit while voiding.

b. Moderate Risk Patients (equals 36 - 44 total score):
   i. Implement Universal and Low Risk interventions.
   ii. Ambulate patients with assistance.
   iii. Re-orient confused patients.
   iv. Move confused patients close to nurse's station.
   v. Encourage family members to sit with confused patients.
   vi. Use bed exit alarms.
   vii. Use chair alarms.
   viii. Teach activity limits to patient and family.
   ~~ix. Large fall risk sign shall be placed at the head of the bed for moderate risk patients.~~
   ~~x.~~**ix.** **Post the** ~~A~~fall risk **signage / tab** ~~magnet shall be placed on the pat~~**on or near the patient's room, wall or unit designated location**~~ient's doorframe with the designated bed indicated on the magnet~~.

c. High Risk Patients (equals 45 or more total score) require:
   i. Implement Universal, Low, and Moderate Risk interventions.
   ii. Place fall risk wristband on patient.
      a. High Risk Rounding: strongly encourage patient to use the bathroom or Bedside Commode at least every four (4) to six (6) hours while awake if they have not gone when offered during hourly rounding (does not include patients with indwelling urinary catheter**s** ~~such as Foleys~~).
   iii. Remain with patient while toileting or showering.
      a. Document if patient refuses.
   iv. Ensure commode is available at bedside if patient is unable to ambulate to the bathroom with assistance.

d. Responsibilities:
   i. Fall Risk Armbands:
      a. The RN or designee is responsible for placing the armbands on the wrist of patients identified as high risk (45 or more).
      b. The RN or designee is responsible for removing the armband upon change in fall risk score or upon discharge.
   ~~ii. Large Fall Risk Laminates:~~
      ~~a. The RN or designee is responsible for placing, updating, and/or removing the large Fall Risk laminates over the head of the patient's bed.~~
   ~~iii.~~**ii.** ~~-~~Fall **R-**~~r~~isk **Signage and or Tabs**~~magnets~~:
      a. The RN or ~~D~~**d**esignee is responsible for p**osting** ~~lacing, updating,~~ and/or removing the fall risk **signage / tab**~~magnet on the patient's doorframe with the designated bed indicated on the magnet~~.
      b. The **nurse leader**~~Assistant Nurse Manager (ANM)/charge nurse~~ **/ designee** ~~-s~~**s**hall check for appropriateness of signage **/ tab** during rounds.

e. The primary RN shall reassess the patient every shift for needs and change in status.
   i. When patient is reassessed and has a change in risk level, interventions are added or discontinued as indicated.

f. The primary RN shall note and document the availability of family/friends to stay with the patient. The care plan shall be revised with any patient status change. ~~-or the absence of family.~~

g. The patient's fall risk status and family presence shall be reported during hand-off communication.

h. If a patient falls, the **nurse leader**~~ANM or~~ **or** ~~-~~designee shall conduct an ~~immediate~~ educational debriefing for all staff involved.

i. **Ensure the fall event is entered in the hospital reporting system e.g.,** ~~An incident report and Post Fall Huddle shall be completed by the ANM or desRLignee.~~
ii. **Ensure the fall events is documented in the medical record by the RN**
~~i.~~iii. **Conduct a post-fall huddle after reviewing the fall event documented in RL and the fall event documented in the medical record.**
~~ii.~~iv. ~~T~~**The fall event and the post fall huddle documentation** ~~he incident report and Post Fall Huddle shall be reviewed by the Director/Manager and~~ Risk Management.

i. **Surgical Services and** ~~E~~each outpatient care area ~~and Emergency Department~~ will assess **patients for** the risk for falls ~~based on their own unit specific guidelines,~~ and intervene as appropriate.

B. **SPECIAL CONSIDERATIONS:**

1. Intensive Care Unit (ICU) Specific Fall Precautions:
   a. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure with the exception of the following:
      i. **Fall signage**~~Stoplight magnets and overhead lam~~ ~~inates~~ are not required.
      ii. Due to patient and RN ratios for ICU, observation is ongoing and High Risk Rounding is not required.
   b. Moderate and/or high-risk patients require RN, Physical Therapist, or **Patient Mobility Technicians (PMT)** ~~Lift Team Technician~~ assistance with getting out of bed ~~(requires physician order)~~.
2. Peri-Anesthesia Nursing Services (PANS) and Labor and Delivery Unit specific fall precautions:
   a. ~~All p~~**P**atients **post anesthesia/sedation** ~~in PANS area and Labor and Delivery Unit~~ are considered high fall risk due to ~~post~~ anesthesia/sedation ~~status~~.
   b. Appropriate interventions shall be used based on the Patient Care Services Fall Risk Procedure.
      i. Place call light within reach of bedside.
      ii. Assist patients to bathroom and ambulate wearing shoes or non-slip socks.
      iii. RN, Advance Care Tech, Peri-Operative Aide or family member must be in attendance behind curtain to assist out-patient while dressing prior to discharge.
   c. Fall Risk **signage** ~~magnets and overhead laminates are~~**is** not required.
3. ED~~mergency Department (ED)~~ specific fall precautions:
   ~~a. Patients seen in the ED are scored for falls using KINDER1 Falls Scale, which is an evidenced based best practice tool developed specifically for ED.~~
   ~~b.~~**a.** Fall risk assessment is performed by an RN upon initial assessment, **using the Morse Fall Risk Assessment.**~~.~~
      ~~i. The patient is deemed not at risk.~~
      ~~ii. The patient is deemed at risk if there is a yes answer to any question.~~
   ~~c.~~**b.** Reassessments are performed with any change of condition.
   ~~d.~~**c.** If a patient falls in the ED the patient automatically becomes an at risk for falls patient.
   ~~e.~~**d.** The following interventions are instituted based on the patient's risk value:
      i. Universal Falls precautions are initiated on all patients in the ED.
      ii. At risk for falls precautions (include but not limited to):
         ~~a. Encourage family to remain with patient~~
         ~~b.~~**a.** Encourage patient to change position slowly
         ~~c.~~**b.** Increase intervals of nursing observation
         ~~d.~~**c.** Patients shall be assisted to bathroom and with ambulation
         ~~e.~~**d.** Fall Risk armband **or booties** placed on patient
4. Imaging Services:
   a. See **Radiology**~~Imaging Services~~: **Patient Safety Standards of Care**~~General Safety Management 128 Policy~~ for Unit Specific Interventions

C. **FORM(S):**

1. Morse Fall Scale - Sample
2. Partnering for Fall Prevention- My Safety Plan
3. ~~Post Fall Huddle – Sample~~

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

1. Administrative Policy: Incident Report – Quality Review Report (QRR) RL Solutions
2. Fall Risk Algorithm
3. Medication Fall Alert Reference Text

Morse Fall Scale - Sample

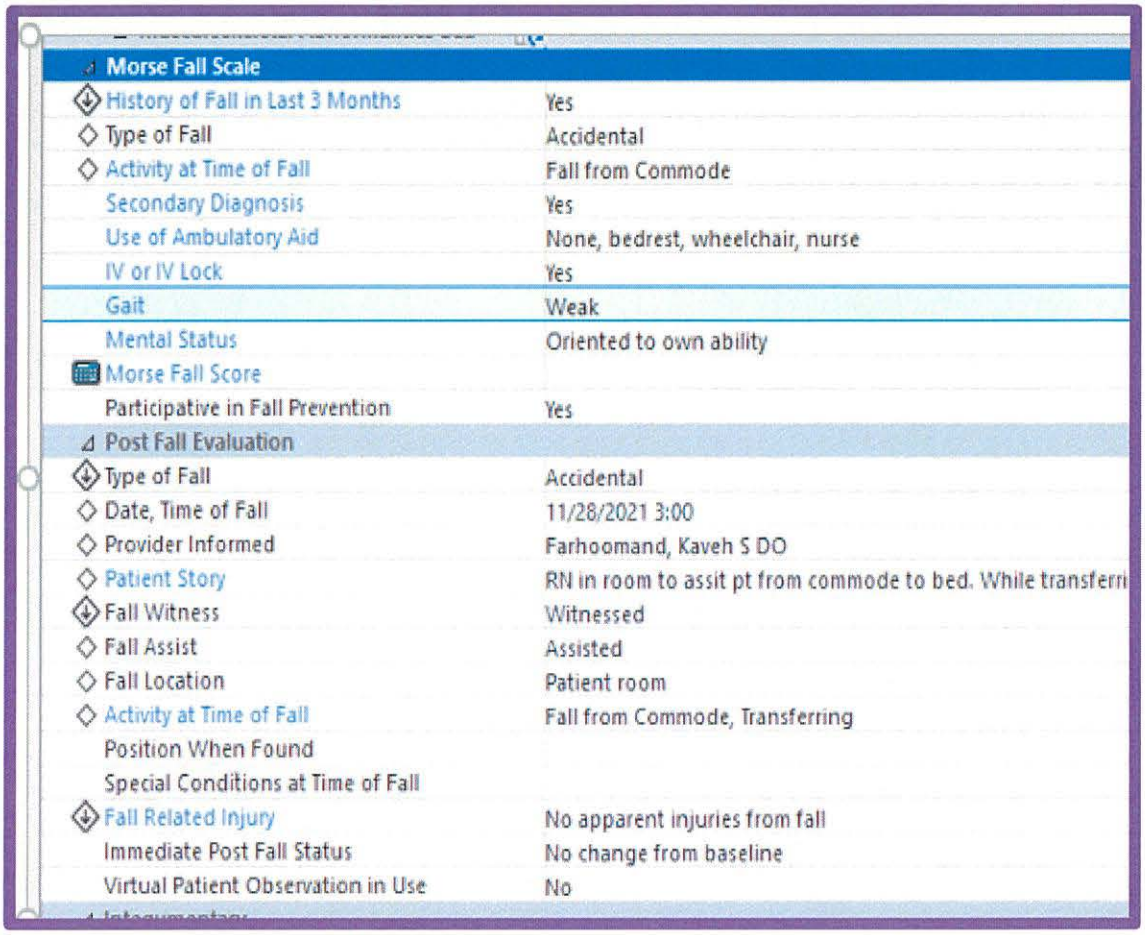
Item	Item Score	Patient Score
1. History of falling (immediate or previous)	No 0 Yes 25	_____
2. Secondary diagnosis (≥ 2 medical diagnoses in chart)	No 0 Yes 15	_____
3. Ambulatory aid None/bedrest/nurse assist Crutches/cane/walker Furniture	 0 15 30	_____
4. Intravenous therapy/heparin lock	No 0 Yes 20	_____
5. Gait Normal/bedrest/wheelchair Weak* Impaired†	 0 10 20	_____
6. Mental status Oriented to own ability Overestimates/forgets limitations	 0 15	_____
Total Score‡: Tally the patient score and record. <25: Low risk 25-45: Moderate risk >45: High risk		_____

* Weak gait: Short steps (may shuffle), stooped but able to lift head while walking, may seek support from furniture while walking, but with light touch (for reassurance).

† Impaired gait: Short steps with shuffle; may have difficulty arising from chair; head down; significantly impaired balance, requiring furniture, support person, or walking aid to walk.

‡ Suggested scoring based on Morse JM, Black C, Oberle K, et al. A prospective study to identify the fall-prone patient. Soc Sci Med 1989; 28(1):81-6. However, note that Morse herself said that the appropriate cut-points to distinguish risk should be determined by each institution based on the risk profile of its patients. For details, see Morse JM, , Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. Can J Aging 1989;8;366-7.

Post Fall Huddle – Sample Questions



Morse Fall Scale	
History of Fall in Last 3 Months	Yes
Type of Fall	Accidental
Activity at Time of Fall	Fall from Commode
Secondary Diagnosis	Yes
Use of Ambulatory Aid	None, bedrest, wheelchair, nurse
IV or IV Lock	Yes
Gait	Weak
Mental Status	Oriented to own ability
Morse Fall Score	
Participative in Fall Prevention	Yes
Post Fall Evaluation	
Type of Fall	Accidental
Date, Time of Fall	11/28/2021 3:00
Provider Informed	Farhoomand, Kaveh S DO
Patient Story	RN in room to assit pt from commode to bed. While transferri
Fall Witness	Witnessed
Fall Assist	Assisted
Fall Location	Patient room
Activity at Time of Fall	Fall from Commode, Transferring
Position When Found	
Special Conditions at Time of Fall	
Fall Related Injury	No apparent injuries from fall
Immediate Post Fall Status	No change from baseline
Virtual Patient Observation in Use	No

Date:__/__/____ Time:_____

Setting:_____ FIN #:_____ Entered By:_____

Reason for Audit: To involve front line staff in identifying problems and solutions, and in creating change in their work environment. To promote trust and team building among team members. To promote a positive Culture of Safety without individual blame.

Instructions:

1. Hold the Huddle as soon as possible
2. Involve the patient, staff involved in t
3. Meeting is organized by primary RN

** Indicates that an answer is requ*

DELETE Form

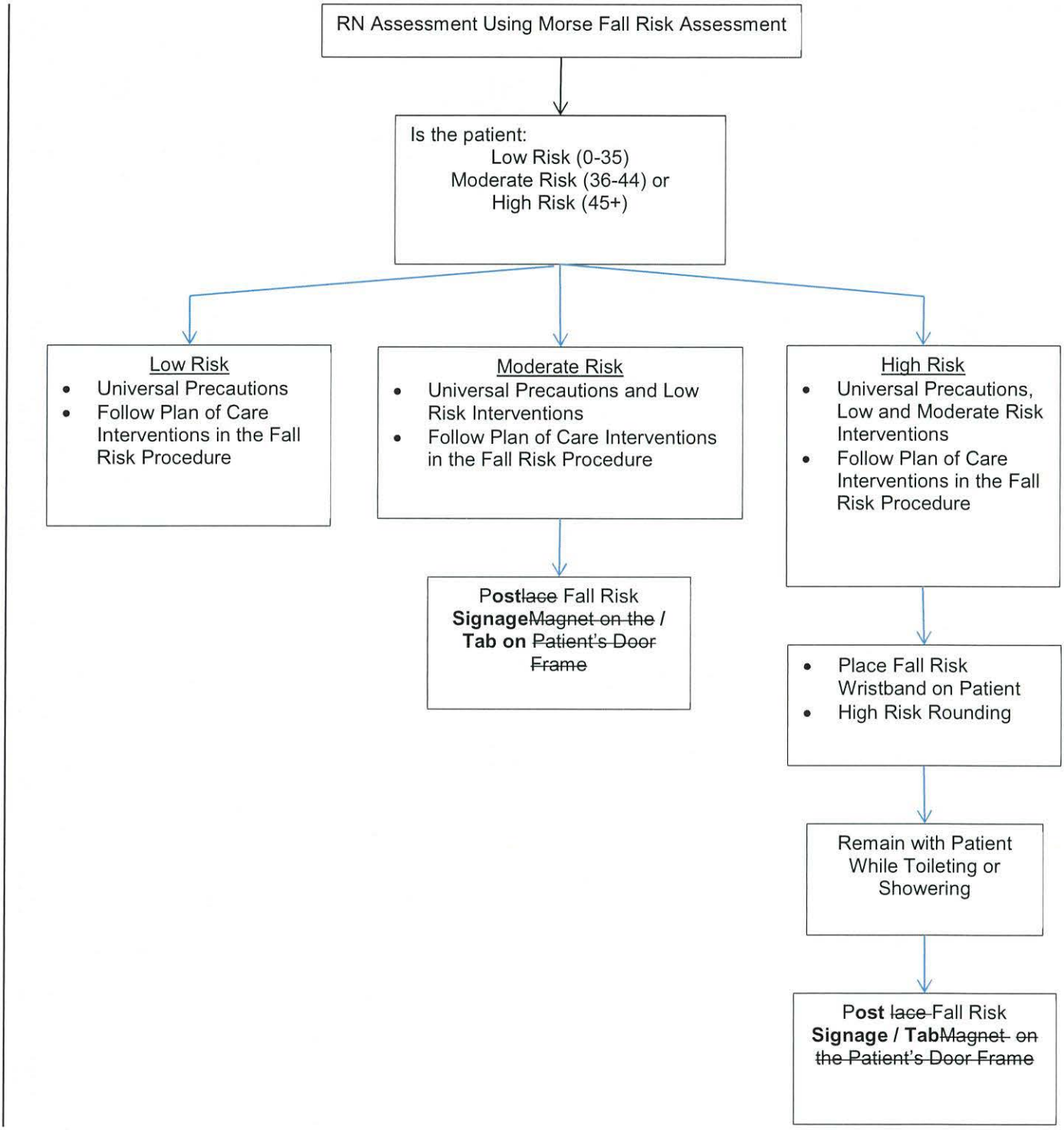
2013 Post Fall Huddle	Comments
1.* What was the lastest Fall Risk S	
2.* How did you find out that this pa	
3.* What was the patient doing at th	
4.* Prior to the patient fall, what was	
5.* Prior to the fall, was the patient ... the fall? (Example-Did staff assist the patient to the toilet and then left the patient alone?)	

6.* Why do you think the patient fell?		
I do not know	[ ]	
Confusion	[ ]	
Catastrophic event (stroke, arrhythmia)	[ ]	
Arms or legs got weak	[ ]	
B		
7.* Prior to the fall, identify the ancillary room.		
8.* Did you do hourly rounding?		
9. The last time you did hourly rounding		
10.* What could you have done to prevent		
11.* What will you do differently in the fut		
12.* Post Fall Checklist		
Documentation in the Medical Record (event, phys exam, intervention)	[ ]	
Morse Fall Risk Score Updated	[ ]	
13.* RN : Patient Ratio (1 : __) Please fill in the number of patients the RN was assigned to.		
14.* Did you feel as though your patient assignment was appropriate?	Yes | No	

DELETE Form

Tri-City Medical Center
Oceanside, California

Fall Risk Procedure Algorithm



Medication Fall Alert Reference Text

Medication Fall Alert

Below are Medications That May Affect Patients' Fall Risk Level

***Denotes individual drugs associated with highest risk of dizziness or falls in each category**

Category One

1. Antihistamines
   a. Chlortrimeton (Chlorpheniramine Maleate)
   b. *Benadryl (Diphenhydramine Hydrochloride)
   c. Dramamine (Dimenhydrinate)
   d. Vistaril (Hydroxyzine)
   e. Antivert (Meclizine)
2. Cardiac Drugs
   a. Tenormin (Atenolol)
   b. Capoten (Captopril)
   c. Cardizem (Diltiazem)
   d. Vasotec (Enalapril)
   e. Zestril (Lisinopril)
   f. Lopressor (Metoprolol)
   g. *Procardia (Nifedipine)
   h. Inderal (Propranolol)
3. Hypotensive Agents
   a. Catapres (Clonidine)
   b. Apresoline (Hydralazine)
   c. Trandate (Labetalol)
   d. *Minipress (Prazosin) (Especially first dose syncope)
   e. *Hytrin (Terazosin)
   f. *Cardura (Doxazosin)

Category Two

1. Neurotoxic Chemotherapeutic Drugs
   a. Ifex (Ifosfamide)
   b. Vincasar (Vincristine)
   c. Platinol (Cisplatin)
   d. Methotrexate
   e. Cytosar-U (Cytarabine)
   f. Adrucil (5-fluorouracil)
   g. Taxol (Paclitaxel)
2. Vasodilating Agents
   a. Isordil (Isosorbide Dinitrate)
   b. *Nitrostat (Nitroglycerin)
3. Opiate Agonists
   a. Codeine (Includes cough syrups and Tylenol #3)
   b. Vicodin (Hydrocodone)
   c. *Morphine
   d. Percocet (Oxycodone)
4. Anticonvulsants
   a. Phenobarbital
   b. *Valium (Diazepam)
   c. Dilantin (Phenytoin)
   d. Tegretol (Carbamazepine)

Category Three

1. Psychotherapeutic Agents
   a. *Anafranil (Clomipramine)
   b. * Elavil (Amitriptyline)

c. *Sinequan (Doxepin)
d. Zoloft (Sertraline)
e. Desyrel (Trazodone)
f. *Tofranil (Imipramine)
g. *Surmontil (Trimipramine)

2. Antipsychotic Agents
   a. *Serentil (Mesoridazine)
   b. *Thorazine (Chlorpromazine)
   c. *Clozaril (Clozapine)
   d. *Mellaril (Thioridazine)
3. Benzodiazepines
   a. Xanax (Alprazolam)
   b. *Librium (Chlordiazepoxide)
   c. *Dalmane (Flurazepam)
   d. Ativan (Lorazepam)
   e. Restoril (Temazepam)
   f. Halcion (Triazolam)
4. Diuretics
   a. Lasix (Furosemide)
   b. Bumex (Bumetanide)
   c. Demadex (Torsemide)
5. Miscellaneous Anxiolytics, Sedatives & Hypnotics
   a. Equanil (Meprobamate)

Partnering for Fall Prevention – My Safety Plan

Directions: This is a tool to partner with the patient and family for education of the patient's fall risk factors and strategies to reduce risk of falls and keep the patient safe.

Partnering for Fall Prevention - Our Safety Plan for You

We care about you and your safety. We want to partner with you and your family to prevent falls.

Your medical exam~~assessment~~ shows you may be at risk for falls.
~~You are at risk for falls~~ or injury for one or more of the following reasons:

- ☐ You are unsteady **(appear as if you need help)** when you walk **or stand up alone**.
- ☐ You may **take medications that make you** bleed easily if you fall.
- ☐ You are taking medications that may make you **light headed or dizzy when you stand and may make you lose your balance and fall** ~~fall more easily~~.
- ☐ Your medical history shows an increased risk for broken bones, due to: _____
- ☐ **Your** ~~R~~recent ~~surgeri~~**surgery**~~es~~ or procedure~~s~~ puts you at risk for falling, such as:_____
- ☐ Medical equipment (sequential devices, foot pumps, **infusion pump** etc.,)-**and medical devices that are required for our care such as oxygen tubing, urinary catheter**
  _____
- ~~☐~~
- ☐ Other:_____

You and your family can help us keep you safe by doing the following:

- ✓ Show I know how to use my call light
  - ☐ RN: Patient demonstrated correct use of call light to notify nursing staff
- ✓ ~~I will a~~Always use the call light to contact the nurse ~~. I promise to s~~
- ✓ Stay in bed and call ~~my~~ **a** nurse **or nursing assistant** for help.
  - Whenever I need to get up
  - Whenever I need help reaching something that is out of my reach
  - ~~o~~ Whenever I am feeling dizzy or sleepy from medications
- ✓ **Always call my nurse or nursing assistant for help**
  - ☐ **Before tyring to get back in bed after sitting in the chair**
  - ☐ **Before tyring to go to the bathroom or return to bed after someone helps me to the bathroom**
- ✓ I will always call the nurse and -not ask family **or my visitors** for help getting out of bed **or trying to get back in bed**
- ☐ I will wear my skid-proof slipper socks and yellow wrist band
- ~~☐ I have a bed alarm that is active at all times. It will alert nursing staff when I am out of bed. I will not turn off the alarm.~~
- ✓ I will **not** use the over-bed table to help me stand; it is on **wheels**~~rollers~~ and may cause me to fall if I lean on it.

~~☐ RN: Reviewed falls prevention plan with patient and family~~

~~☐ Patient unable to sign the form~~

~~☐ Patient refuses to sign the form~~

~~**Patient Initials/Date/Time:**~~_____
~~**RN Signature/Date/Time:**~~_____

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**NEWBORN SCREENING, COLLECTION OF SPECIMEN**
Purpose:	All newborn babies are required to have a newborn screening test before the baby is discharged. Proper collection is mandatory. This procedure specifically addresses the proper collection of these blood specimens for the California Newborn Screening Program to detect such inborn errors as phenylketonuria (PKU), galactosemia, hypothyroidism, and other metabolic/genetic disorders.
Supportive Data:	Required under California Department of Health Newborn Screening - Title 17.
Equipment:	1. Newborn Screening Form 2. Skin cleanser per unit standards 3. Sterile Lancet type device 4. Dry gauze 5. Heel Warmer 6. Single dose, pre-filled twist-tip vial Sucrose 24% (RN to administer, if ordered) (note: this is outside the scope of practice for phlebotomist)

A. **PROCEDURE:**

1. Initial newborn screening specimens shall be collected on State provided filter forms
   a. Clinical staff shall accurately complete the demographic data. The follow-up **outpatient** provider (physician) and provider number must be completely accurate.
      i. A ballpoint pen should be used to print clearly.
      ii. If the form is not completed in its entirety, the lab must contact the nurse to complete the form.
   b. The nurse or phlebotomist must fill in the date, time of collection, and initial as the collector.
2. Follow proper patient identification and labeling procedure:
   a. Verify the infant's name and medical record number on the armband against all the demographics on the Newborn Screening Form.
   b. Place additional infant label on back of Newborn (NB) Screen Blood Collection card to ensure specimen test card is still identified with NB should the top page with infant label become separated. Attach label to back side of lower portion. Lab will not process if it is separated.
   c. Verify all information on the Newborn Screening Form is correct with a second RN.
3. Timing of Collection:
   a. ~~In postpartum c~~**C**ollect the specimen between 24-48 hours of age.
   ~~b. In neonatal intensive care unit (NICU) collect the specimen at 48 hours of age.~~
   ~~c.~~**b.** If for any reason (e.g., transfusion, discharge earlier than 12 hours or hospital error) the specimen is collected prior to 12 hours, a second specimen will be required.
   ~~d.~~**c.** In Critically ill newborns, the attending NICU Physician~~/Allied Health Professional (AHP)~~ may postpone the collection of newborn screening specimen until the newborn's emergency condition is stabilized.
4. Dried Blood Spot (DBS) Collection: Instructions for collecting adequate dried blood spots are on the back of the California Newborn Screening Specimen Collection Card.
   a. Do not handle the blood collection area of specimen collection card prior to, during, or following sampling.
   b. A new test request form must be used for each collection. If a mishap occurs during a collection, use a new specimen collection card.

Patient Care Content Expert ~~Department Review~~	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Perinatal Collaborative Practice	Department of Pediatrics	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/00, 05/12, 02/15, 11/16, **02/21**	05/12, 02/15, 11/16, 03/17, **10/21**	05/12, 02/15, 05/17, **11/21**	08/16, 07/17, **03/22**	08/17, **04/22**	03/16, 09/17, **08/22**	09/12, 10/17, **09/22**	**11/22**	10/12, 11/17, **n/a**	11/12, 12/17

c. Do not use capillary tubes for collecting the blood to apply to the card. It can damage the filter paper, resulting in an inadequate specimen.
d. See Patient Care Services Procedure: Collection of Blood Specimen by Skin Puncture for specimen collection.
e. Follow instructions on Newborn Screening Collection card.
i. Fill all circles.

5. Use of Venous or Arterial Blood:
a. A heel stick is strongly preferred.
b. If unable to obtain a heel stick specimen due to prematurity or other issues with infant, arterial or venous blood may be used after the line has been properly cleared.
c. Allow blood to freely drop from the syringe onto the filter paper, filling each circle completely.
d. Mark "Other" in type of specimen category on test request form, and indicate source of blood (Umbilical Arterial Catheter, etc.)

6. Infants Requiring Transfusions. If a transfusion is anticipated:
a. Collect the specimen prior to the transfusion of red blood cells (RBC), even if the newborn is under 12 hours of age. Infants who are transfused with red blood cells must have a specimen collected prior to the transfusion. (Transfusions with plasma, platelets, or albumin will not significantly affect the screening.)
b. If the neonate is less than 12 hours old at the time the pre-transfusion specimen is collected or if no adequate specimen was obtained prior to transfusion, a specimen should be collected 24 – 48 hours after the last transfusion.

7. Processing Newborn Screening Forms:
a. Allow the blood to thoroughly dry at room temperature for at least three (3) hours and follow hospital policy for processing the specimen. Keep away from heat lamps, direct sunlight, and humidity.
~~b.~~**i.** Note: Touching or smearing the blood spots should be avoided. Blood spots on the filter paper should not be heated, stacked or allowed to touch other surfaces during the drying process.
~~c.~~**b.** The health care provider will order the Newborn Metabolic Screening (NBMS) test in the Electronic health record (EHR).
~~d.~~**c.** ~~Do not seal the bag containing the specimen.~~**Place in an unsealed paper envelop**
d. The newborn screening requisition form will be taken to the Laboratory and the clerical staff will receive them and place the Accession Number on the slip.
~~e.~~**i.** Note: The lab staff will call nursing for information if the forms are not completely filled out.
~~f.~~**e.** The clerical staff will log these specimens on the Newborn Screening Form log. Specimens that are awaiting transport shall be stored at room temperature, away from heat and moisture.

8. Document completion and RN verification/ witness of the newborn screen in the EHR.

B. **LABORATORY:**

1. The clerical or phlebotomy staff will receive the specimen in the Laboratory Information System (LIS) and place the Accession Number on the slip.
a. If dispatched receive using the miscellaneous reference lab as the location.
b. If the patient was discharged and the NBMS discontinued or was not initially ordered, re-order the NBMS using Department Order Entry using Miscellaneous Reference Lab as the location.

2. Check the NBMS collection form for completeness and that the collection time is greater than 12 hours of age.
a. Lab staff will call nursing for information if the forms are not completely filled out.

3. The clerical staff will log these specimens on the Newborn Screening Form Log and place them in the appropriate bin in the Chemistry refrigerator #5 at 2-8 degrees C for courier pickup.

4. Completion in Cerner:
   a. Using Batch Result Entry enter Newborn Metabolic Screening.
   b. A list of NBMSs will display. The default entry is "See Separate Report".
      i. Be sure all accession numbers have a check mark displayed.
   c. Click Verify.

C. **PROCEDURE IN EVENT SPECIMEN IS NOT COLLECTED PRIOR TO DISCHARGE:**

1. Notify the appropriate **Department Leader**~~Unit Clinical Manager~~ that the specimen was not collected. Arrangements for follow-up of infant will be made by the appropriate **Department Leader**~~Unit Clinical Manager~~.
2. If no specimen is obtained for Newborn Screening, fill in "Specimen Not Obtained" section on the Newborn Metabolic Screening form. Situations which might apply include:
   a. A newborn that is transferred to another facility.
      i. The receiving hospital is responsible for obtaining the specimen.
   b. A newborn that expires prior to 48 hours of age.
   c. Staff error results in infant being discharged without specimen being collected.
3. If newborn's parent(s) refuses testing, the "Newborn Screening Test Refusal" (NBS-TR) form must be completed and submitted.
4. NBS-TR forms may be obtained from the OB Clinical Manager, OB Charge Nurse, OB Patient Data Coordinator, or the NICU Unit Secretary.

D. **PROCEDURE IN EVENT NBS RESULT IS INVALID OR ABNORMAL:**

1. The performing laboratory contacts the pediatrician provided on the NBS form for recollection of an invalid result, abnormal results and subsequent testing needs. ~~.~~

~~4. The performing laboratory contacts the pediatrician provided on the NBS form for abnormal results and subsequent testing needs.~~

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

1. NICU Pain Management, Neonates & Infants Policy

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

1. "Blood Collection on Filter Paper for Neonatal Screening Programs" NCCLS Document LA4-A2 Vol. 12, No. 13, July 2002.
2. AWHONN Evidence-based Clinical Practice Guideline. Neonatal Skin Care. 2008.
3. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses - Templates for Protocols and Procedures for Maternity Services, 2nd Edition. Washington, DC
4. State of California Website, www.dhs.ca.gov.pcfh/gdb/html/NBS/ProgramOVforProviders.htm
5. The California Newborn Screening Program. (2013, April). New Addition to Newborn Screening: Severe Combined Immunodeficiency (SCID). *Newborn Screening News Issue #16, pp.1-4*

Tri-City Health Care District
Oceanside, California

~~PATIENT CARE SERVICES~~

ISSUE DATE: 01/86

SUBJECT: Grievance Policy- Patient and/or Patient Representative ~~Complaints and Grievances~~

REVISION DATE: 12/93; 01/97; 06/97; 08/97; 11/97, 03/00; 09/00, 06/02, 04/03, 04/09, 03/11, 06/1105/12; 01/16

POLICY NUMBER: 8610- 318

~~Clinical Policies & Procedures Committee Approval:~~	~~10/15~~
~~Nurse Executive Committee Approval:~~	~~10/15~~
Administrative Content Expert:	08/22
Administrative Policies & Procedures Committee Approval:	08/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/15~~, 09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~01/16~~..n/a
Board of Directors Approval:	01/16

A. **PURPOSE:**

1. ~~To provide a process that substantively addresses grievances and complaints from patients or patient representatives as a method of improving patient care and services delivered through problem resolution; to track and analyze patient grievances and complaints; and, to identify specific issues or trends which can be improved.~~ **To provide patient's and/or patient's representative, a path to verbally, or in writing, register a concern or complaint regarding any aspect of their care experience and be assured that the issue is addressed through a timely and through process.**

B. **DEFINITIONS:**

~~1. Complaint is an expression of displeasure or discontent about a situation (housekeeping issue, food dissatisfaction, etc.) requiring a response taken to address the concern at or issue. Post hospital verbal communication regarding patient care that would routinely have been handled by staff present if the communication had occurred during the hospital stay is typically considered a complaint.~~

~~2. **A "patient grievance" is a formal or informal written or verbal complaint that is made to the hospital by a patient, or the patient's representative, regarding the patient's care (when the complaint is not resolved at the time of the complaint by staff present)**~~
~~Grievance - is a written or verbal complaint (when the verbal complaint about patient care is not resolved at the time of the complaint by staff present) by a patient, or the patient's representative, regarding the patient's care, alleged abuse or neglect, issues related to the hospital's compliance with the Centers for Medicare & Medicaid Services Hospital Conditions of Participation, or a Medicare beneficiary billing complaint related to rights and limitations.~~

~~a. Types of complaints/grievances:~~

~~i. Billing issues are not usually considered grievances for the purposes of requirement unless a Medicare beneficiary billing complaint is related to rights and limitations.~~

~~ii. A written complaint is always considered a grievance, whether from an inpatient, outpatient, released/discharged patient or their representative regarding the patient care provided, abuse or neglect, or the hospital's compliance with~~

~~Conditions of Participation. For the purpose of the requirement an Email or fax is considered "written."~~

~~1) Information obtained with patient satisfaction survey(s) does not usually meet the definition of a grievance. If an "identified" individual writes or attaches a written complaint on the survey and requests resolution, then the complaint meets the definition of a grievance.~~

~~iii. Patient complaints that become grievances also include situations where a patient or a patient's representative telephones the hospital with a complaint regarding their patient care or with an allegation of abuse or neglect, or failure of the hospital to comply with one or more Conditions of Participation, or other Centers for Medicare & Medicaid Services (CMS) requirements. Those post-hospital verbal communications regarding patient care that would routinely have been handled by staff present if the communication had occurred during the stay/visit are not required to be defined as a grievance.~~

~~i. All verbal or written complaints regarding alleged abuse, neglect, patient harm or hospital compliance with CMS requirements, are to be considered a grievance for the purposes of these requirements.~~

~~2. Whenever the patient or the patient's representative's requests that his or her complaint be handled as formal complaint or grievance or when the patient requests a response from the hospital, the complaint is considered a grievance and all the requirements apply.~~

1. **Patient Representative: Is the person who has authority, under California law, to make health care decisions on behalf of the patient.**
2. **Concern: Concerns expressed by the patient and/or patient representative to a representative of the hospital during a patient's stay which can be resolved at the time of the occurrence and to the satisfaction of the patient and/or patient representative.**
3. **Grievance: A formal, written or verbal grievance that is filed by a patient, when a patient issue cannot be resolved promptly by staff present. Any allegations regarding quality of care or premature discharge shall be defined as a grievance for the purposes of this policy.**
4. **Verbal: Face to face expression or telephone to a hospital staff member, physician or volunteer.**
5. **Written:**
   a. **The patient and/or patient's representative may email, fax or write their concerns in a letter to the hospital.**
   b. **The patient and/or patient's representative may file their concern with the state Department of Public Health Services, the Joint Commission, the Centers for Medicare and Medicaid, the Office of Civil Rights, and/or any other body overseeing the operations of the facilities**

B. **POLICY:**

1. **Tri-City Healthcare District (TCHD) encourages questions and concerns to be resolved at the time they are presented and for employees to support one another to facilitate a speedy resolution. Each employee has the responsibility and authority to be an active participant in maintaining the highest standards of patient and/or patient's representative's satisfaction before, during and after the patient's stay.**
2. **When the patient and/or patient's representative's expectations are not met, they are entitled to register their concern and receive information of action(s) taken for its resolution. At no time should a patient and/or patient's representative feel threatened or intimidated because they have voiced a concern.**
3. **If the concern is regarding the quality of care or premature discharge, the patient and/or patient's representative has the right to refer the case to the appropriate Peer Review Organization (Medicare beneficiary) that is outlined in the patient handbook provided at admission.**

4. The Tri –City Healthcare District Board of Director's is responsible for the effective operation of the grievance process and delegates its authority herein for the review and resolution of grievances to the **Risk Manager or designee.** ~~**Compliance Committee.** Grievance Committee. The Patient Relations Specialist~~**Risk Management** shall operate and maintain the hospital's grievance mechanism designed to process and resolve patient complaints and formal grievances ~~while maintaining a comprehensive record of complaints presented to Tri-City HealthCare District (TCHD).~~
5. **Upon admission, patients will be provided with information summarizing the patient's right to file a formal grievance or complaint. All patients will receive a Patient's Bill of Rights upon admission. The information provided to the patient and/or patient representative shall contain the address and telephone number for the State agency as well as The Joint Commission. Patients and/or patient representatives have the right to voice concerns freely and to voice recommended changes. Patients and/or patient representatives have the right to voice concerns and recommendations without fear of retaliation.**
~~1.~~

C. **PROCEDURE:**

1. **Staff should attempt to resolve any concern to the satisfaction of the patient and/or patient's representative, within the policies and procedures of the facilities. The department charge nurse/supervisor, manager, or director should be made aware of the concern and should be actively involved in the resolution of the issue.**
~~The Hospital Compliance Officer shall be notified of any concern that involves a compliance-related matter. Such matters include, but are not limited to, a probable violation of law or a violation of the facilities' obligation to provide items or services that meet professionally recognized standards of health care quality where such violation presented an imminent danger to the health, safety, or well-being of a patient or placed the patient in high-risk situations.~~
2. **If the manager/director is unable to resolve the situation at the time that it is expressed or if further resources or investigation are necessary, the issue will be communicated and documented up the chain of command.**
   a. **Grievances will be communicated to Risk Management where the concern will be logged as part of the incident reporting system for data analysis and referral to the appropriate hospital manager, director, administrator or peer review person(s) or department(s), as appropriate.**
      i. **Within 7 business days of receipt of a grievance, a written response will be sent to the patient and/or patient's representative acknowledging receipt of their concerns.**
      ii. **If the investigation of the grievance cannot be completed within 7 business days, the patient and/or patient's representative will be informed that the hospital is still working to resolve the grievance and will follow up with a written response within 30 business days.**
   b. **At the conclusion of the investigation, the responsible manager, director and/or administrator involved with the patient will be responsible for providing the content needed for the written response to the concern.**
      i. **All grievances will be reviewed monthly, or as needed by the Grievance Committee.**
      ii. **Grievances will be addressed in a timely process according to the nature of the issue, the seriousness of the allegations, and the potential for harm to the patient. Regardless of the nature of the issue, all grievances must be responded to, in writing, to the patient and/or patient representative within at least 30 business days of receipt. The written notice will be communicated to the patient and/or patient's representative in a language and manner the patient**

and/or patient's representative understands. The written notice will contain:

1. **The name of the hospital contact person,**
2. **The steps taken on behalf of the patient and/or patient's representative to investigate the grievance,**
3. **The outcome of the review,**
4. **The date of completion**

iii. **A grievance will be considered resolved when the patient is satisfied with the action(s) taken on their behalf.**

iv. **In situations where the hospital has taken appropriate and reasonable actions on the patient and/or patient representative's behalf in order to resolve the grievance and the patient and/or patient's representative remains unsatisfied with the hospital's actions, the hospital may consider the grievance closed.**

c. **If in the course of the investigation an opportunity to improve care or services to future patients has been identified, action will be taken.**

d. **Risk Management will track timely follow-up to concerns, communicate opportunities to improve care to appropriate departments and report trends/patterns to the Quality Assurance Performance Improvement through Patient Safety Committee as part of the quality improvement process.**

e. **Records and documents pertaining to concerns and grievances shall be maintained by TCHD~~the facilities~~ for a minimum of six years and shall be open to inspection by the California Department of Public Health Services and the U.S. Department of Health and Human Services during such six-year periods.**

~~1. Patient Education~~

~~a. Upon admission, patients will be provided with information summarizing the patient's right to file a formal grievance or complaint. All patients will receive a Patient's Bill of Rights upon admission. The information provided to the patient/patient representative shall contain the address and telephone number for the State agency to all patients/patient representatives, as well as The Joint Commission. Patients have the right to voice complaints or concerns freely and to voice recommended changes. Patients have the right to voice complaints and recommendation without fear of retaliation.~~

~~2. Receipt of complaints:~~

~~a. All patient/family complaints regarding medical or nursing care will be discussed first with the individuals at the lowest possible level in the organization. Every hospital employee is accountable for receiving and managing verbal complaints from patients/families.~~

~~i. Attempts to resolve patient/family concerns or complaints will be made at bedside with individuals involved. Expression of a concern or voicing a complaint regarding patient care will in no way compromise the quality of services delivered.~~

~~ii. Any unresolved complaint/concern will be reported to the **Clinical Leader** supervisor/ or designee. The **Clinical Leader**supervisor/ or designee will attempt to resolve. If the complaint is resolved to their satisfaction, no further follow-up is required. If no resolution, the Director/Manager/designee will become involved in resolution efforts. If still no resolution, the parties may involve the Director of Risk Management or the Chief Nurse Executive in the resolution efforts.~~

~~b. Processing of **unresolved** verbal complaints:~~

~~i. Receipt of a verbal complaint is to be addressed promptly by the staff present ("staff present" includes any hospital staff present at the time of the complaint or who can quickly be at the patient's location (i.e. nursing, administration, nursing supervisors, patient advocate, etc.) to resolve the patient's complaints.~~

~~1. If the verbal complaint is resolved, no further action is required~~

ii. Unresolved complaints shall be entered into RL Solutions**the occurrence reporting software system (RL Solutions)** immediately stating facts of the complaint and any attempts at resolution. (A complaint/grievance is considered resolved when the patient is satisfied with the actions taken on their behalf.)
1. The Patient Relations Specialist**Risk Management** will review **the information** for completeness or **the** need to follow up.
2. The **Clinical Leader/designee**manager of the involved area will review the unsolved**unresolved** compliant**complaint** and enter any resolution actions taken into RL Solutions.
3. The Patient Relations Specialist**Risk Management** will follow-up with the patient as needed.

iii. Patients choosing not to voice complaints to unit staff providing their care may choose to call the Patient Representative. In the absence of the Patient Representative, **Risk Management** the Patient Relations Specialist or Administrative Supervisor may be called.

c. Complaints not resolved on the spot by staff present are "grievances".

d. Grievances made about situations endangering the patient (neglect/abuse), given the seriousness of the allegations and potential to harm patients, require immediate investigation and review.

e. Grievances require written notice (response) to the patient within seven (7) days.
i. The written response shall contain the name of the hospital contact person and identify the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process and the date of completion.
ii. The written notice of the hospital's determination regarding the grievance must be communicated to the patient or patient's representative in a language and manner the patient or patient's legal representative understands.
iii. If the grievance is not resolved within seven (7) days and if investigation is not complete or if corrective action is still being evaluated, the hospital's response should address that the hospital is still working to resolve the complaint and that the hospital will follow-up with another written response within thirty days.
iv. Every effort will be made to resolve all grievances as soon as possible. In collaboration with the manager/director of the involved area of the grievance, the hospitals written notice (letter) to the patient will be prepared and sent by the Patient Relations Specialist and/or the Director of Risk Management for which the complaint involves.

f. A written complaint is always considered a grievance. To process written complaints:
i. Upon written receipt of complaint from patient or patient representative, the department receiving shall date the complaint and immediately place it into RL Solutions. (Emails may be utilized as a method of communication of grievances only if the patient has emailed their complaint/grievance and/or are asking for a written response via email.)
ii. Once the complaint has been entered electronically, the appropriate Manager(s) of the area(s) involved will be automatically notified.
iii. A call will be placed to the patient, investigation conducted and actions thoroughly documented in RL Solutions by the **Risk Management** Patient Relations Specialist/**M**manager(s) of the area(s) within four days.
iv. Cases requiring immediate action or intervention may be shared directly from the Director of Risk Manager**ment** or his/her designee to the Department Chairman or Chairman of Quality Assurance/Performance Improvement Committee as outlined in the Medical Staff On-Going Professional Practice Evaluation/Peer Review Policy (8710-509)**policies.**
v. The Patient Relations Specialist or Director of Risk Management will draft a response letter containing those findings documented in RL Solutions. It shall contain the name of the hospital contact person, the steps taken on behalf of the

patient to investigate the grievance, the results of the grievance process and the date of completion. **Risk Management** The Patient Relations Specialist will document same and scan the letter into RL Solutions and mail **the** letter, after review by the Risk Management Director's approval.

vi. Risk Management Director will provide oversight to all letter responses. Response letters are not to be sent by the other individuals except as named herein.

3. Patient Representative/ Patient Relations Specialist Responsibilities:
   a. For each complaint received by the Patient Representative or **Risk Management** Patient Relations Specialist he/she will:
      i. Enter **the information** into RL Solutions. The data collected regarding patient grievances, as well as other complaints that not defined as grievances (as determined by the hospital) may be incorporated into the hospital's Performance Improvement Program **by reporting through the Compliance Committee and the Patient Safety Committee**.
      ii. Communicate with patient the projected time of response and/or resolution, immediate and/or up to 24 **72** hours for verbal feedback and seven (7) days for written feedback. Acknowledgement letter for all grievances is to be mailed within 72 hours by the Patient Relations Specialist.
      iii. Assist appropriate leadership with complaint review, facts, and discovery upon requests.
      iv. Should a patient or designated patient representative disagree with complaint findings, they will contact the Patient Relations Specialist and/or the Director of Risk Management. Grievance Committee/**A** Patient Care Conference may be offered as **a** process for resolution. The California Department of Public Health and The Joint Commission may be offered as an agency for complaint resolution to all patients.
4. Individual ancillary department' responsibilities:
   a. When received by an ancillary department, a complaint specific to that department shall be formally acknowledged immediately by the manager(s) of the area(s). The complaint will be entered into RL Solutions within 72 hours.
   b. Any written documentation submitted to the department will be scanned into RL Solutions by the department.
   c. All patient complaints shall be answered promptly (e.g. within seven (7) working days with a closing statement reflecting availability of individual department, as well as the Patient Relations Specialist/Patient Representatives as a future problem resources.
5. Resolutions of the grievance:
   a. When a patient communicates a grievance to the hospital via email the hospital may provide its response via email.
   b. There may be situations where the hospital has taken appropriate and reasonable actions on the patient's behalf in order to resolve the patient's grievance and the patient or the patient's representative remains unsatisfied with the hospital's actions. In this situation the hospital may offer the Grievance Committee **other alternatives** as a method for resolution. It will be necessary to maintain documentation of its efforts and demonstrate compliance with CMS requirements.
   c. In written responses, the hospital is not required to include statements that could be used in legal action against the hospital, but the hospital must provide adequate information to address each item as stated in this requirement.

D. **GRIEVANCE COMMITTEE/PATIENT CARE CONFERENCE COMMITTEE:**

1. The Grievance Committee shall consist of Chief Nursing Executive or designee, Patient Relations Specialist, Risk Management, Performance Improvement and other departments and/or members as indicated.

~~2. The Grievance Committee shall meet as needed to evaluate grievances and complaints from prior month and review resolutions.~~
~~3. Reports from Grievance Committee shall be integrated into the hospital performance improvement program.~~
~~4. The governing body has the responsibility of the oversight of the grievance process and delegates the review and resolution of complaints to the Grievance Committee. The Grievance will provide to the governing body at least annually.~~
~~5. The Grievance Committee shall meet to review grievances unable to be resolved at by the involved manager, patient relations and risk management.~~

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

1. Centers for Medicare & Medicaid Services (CMS) **Conditions of Participation Rev. 200, 02-21-20**~~2015~~
2. The Joint Commission ~~(TJC) LD.01.03.01; RI.01.07.01; MS.09.01.01 2015~~**Hospital Accreditation Manual 2021**
3. California Hospital Association Consent Manual ~~2015~~**2020**

~~F. RELATED DOCUMENTS:~~

~~1. Patient Complaints & Grievances Flow Chart~~

Tri-City Medical Center	~~Distribution:~~ **Patient Care Services**
PROCEDURE:	**PERINATAL DEATH (MISCARRIAGE, STILLBIRTH AND NEONATAL DEATH CARE AND DISPOSITION)**
Purpose:	To assist the family in coping with a perinatal death via miscarriage, stillbirth or neonatal death, obtain mementos, if applicable and provide postmortem care. Families experiencing a Perinatal death shall be provided support for grieving.
Supportive Data:	Data shows that assisting families in making memories during a perinatal death helps validate the lost life and can help facilitate an effective grieving process. Use of multidisciplinary resource support during this time also has a vital role in helping these grieving families.
Equipment:	1. Personal protective equipment 2. Infant scale 3. Disposable measuring tape 4. ID bracelets, if applicable 5. Disposition preparation items for transfer to the morgue –(Chux, baby blanket, instrument packing drape, tape and 3x 5 card) 6. Authority for Release of Deceased/ Miscarriage Form – triplicate, if applicable 7. Authorization for Autopsy form, if applicable 8. Camera 9. Grief packet, including: • Mementos folder • Mementos box • Discharge Instruction Form

A. **POLICY:**

1. Families who experience a perinatal death during pregnancy or shortly after birth may grieve for their baby and the loss of an entire lifetime with that child. Caring, supportive people can help families move through the initial crisis toward re-establishing their lives without their babies.
2. It is important to meet the needs of bereaved parents and their family during the initial crisis of their perinatal loss by offering comprehensive care that includes compassion and an interdisciplinary perspective.

B. **PROCEDURE:**

1. Miscarriage
   a. Assign patient to a room away from other patients and unit activity to promote a private and quite atmosphere free from chaos, laboring patients and crying babies if possible.
      i. If miscarriage greater than 16 weeks estimated gestational age (EGA) occurs in the ED and the ED provider initiates an Obstetrical consult, arrangements may be made to transfer the patient to the labor and delivery (L&D) unit for admission and care coordination as available **per the L&D Charge RN.**
      ii. Efforts shall be made to ensure the patient has necessary supports to assist her through this difficult time if not already present.
2. Newborn or stillbirth
   a. Complete the same patient admission requirements to the unit per standards of care for the patient and for the newborn if born alive. See Standards of Care for Intrapartum, Postpartum and Newborn Care.

Patient Care Services Content Expert ~~Revision Date~~	**Clinical Policies & Procedures**	**Nursing Leadership ~~Executive Council~~**	**Department of OB/GYN**	**Perinatal Collaborative Practice ~~Division of Neonatology~~**	**Pharmacy & Therapeutics Committee**	**Medical Executive Committee**	**Admini stration**	**Professional Affairs Committee**	**Board of Directors**
12/08; 6/11, **09/21**	04/11, 10/16, **10/21**	04/11, 10/16, **11/21**	12/16, **12/21**	01/17, **08/22**	n/a	05/11, 02/17, **09/22**	**11/22**	06/11, 03/17, **n/a**	06/11, 03/17

i. If the delivery is a stillbirth, there will NOT be a medical record created for baby. All of the delivery information is charted in the mother's chart.
   1) Identification band information shall be entered on the bands manually and include:
      a) Last name and baby's sex, if known
      b) Patient's first and last name
      c) Patient's medical record number
   2) Attach one band to the stillbirth's **ankle**~~arm~~ for identification for remains disposition.
   3) The other baby band/parent bands can be saved and included as a part of the memory making process.

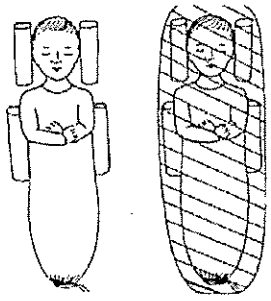
ii. If the delivery is a LIVE birth, but then later dies, the banding process for the baby is followed per unit routine and is usually computer generated.
   1) One band shall remain on the baby's **ankle**~~arm~~ for identification for remains disposition.
   2) The other baby band/parent bands can be saved and included as part of the memory making process.

iii. The patient shall be included in the decision of where she would like to remain post-delivery and for the remainder of her stay. Transfer off the unit may be coordinated with a providers order, once the patient is stable, and as indicated.

3. Staffing considerations should include recognition that this situation may require more intense psychosocial and emotional support and assignments adjusted, as indicated.
4. Post a special bereavement card outside the entrance to the patient to notify staff entering the space that a loss/ death has occurred to ensure sensitivity.
5. Inform Social Services and/or pastoral care of the perinatal death to ensure alternate support measures are offered to the family.
   a. Social Services can evaluate any psychosocial needs, provide bereavement support and discuss disposition options with the family if desired.
      i. For miscarriage see Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process.
      ii. A "Comfort Cub" may be given to the family to assist with bereavement support and shall be determined by the social worker.
   b. Pastoral care provides both spiritual comfort and support to families and can provide blessings, naming ceremony, baptism and/or a memorial service as indicated.
6. Discuss the anticipated plan of care with the patient including these options as appropriate:
   a. To see and hold their pregnancy tissue/baby.
      i. The family may wish to hold the newborn/fetus immediately after delivery.
      ii. Care should be taken to treat anything that comes from the mother's body with respect.
      iii. It is helpful to prepare them for what they will see: color, shiny skin, fused eyes, translucency, tiny hands and feet, any defects, skin sluffage, deformities, coloring, etc.
      iv. When handling the remains it is important to use gloves and complete good hand hygiene
      v. Ask the family if they have an outfit they want the baby to wear, a special blanket to wrap him/her, when appropriate
         1) If no outfit, staff can offer donated outfit layettes from the angel room. ~~Have the family select one.~~
   b. Weigh and measure the length of the remains, if able.
   c. Obtain footprints, ~~if able Or,~~ if loss is small, can trace around the baby's hands, feet and/or body on paper background to represent size.
      i. The application of acetone to the surface of the foot and then use of a black marker (rather than an ink pad) will make prints clearer in this small gestation

d. Complete newborn identification certificate/card with parent's name and birth information.
e. Discuss naming the baby
f. Cut locks of the baby's hair if available.
g. Obtain photos upon verbal consent
   i. The parents may take their own photos on personal camera
   ii. A hospital camera may be used for non-medical photography after verbal consent is obtained from the parents.
   iii. When appropriate, attempt to capture candids with the baby and family interactions as well as posed positions to highlight some of the physical attributes of the newborn/stillbirth.
h. Ask family if they want to bathe the baby and facilitate as indicated.

7. Collect all of the mementos and place them in the memory box including any photos, memento booklet, the outfit the baby was wearing, the blanket and hat and any other mementos.
   a. The Labor and Delivery unit has a dedicated room where the memento box and other memory making supplies are stored.
   b. If parents refuse mementos, they remain in a locked file in Women's & Newborn Services Department.
8. If the family desires to make arrangements for the miscarriage disposition, ensure the Authority for Miscarriage Remains Release form is completed.
   a. Staff should move the remains to an appropriate and private room to prepare for transport.
   b. It is important that placement of the remains for transport not be done in the parent's presence to ensure dignity is maintained.
   c. Send remains to the Laboratory using the corresponding tissue requisition and per PCS Procedure: Miscarriage and Stillbirth Identification and Disposition Process.
9. When the family is ready for the stillbirth/newborn remains (baby) to be brought to the morgue, it is important that the preparation and positioning of the baby be performed in a way that combats the combined effects of rigor mortis, algormortis (cooling of the body), and permanent discoloration in case the parents wish to view the baby at another time.
   a. The baby should be unclothed except for a diaper in place, if desired and have an identification band located on its **ankle**~~arm~~.
   b. Place on a chucks pad first, the body supine.
      i. Care should be taken to not place any textured blankets or towels on exposed skin because it may leave permanent impressions.
   c. Support the head in position, by having two rolled towels/chux pads positioned at each side of the head to keep it upright.
      i. If the head is left unsupported, it may fall to one side and blood may collect in the soft facial tissues, leaving permanent discolorations.



   d. Fold the arms with a towel roll inserted under the arms at the side of the body to support the position.
      i. Place the hands crossed or next to each other on the chest.
   e. Wrap the body in the chux and baby blanket mummy-fashion to secure positioning, followed by an instrument packing drape which shall be taped in place.
   f. Complete an index card with the following information and tape it to the outside of the baby's wrap:
      i. Baby's last name and gender (baby girl/baby boy)
      ii. Mother's name and medical record number
         1) May use an admission sticker
         2) Newborn's medical record number if a newborn death

iii. Date and time of delivery
iv. Weight (~~gms~~) and length (cm)
v. Attending provider

g. Coordinate transfer to the morgue per PCS: Release of the Deceased Procedure.
i. Ensure the morgue log book is completed when bringing baby to and from the morgue for family viewing.

10. Give the family bereavement support material to review as indicated and discharge instructions for follow-up:
a. Provide information about medical care options available to them by their provider depending on their perinatal loss diagnosis
b. Include in the plan of care regarding post procedure and/or post delivery options, and disposition options.
c. For a miscarriage please review the "Authority for Miscarriage Remains Release form" with the family, per Patient Care Services (PCS) procedure: Miscarriage and Stillbirth identification and disposition process.
d. For a stillbirth or neonatal death, please review the "Release of the Deceased form" with the family per PCS procedure: Miscarriage and Stillbirth identification and disposition process.

~~11. A grief checklist should be completed to provide information on what has been done.~~

C. **DOCUMENTATION:**

1. Document the miscarriage and/or delivery information and other interventions in the ~~Perinatal Death Ad Hoc form~~**mother's Electronic Medical Record**, including the disposition **of**~~with~~ fetal remains.
2. If born alive, document admission items per standards of care in the Electronic Medical Record, ~~complete Perinatal Death Ad Hoc form,~~ including the disposition of the newborn.

D. **RELATED DOCUMENTS:**

1. Patient Care Service Procedure: Miscarriage and Stillbirth Identification and Disposition Process
2. Women and Newborn Services Standards of Care for Intrapartum
3. Women and Newborn Services Standards of Care Postpartum
4. Women and Newborn Services Standards of Care Newborn Care
5. Authority for Miscarriage Remains Release Form Sample

~~6. Authority for Release of the Deceased Form Sample~~

E. **REFERENCES:**

1. Wilke, J. & Limbo, R. (2012) *Bereavement training in perinatal death (8th ed.)*. La Crosse: Gunderson Lutheran Medical Foundation, Inc.
2. Simpson, K. & Creehan, P. (20**21**~~14~~) *AWHONN Perinatal nursing (45th ed.)*. Philadelphia: Lippincott, Williams & Wilkins.
3. Rosenbaum, J., Renaud-Smith, J., & Zollfrank, R. (2011) Neonatal end-of-life spiritual support care. The Journal of Perinatal and Neonatal Nursing 25(1), 61-69.
4. Mattson, S., & Smith, J.E. (201~~4~~6). *Core-curriculum to maternal-newborn nursing (45th Ed.)*. Philadelphia: Saunders.

Authority for Release of Deceased Form – Sample

Test, Fred MR# 00000547 FIN# 6002100724

2 SSN 487-66-5555 Room # 516

Oceanside CA 92056

Next of kin: Test, Fred **Relation:** Pt **Phone Number:** (111) 111-1111

Patient a donor: Yes

Attending Physician: Test, DME Physician

Pronounced Time: 04/04/2016 14:56 **Medical Examiner Notified:** Yes **Waive No.:** 55555

I acknowledge the receipt of personal effects (Acuso recibo de los efectos personales)

Dat

I he

aut

To

Mo

(No

fono) Phone

Date

(Fe

fono)

Physicia

Mortua

Receive

Date/Tir

Returne

Receive

Date/Tir

Public A

DELETE

0

Tri-City Medical Center

Authority for Release of Deceased

00000547
Test, Fred
02/02/1954/62 Years/Male
TCMC/Inpatient/6002100724

PLEASE MAKE COPY OF ORIGINAL WITH FAMILY SIGNATURES FOR MORTUARY PICK UP SERVICE

Authority for Release of the Deceased Form - 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

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

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:	**PRONATION THERAPY FOR THE MECHANICALLY VENTILATED PATIENT**
Purpose:	To assist ICU staff in safely caring for the mechanically ventilated patient requiring pronation therapy; to outline inclusion and exclusion criteria for pronation therapy; to identify the equipment and personnel needed before, during and after performing the prone maneuver; and to outline the steps to safely turning a patient on mechanical ventilation to the prone position.
Supportive Data:	Prone positioning is an adjunct, short term, supportive therapy for critically ill patients with Adult Respiratory Distress Syndrome (ARDS) with severe hypoxemia. Prone positioning helps to recruit alveoli, leading to reduced Ventilator Induced Lung Injury (VILI), improved oxygenation, improved ventilation, improved mobilization of secretions and reduced mortality. When the body is placed in a prone position, pleural pressures, compliance, and volume distribution in different regions of the lungs change.
Equipment:	1. For Manual Proning: a. Two flat sheets b. Three pillows c. One large white chux pad d. One blue chux pad e. Two Hover mats f. ECG electrodes g. Silicone composite foam dressings for pressure points (Prone Pack) h. Bite block i. Ophthalmic lubricant j. Clamp, in case the patient needs to be disconnected from ventilator ~~2. For Proning using RotoProne Therapy System~~ ~~a. RotoProne Therapy System bed~~ ~~b. Two chux pads~~ ~~c. ECG electrodes~~ ~~d. Silicone composite foam dressings for pressure points~~ ~~e. Ophthalmic lubricant~~ ~~f. Eye patch, or paper tape to close eyelids~~ ~~g. Clamp, in case the patient needs to be disconnected from ventilator~~

A. **DEFINITIONS:**

1. ARDS: A life threatening respiratory condition characterized by hypoxemia, and stiff lungs.
2. Kinetic Therapy: A slow, gentle, side-to-side rotation of the patient to an angle between 40-62 degrees.
3. P/F Ratio: Partial pressure of arterial oxygen (PaO_2) ÷ fraction of inspired oxygen (FiO_2) X 100.
4. Prone positioning: the process of turning a patient with precise, safe motions from their back onto their abdomen so the patient is lying face down.
5. ~~RotoProne Therapy System: A bed designed to place a patient with acute pulmonary complications such as acute lung injury and ARDS in the prone position and provide kinetic therapy.~~
6. ~~6.~~**5.** Severe hypoxemia: A condition in which the P/F ratio is < 150 mm Hg with an FiO2 of at least 60% and positive end-expiratory pressure (PEEP) of at least 4 cm H_2O and a tidal volume close to 6 mL/kg of predicted body weight.
7. ~~7.~~**6.** Spontaneous Awakening Trial (SAT): A period of time during which a mechanically ventilated patient's sedative medications are discontinued to assess for the ability to comfortably engage in a trial of spontaneous breathing.

Patient Care Services Content Expert	Clinical Policies and Procedures Committee	Nursing Leadership	Critical Care Committee	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
11/20 NEW	12/20	08/21	08/22	n/a	10/22	11/22	n/a	

~~8.~~**7.** Spontaneous Breathing Trial (SBT): An assessment of a mechanically ventilated patient's ability to breathe while receiving minimal or no ventilator support.

~~9.~~**8.** Train of four **(TOF)**: A peripheral nerve stimulator tool used to monitor the level of paralyzation of the patient undergoing intravenous neuromuscular blockade therapy. A stimulator delivers four electrical impulses in succession, eliciting a baseline twitch response after each stimulus ("4/4") with 10 mA.

B. **POLICY**

1. A Physician or Allied Health Professional (AHP) order is required for initiation and discontinuation of pronation therapy.
2. Pronation therapy will be provided for 16 to 20 hours per 24-hour day, with a schedule of prone and supine time specified in the Physician/AHP order.
   a. For manual proning, an alternating schedule of 16-20 hours prone and 4-8 hours supine is recommended.
   ~~b. For proning with the RotoProne Therapy System, an initial prone time of 20 hours is recommended, followed by an alternating schedule of 1 hour supine and 6 hours prone.~~
3. While on manual pronation therapy, the patient shall be repositioned every two hours.
   a. The patient may be manually tilted using pillows on the side the face is turned toward.
   b. The head shall be turned from side to side.
      i. Ensure ears are not kinked.
   c. Reposition arms in "swimmers' freestyle position": place one arm straight down at the side; opposite arm bent at 90 degree angle, arm reaching up with palm down. The head should be facing same direction as the bent arm.
4. While in prone position, eyes shall be protected with ocular lubricant every **4~~2~~** hours **and prn**.
5. Patients undergoing pronation therapy shall be adequately sedated to a RASS score of -4 to -5.
   a. Assess and document RASS every 1 hour.
6. If neuromuscular blockade is used, titrate to a TOF of 2/4.
   a. Assess and document TOF every 4 hours or per physician/AHP orders.
7. At least five staff required to perform manual turns
   a. Primary RN will communicate plan and assign roles to team
   b. Minimum of 2 staff (i.e. RN, Lift Team Technician) on each side of the patient at the shoulders and hips.
   c. Respiratory Care Practitioner (RCP) shall act as the team leader and stand at the head of bed to secure endotracheal tube (ETT)

~~8. All manual turns are done on a count of 3 as directed by the team leader.~~

~~9.~~**8.** The Physician/Allied Health Care Provider shall be present during the initial manual prone maneuver **to** deem patient viable for current and future turns, to ensure the turn is done safely, and to assist in the event the patient suddenly decompensates.

~~10.~~**9.** ABGs shall be drawn approximately 15 minutes prior to the initial prone maneuver, approximately 30 minutes after the **initial** turn, then per Physician/AHP orders (i.e. every 4 hours until stable, daily while prone and, PRN).

~~11.~~**10.** The P/F ratio shall be calculated with each ABG, and monitored to trend for improvement.

~~12.~~**11.** Every 2 hours and prn:
   a. Clear ETT, oral cavity and nose of secretions
   b. Assess face, elbows, knees, toes and genitals for breakdown.
   c. Provide oral care
   d. Reposition patient's head to face opposite side while manually proned.

~~13.~~**12.** In the event of a cardiac arrest, call a Code Blue, and return patient to supine position as soon as possible (for the manually proned patient, when adequate number staff present).
   a. In the event of a cardiopulmonary arrest and the patient cannot be turned supine, perform cardiopulmonary resuscitation (CPR) in the prone position over the midthoracic spine.
      i. Position hands one vertebral level below the line crossing both the inferior angles of the scapula.

ii. Perform CPR at the same depth and rate as if the patient were supine.

~~14.~~**13.** When the patient is in the supine position:
- a. Perform systems assessment; assess face, elbows, knees, toes, and genitals for skin breakdown.
- b. Perform SAT/SBT if possible.
- c. Perform hygiene care.
- d. Perform diagnostic tests if ordered.
- e. Provide passive range of motion (ROM) exercises.
- f. Perform any scheduled dressing changes prior to the next prone maneuver.
- g. Raise head of bed to 30 degrees or as tolerated.
- h. Reposition patient every 2 hours.

C. INCLUSION CRITERIA FOR PRONE POSITIONING
1. ARDS with severe hypoxemia.
2. FiO2 ≥ 0.6
3. PEEP ≥ 10 cm H_2O
4. P/F ratio ≤ 150 mm Hg
5. Chest x-ray showing bilateral patchy alveolar infiltrates

D. EXCLUSION CRITERIA FOR PRONE POSITIONING
1. Unstable cervical, thoracic, lumbar, pelvic, skull, or facial fractures
2. Cervical or skeletal traction
3. Uncontrolled ICP
4. Weight ~~< 40 kg or~~**greater than (>)** 160 kg
5. Height > 198.12 cm (6'6")
6. Inability to tolerate face down position
7. Massive hemoptysis
8. Relative contraindications exist (risk to benefit ratio to be considered):
   - a. Severe hemodynamic instability
   - b. History of difficult intubation
   - c. Excessive size or bulk that precludes the ability to manually turn within the bed frame
   - d. Intra-Aortic Balloon Pump (IABP) therapy
   - e. Thoracic outlet syndrome
   - f. Pregnancy (consult with obstetrics)
   - g. Recent thoracic or tracheal surgery (consult with surgeon)
   - h. Abdominal compartment syndrome
   - i. Acute pulmonary embolism or deep vein thrombosis

E. PROCEDURE FOR MANUAL PRONING:
1. **Trial Positioning**
   - a. When clinically indicated, a trial of prone positioning will be performed to assess for potential problems. The patient will be slowly turned on one side and assessed for:
     - i. Heart rate and blood pressure instability
     - ii. SpO_2 < 90%
     - iii. Patient safety
   - b. If the Physician/AHP is satisfied that the patient can tolerate the prone position, proceed with full prone positioning as outlined below.
2. **Preparation**:
   - a. Perform hand hygiene and don gloves and appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.
   - b. Verify the correct patient using two identifiers.
   - c. Explain the procedure to the patient/family.
   - d. Hold tube feeding ~~1 hour~~ prior to proning ~~(may resume once in prone position)~~.
   - e. Gather supplies

f. Perform any dressing changes necessary and/or scheduled for the time period the patient is scheduled to be proned
g. Empty Foley catheter bag and securement device.
h. Empty any other drainage bags.
i. Assess and verify the prescribed level of sedation has been achieved.
j. Disconnect unnecessary cables, lines, or tubes.
k. Untangle cables, lines, tubes that need to stay on the patient.
l. Place all lines in the upper torso over the right or left shoulder of the patient, with the exception of chest tubes which should be placed at the foot of the bed. Place all lines in the lower torso at the foot of the bed.
m. Place protective foam dressings on pressure points:
    i. Cheeks
    ii. Chin
    iii. Anterior shoulders to chest
    iv. Bilateral iliac crest
    v. Bilateral knees
    vi. Bilateral tops of feet
n. Apply skin protectant (i.e. Cavalon skin barrier) to face prn to protect skin from oral secretions.
o. Lubricate eyes.
p. Insert bite block, if applicable (i.e. swollen or protruding tongue).
q. Assure ETT is secured, and re-tape if necessary.
    i. Document ETT marking at the lip
r. Gather necessary staff (minimum of 5).
    i. Primary RN (Leader) at head of bed
        1) Assigns roles
        2) Supports the head and neck
        3) Ensures procedure is being followed correctly
        4) Calls the turns on the count of 3.
    ii. RCP at the head of bed secures the airway and monitors ventilator tubing.
    iii. Additional RNs and/or Lift Team Technicians assist with turning and body alignment post-turn.
    iv. Physician/AHP available
s. Assure reintubation equipment and ambu bag with peep valve and inline filter are available.
t. Obtain arterial blood gas (ABG) 15 minutes prior to initial turn, otherwise as ordered or PRN
u. Preoxygenate with 100% FiO_2 for 2-3 minutes prior to turn.

3. **Manual Proning Maneuver:**
a. Place a new clean flat sheet under a Hover mat under the patient (roll side-to-side)
b. Ensure patient privacy and remove patient gown.
c. If patient is on a low air-loss surface, adjust the inflation to Max Inflate.
d. Remove headboard and pillow. Lower side rails.
e. Loop vent tubing above patient's head to prevent accidental disconnection or kinking during turn maneuver.
f. Tuck both hands under patient's hips.
g. Remove anterior ECG leads and pulse oximeter.
h. Place a blue chux on top of patient's abdomen/pelvis, absorbent side against patient.
i. Place one pillow across the chest, one pillow across the abdomen, and one pillow across the shins.
    i. Fewer pillows may be used depending on patient size and body features.
j. Place a large white chux (or a flat white sheet) over the pillows.
k. Place the second Hover mat, slick side up, on top of the white chux (or sheet).
    i. Can be used to reposition patient while in the prone position.

l. Place another flat sheet on top of the Hover mat.
m. Avoid disconnecting the patient from the ventilator unless it is deemed unavoidable.
    i. If the patient has to be disconnected from the ventilator, clamp the ETT at end expiration before disconnecting and then unclamp after reconnecting.
n. Determine which direction patient will turn, based on location of IV lines. The side of the IV site will be UP during each turn:
    i. If IV lines are on the right side of the upper body, patient will turn towards the left (the right side of the body will be UP).
    ii. If IV lines are on the left side of the upper body, the patient will turn towards the right (the left side of the body will be UP).
o. Roll top and bottom sheets together toward the patient
    i. "Receiving Team" on same the side the patient will turn towards rolls sheets downward toward the patient, tucking under.
    ii. "Delivering Team" on opposite side the patient will turn towards rolls sheets upward toward the patient.
p. On the Lead's count of 3, slide patient to edge of bed away from the direction of the turn.
q. On the Lead's count of 3, do ½ turn towards the direction of the turn onto patient's side (away from "Delivering Team").
r. "Receiving Team" will guide patient down into prone position.
s. "Delivering Team" will pull the rolled sheets to complete the turn.
t. The Lead RCP will guide patient's head down to a side-lying position on a foam head support pillow.
u. Apply ECG electrodes to patient's back (reversed positions).
v. Place patient in swimmer's position (arm is placed upward with shoulder in neutral position and elbow at 90 degrees).
w. If patient is on a low air-loss surface, adjust inflation as appropriate.
x. Use pillows for positioning as needed:
    i. Place pillows under shins to raise ankles off bed and to maintain dorsiflexion
    ii. Pillows under hips can ease low back discomfort
    iii. Pillows can be used to offload any areas necessary (i.e. drain sites)
    iv. Ensure patient's toes are elevated off the surface of the bed.
    v. For female patients, displace the breasts. Verify the nipples are free from pressure.
    vi. For male patients, verify the genitals are hanging freely and not compressed between the legs.
y. Ensure ETT and other catheters and tubes are secure and patent.
z. Assess patient for proper body alignment: neck, spine, hips and extremities. Avoid hyperextension or hyper-abduction (>90 degrees) of the extremities and neck.
aa. Cover patient, raise side rails.
bb. Place the bed in reverse Trendelenburg position to decrease edema and risk for aspiration
cc. Resume tube feeding ~~one hour~~ after turn.
dd. Head will require repositioning side-to-side approximately Q2h while prone
    i. Two people at HOB – one to turn head to opposite side, one to monitor/secure ETT
    ii. Place both arms down by patient's side during reposition.
    iii. After repositioning place opposite arm up in swimmer's position.
ee. Gently reposition patient's body prn to relieve pressure points.
ff. Continue prone position for 16 to 20 hours as ordered.
gg. Alert the rest of the unit staff that a patient has been placed in a prone position. Staff must be available to quickly return the patient to supine position if the patient's condition deteriorates.

hh. Assess the patient's tolerance to the full prone position. Failure of the respiratory rate/effort, heart rate and blood pressure to return to normal 5 to 10 minutes after the turn may be the initial sign of intolerance.
  i. Patient must be returned to the supine position in the event of:
    1) Loss of airway
    2) ETT obstruction
    3) Hemoptysis
    4) Heart rate <30 for more than 30 seconds
    5) Mean arterial blood pressure (MAP) < 40 for more than 5 minutes
    6) Cardiac arrest
    7) Rapid deterioration in SpO_2 and/or blood pressure
    8) Clinically significant drip in oxygenation (>10 mm Hg) or oxygen saturation < 85%.
    9) Inability to maintain RASS score of -5
  ii. Institute prone positioning assessments if SpO_2 > 90% and blood pressure remains stable:
    i. Draw ABG approximately 30 minutes after turn, and 4 hours after turn; then repeat as indicated or ordered (i.e. every 4 hours until stable, daily in the prone position and prn).
    ii. Assess hourly:
      1) RASS score
      2) TOF if applicable
      3) Vital signs
      4) Tolerance to prone position
      5) Security of ETT

4. **Returning Patient to Supine Position**
  a. Obtain arterial blood gas (ABG) approximately 15 minutes prior to turn.
  b. Perform steps above in reverse.
  c. Ensure patient privacy and remove patient gown.
  d. If patient is on a low air-loss surface, adjust the inflation to Max Inflate.
  e. Remove headboard and pillow. Lower side rails.
  f. Loop vent tubing above patient's head to prevent accidental disconnection or kinking during turn maneuver.
  g. Tuck both hands under patient's hips.
  h. Remove posterior ECG leads and pulse oximeter.
  i. Place a clean blue chux on top of patient, absorbent side against patient.
  j. Remove pillows from top of patient.
  k. Place a large white chux (or a flat white sheet) over the blue chux.
  l. Place a Hover mat, slick side up, on top of the white chux (or sheet).
  m. Place another flat sheet on top of the Hover mat.
  n. Avoid disconnecting the patient from the ventilator unless it is deemed unavoidable.
    i. If the patient has to be disconnected from the ventilator, clamp the ETT at end expiration before disconnecting and then unclamp after reconnecting.
  o. Determine which direction patient will turn, based on location of IV lines. The side of the IV site will be UP during each turn:
    i. If IV lines are on the right side of the upper body, patient will turn towards the left (the right side of the body will be UP).
    ii. If IV lines are on the left side of the upper body, the patient will turn towards the right (the left side of the body will be UP).
  p. Roll top and bottom sheets together toward the patient
    i. "Receiving Team" on same the side the patient will turn towards rolls sheets downward toward the patient, tucking under.
    ii. "Delivering Team" on opposite side the patient will turn towards rolls sheets upward toward the patient.

q. On the Lead's count of 3, slide patient to edge of bed away from the direction of the turn.
r. On the Lead's count of 3, do ½ turn towards the direction of the turn onto patient's side (away from "Delivering Team").
s. "Receiving Team" will guide patient down into prone position.
t. "Delivering Team" will pull the rolled sheets to complete the turn.
u. The Lead RCP will guide patient's head down to a side-lying position on a foam head support pillow.
v. If patient is on a low air-loss surface, adjust inflation as appropriate.
w. Verify proper body alignment.
x. Replace all monitoring equipment. Apply ECG leads to anterior chest.
y. Assess placement and patency of all lines and tubes.
z. Assess post-turn hemodynamic and pulmonary data.
aa. Notify Physician/AHP of any deviations from baseline assessments and of any respiratory deterioration after return to supine position.
bb. Assess skin condition at pressure points
cc. Assess for facial edema. Apply ice packs to eyes prn.
dd. Obtain ABG approximately 4 hours after turn to supine.

~~F. **PROCEDURE FOR PRONING USING ROTOPRONE THERAPY SYSTEM:**~~

~~1. The following patient identification practices shall be implemented for patients requiring RotoProne Therapy:~~
~~a. Print and verify two patient wrist ID bands, place one ID band on the patient and attach the second ID band to the ventilator. Do not attach the wrist ID band to the ventilator tubing.~~
~~b. Patient Identification Verification Process:~~
~~i. Shift Handoff and Break Handoffs – two RNs will verify the patient's identity using the wrist ID band on the ventilator, if the wrist ID band on the patient is not accessible.~~
~~ii. Shift Assessment – the primary RN will verify the information on the wrist ID band on the patient with another source of information e.g., MAR, census, ID band on the ventilator. RTs are also required to implement this verification process.~~
~~c. After verifying the patient's identify using their wrist ID band, the ID band attached to the ventilator may be used for scanning and identifying the patient, when the wrist ID band on the patient is not accessible.~~
~~d. If either ID band is removed for any reason, the staff removing the band(s) is responsible for replacing the band(s) and ensuring accuracy and legibility of the information written on the ID band.~~
~~e. When RotoProne therapy is discontinued, remove the patient ID band from the ventilator and discontinue this practice modification.~~
~~2. Perform hand hygiene and don gloves and appropriate PPE based on the patient's signs and symptoms and indications for isolation precautions.~~
~~3. Verify the correct patient using two identifiers.~~
~~4. Explain the procedure to the patient and ensure that he or she agrees to treatment.~~
~~5. After removing all removable pieces from the RotoProne (Figure 6) surface, move the patient from the bed to the RotoProne surface.~~
~~6. Position the patient in the center of the surface with the head in the attached head support and the ears visible through the ear holes on the headpiece.~~
~~7. Position all tubes and invasive lines.~~
~~a. Add extension tubing, as necessary, to lines that are too short to be placed at the head or end of the bed.~~
~~b. Align the lines inserted in the upper torso with either shoulder and position them at the head of the bed in the tube management system.~~
~~c. Align chest tubes and lines or tubes placed in the lower torso with either leg and extend them through the center hole at the foot of the RotoProne surface.~~

8. Follow the manufacturer's recommendations for securing the patient on the therapy surface.
   a. Place the leg piece and side packs on the surface. Ensure that the patient is snugly secured within the side packs.
   b. Place the abdominal support mesh over the patient's abdomen.
   c. Position the additional pads on the patient (lower leg packs over the shins, pelvic packs along the iliac crests, chest pack).
   d. Tighten the headpiece snugly around the patient's head.
   e. Position all packs snugly over the patient.
   f. Place the face pack on the patient's face, ensuring that the top pad is above the eyebrows and that the side pieces frame the mouth.
9. On the touch screen at the foot of the bed, set therapy on the RotoProne to rotate the patient into the prone position by turning the patient toward the direction of the ventilator.
10. Check the tubing, airway, and head support and press the corresponding button on the touch screen after each check.
11. Press the "Rotate" button.
12. Press and hold the "Rotate and Lower" button until the screen changes.
13. Check the tubing, airway, head support, abdominal support, and arm slings and then press the corresponding button on the screen.
14. Reconfirm the position of the face pack and press the button on the touch screen.
15. Press the "Prone" button and hold it during the entire turning procedure. Alternatively, press the "Prone/Supine" button on the hand control unit.
16. Check the tubing, airway, and head support and press the corresponding buttons on the touch screen after each check.
17. Press the "Rotate" button. Adjust the rotation and pause times on each side based on the patient's response to therapy.
18. Press the "Surface Position" button.
19. Place the patient in reverse Trendelenburg position by pressing and holding the corresponding button on the touch screen until the head of the bed is tilted upward at a slight angle.
20. Resume the tube feeding.
21. Open the back and foot hatches when the patient is in the prone position.
22. Determine the length of time to leave the patient in the prone position based on his or her response to prone positioning.
23. After the time in the prone position is complete, place the patient supine for a designated time as tolerated.
   a. The positioning schedule is based on whether the patient is able to sustain improvements in PaO2 made while in the prone or supine position.
   b. The health care team may decide to vary the recommended time intervals and rotation times based on the patient's response to therapy.
   c. Press the "Therapy Settings" button to change the degree of rotation or pause times.
24. Turn the patient to the supine position.
   a. Close all open hatches.
   b. Stop the tube feeding.
   c. Press the "Supine" button.
   d. Press and hold the "Rotate and Lower" button until the screen changes.
   e. Check the tubing, airway, and head support and press the corresponding button after each check.
   f. Press the "Supine" button and hold it during the entire turning procedure. Alternatively, press the "Prone/Supine" button on the hand control.
   g. Insert the locking pin after the patient assumes the supine position.
   h. Open the packs over the patient as needed for patient care.
   i. Carefully remove the face pack.
25. Before rotating the supine patient, secure the lower leg packs and either the chest or pelvic packs over the patient.
26. Rotate the patient as tolerated.

~~27. Place the patient in reverse Trendelenburg position, elevating the head of the bed slightly by pressing the "Surface Position" button and then pressing "Reverse Trendelenburg."~~
~~28. Resume the tube feeding.~~
~~29. Discard supplies, remove PPE, and perform hand hygiene.~~
~~30. Document the procedure in the patient's record.~~

~~G.~~F. REPORTABLE CONDITIONS:

1. **Notify physician immediately:**
   - **a.** Hemodynamic instability
   - ~~1.~~**b. Significant bloody drainage or stomach contents from nares or mouth**
2. **Notify physician during daily rounds**
   - ~~2.~~**a.** Skin breakdown, nonblanchable redness, shearing/friction injuries

~~3. Drainage from nares, change in color or character of secretions~~

~~H.~~G. DOCUMENTATION:

1. Patient's tolerance of the procedure
2. Length of time in the prone position
3. Oxygenation response while in the prone position
4. Oxygenation response when returned to the supine position
5. Pre- and post-hemodynamic and pulmonary data
6. Complications noted during and after the procedure
7. Amount and type of secretions
8. Sedation assessment and management (RASS) hourly
9. TOF every 4 hours if applicable
10. Pain assessment and management.
11. Passive ROM provided.
12. Changes in edema or skin status.
13. Patient and family education.

~~I.~~H. DISCONTINUING PRONATION THERAPY

1. Obtain an ABG in the supine position 4 hours after last prone maneuver completed.
2. The decision to discontinue pronation therapy is made when the following criteria are met:
   - a. $FiO_2 < 0.6$
   - b. P/F ratio > 150 mm Hg
   - c. PEEP < 10 cm H_2O

~~J.~~I. PATIENT AND FAMILY EDUCATION:

1. Assess current understanding of lung/oxygenation problem with family and if possible with patient.
2. Explain turning procedure, along with criteria for returning to supine position.

~~K.~~J. REFERENCE(S):

1. AACN Pronation Therapy Training Video, retrieved from https://youtu.be/yb1ppe8Y-70
2. Bein, T., Grasso, S., Moerer, O., Quintel, M., Guerin, C., Deja, M., Brondani, A.,
3. Drahnak, D., & Custer, N. (2015). Prone positioning of patients with Acute Respiratory Distress Syndrome. *Critical Care Nurse*, 32(6): 29-37.
4. Guérin, C., Reignier, J., Richard, J. C., Beuret, P., Gacouin, A., Boulain, T., & Ayzac, L. (2013). Prone positioning in severe acute respiratory distress syndrome. *New England Journal of Medicine*, *368*(23), 2159-2168.
5. Kwon, M.J. and others. (2017). Optimizing prone cardiopulmonary resuscitation: Identifying the vertebral level correlating with the largest left ventricle cross-sectional area via computed tomography scan. Anesthesia & Analgesia, 124(2), 520-523. doi:10.1213/ANE.0000000000001369
6. Mehta, S. (2016). The standard of care of patients with ARDS: ventilatory settings and rescue

therapies for refractory hypoxemia. Intensive Care Medicine, 42:699–711.
7. Vollman, K., Dickinson, S., & Powers, J. (2017). Pronation therapy. *AACN Procedure Manual for Critical Care* (7th ed.). St. Louis: Elsevier Sanders.
8. Wiegand, D.L. (Ed.). (2017). *AACN procedure manual for high acuity, progressive, and critical care* (7th ed.). St. Louis: Elsevier

~~L.~~**K. RELATED DOCUMENTS:**

1. Clinical Algorithm for Manual Prone Positioning
2. Checklist for Manual Prone Positioning
3. Prone Dressing Placement Guide
4. ~~RotoProne Placement Guide~~
5. ~~RotoProne Instructions For Use. Arjo (2019)~~

Tri-City Medical Center	Patient Ca
PROCEDURE:	**PYXIS CONNECT SCANNER**
Purpose:	To optimize the consistent and efficient use of orders.

DELETE – with computerized physician order entry (CPOE) no longer have paper orders except for chemotherapy which are faxed to Pharmacy

A. **PROCEDURE:**

1. Processing Orders: Nursing Responsibilities:
   a. Nursing personnel will scan the original Physicians Order Form as soon as possible after the order is written.
   b. All Physician Order Forms will be scanned into the Pyxis Connect System.
   c. After scanning the original Physician Order, the letter Ⓢ (meaning scanned) will be stamped on the scanned orders. Additional orders may not be added to the section with scanned orders.
   d. Immediate (STAT) orders:
      i. When scanning a "STAT" order, select the "STAT" option from the scanner menu screen. The scan will appear in red with a priority level of "STAT" in Pyxis Connect.
   e. If the order is unclear or unreadable, nursing personnel will clarify the order before scanning.
      i. If the Pharmacist receives a scanned order that needs clarification, the Pharmacist will contact the nursing unit from which the scanned document was received and request clarification as needed.
      ii. Once the order is clarified by nursing personnel, the order will then be rescanned through the Pyxis Connect System.
2. Processing Orders: Pharmacy Responsibility
   a. Scanned orders will automatically route to specific workstations such that specific pharmacist personnel will be responsible for physician order processing occurring in the hospital.
   b. Scanned orders queue up similar to e-mail, with the first order scanned listed at the top of the queue for processing by Pharmacy personnel.
   c. Each scanned order is electronically stamped with the location and the time it was scanned.
   d. If orders in a particular areas queue for longer than twenty (20) minutes, the Pharmacist will ask for assistance as available.
   e. If the pharmacist clarifies or changes the order, corresponding annotations will be marked on the scanned order within Pyxis Connect. The pharmacist will then place a new medication order in Cerner as a telephone or verbal order per the Physician Orders policy. The pharmacist will notify nursing of the new order and inform them if the order is STAT or urgent.
3. Downtime Procedures:
   a. When the scanner is down, nursing personnel will notify the Pharmacy Department.
   b. Nursing personnel will fax Physicians Order Form to (760) 940-3786.
   c. When the scanner system returns to normal status, the Pharmacist will scan the orders into the system.
      i. A Ⓢ would be stamped on the order before scanning occurs by the Pharmacist if the order has been entered.
      ii. For STAT orders during down time, nursing will notify the pharmacist by phone.

B. **FORM(S):**

1. Physicians Order Form

Department Review	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Pharmacy and Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/05, 08/07, 05/10, 02/14, 10/17, **08/22**	05/10, 02/14, 11/17, **09/22**	05/10, 02/14, 12/17, **10/22**	n/a	n/a	**11/22**	06/10, 03/14, 01/18, **n/a**	06/10, 03/14, 01/18

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/12 **SUBJECT:** Safe Medical Device Act Tracking Requirements

REVISION DATE: 08/12, 03/18

Patient Care Services Content Expert~~Department~~ Review:	**~~11/17~~01/~~22~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~12/17~~09/22**
Nursinge Leadership~~Executive Council~~ Approval:	**~~01/18~~10/22**
Medical Department or Division Approval:	**n/a**
Pharmacy and Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/18~~10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**~~03/18~~ n/a**
Board of Directors Approval:	**03/18**

A. **PURPOSE:**

1. **To ensure implants and explants are tracked and recorded according the Safe Medical Devices Act Part 821 – Medical Device Tracking.**
2. **~~1.~~To "ensure tracked devices can be traced from the device manufacturing facility to" the patient.**

B. **POLICY:**

1. **The** ~~In compliance with the Safe Medical Devices Act of 1990 (effective 8/29/93), a~~**A**ll implants and explants **required tracking data** will be **documented** ~~recorded~~ ~~into~~ the patient's **medical record.** ~~surgical record.~~

C. **DEFINITION(S):**

1. ~~Permanently implantable device: A device that is intended to be placed into a surgically or naturally formed cavity for more than one (1) year to continuously assist, restore, or replace the function of an organ system or structure throughout the useful life of the device. (Does not include the devices intended and used for temporary purposes or that are intended for explanation within one [1] year or less).~~
2. **Device intended to be implanted in the human body for more than 1 year: means a device that is intended to be placed into a surgically or naturally formed cavity of the human body for more than 1 year to continuously assist, restore, or replace the function of an organ system or structure of the human body throughout the useful life of the device.**
   - **~~1.~~a. The term does not include a device that is intended and used only for temporary purposes or that is intended for explantation in 1 year or less**
3. Life-supporting or life-sustaining device used outside a device user facility: **means** ~~A~~**a** device that is essential, or yields information that is essential, to the restoration or continuation of a bodily function important to the continuation of human life that is intended for use outside a hospital, nursing home, ambulatory surgical facility, or diagnostic or outpatient treatment facility.
4. ~~2.~~ **~~§ 821.55 Confidentiality. (a)~~ Any patient receiving a device subject to tracking requirements under this part may refuse to release, or refuse permission to release, the patient's name, address, telephone number, and social security number, or other identifying information for the purpose of tracking.**

D. **PROCEDURE:**

1. Examples of devices for tracking, including but not limited to:
   a. Permanently implantable devices:
      i. Abdominal Aortic Aneurysm (AAA) stent grafts
      ii. Automatic implantable cardioverter/defibrillator
      iii. Implantable pacemaker pulse generator
      iv. Cardiovascular permanent implantable pacemaker electrode
      v. Silicone gel-filled breast implants
      vi. Replacement heart valve (mechanical only)
      vii. Automatic implantable cardioverter/defibrillator
      viii. Cultured epidermal autographs
      ix. Implanted cerebellar stimulator
      x. Implanted diaphragmatic/phrenic nerve stimulator
      xi. Implantable infusion pumps
      xii. Temporomandibular Joint (TMJ) prosthesis
      xiii. Glenoid fossa prosthesis
      xiv. Mandibular condyle prosthesis
      xv. Thoracic Aortic Aneurysm (TAA) stent graphs
      xvi. Transcatheter Pulmonary Valve (TPV) Prothesis
   b. Life-sustaining or life-supporting devices used outside device user facilities:
      i. Breathing frequency monitors
      ii. Continuous ventilator
      iii. Ventricular bypass (assist) device
      iv. Direct current (DC) defibrillator and paddles
2. Documentation of Implants (on Implant Record) must include:
   a. Name, address, telephone number and **s**~~S~~ocial **s**~~S~~ecurity number ~~of patient~~**(if available) of patient receiving the device, unless not released by the patient** ~~under § 821.55(a);~~
   b. Name/type of implant, size if applicable
   c. Site of implantation
   d. Manufacturer of implant
   e. Catalog number of implant if available
   f. Serial, batch, model, lot number, or other identifier necessary to track device
   g. Expiration date if noted on packaging
   h. Date of implantation
   i. Name, address and phone number of the **physician** ~~surgeon~~ implanting the device
   ~~i.~~**j. The name, mailing address, and telephone number of the physician regularly following the patient if different than the physician implanting the device**
3. If an implantable device has patient user information included in the packaging, this must be labeled with the patient's name and sent with the patient.
4. If the packaging includes a manufacturer tracking device form this must be completed and mailed back to the company for their records.
5. Documentation of explanted items must include:
   a. The date the device was explanted
   b. Name, mailing address, and telephone number of the explanting physician
   c. The date of the patient's death (if applicable)
   d. The date the device was returned to the manufacturer or distributor, permanently retired from use, or otherwise permanently disposed of.
6. Device Tracking Records:
   a. Device tracking records must be maintained for the useful life of the tracked device.
   b. Records required for the device are documented in the patient's electronic health record (EHR).

E. **REFERENCE(S):**

1. The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from: https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf
~~1.~~**2. Code of Federal Regulations (CFR), Title 21. Part 821 – Medical Device Tracking Requirements Retrieved from: eCFR : 21 CFR Part 821 -- Medical Device Tracking Requirements**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	~~**SEDATION/ANALGESIA USED DURING THERAPEUTIC OR DIAGNOSTIC PROCEDURE**~~**PROCEDURAL SEDATION**
Purpose:	To establish guidance for the safe **management of procedural sedation administered to patients undergoing short-term therapeutic or diagnostic procedures.** ~~administration of sedatives used specifically for a level of sedation referred to as moderate sedation/analgesia (previously referred to as "conscious sedation") and deep sedation, delineate required components of care delivery and facilitate comparability of care organization-wide in sedation/analgesia. This procedure does not apply to therapeutic/diagnostic procedures when anesthesiologist is present or NICU setting.~~ **Procedural sedation encompasses a continuum of altered levels of consciousness, including mild, moderate, and deep sedation.**
Equipment:	The following equipment/supplies are readily available and functional during sedation and recovery periods: Emergency cart with cardiac monitor/defibrillator and airway management equipment ~~readily available~~ Cardiac Monitor Capnography Monitor Pulse oximeter with alarm Blood Pressure (BP) Monitor Suction Equipment Positive-pressure oxygen delivery system ~~available~~ Reversal medications -Naloxone (Narcan) and Flumazenil (Romazicon)~~—readily available~~

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

~~1. Richmond Agitation-Sedation Scale (RASS):~~

~~4~~	~~Combative~~	~~Overly combative or violent, immediate danger to staff~~
~~3~~	~~Very Agitated~~	~~Pulls on or removes tubes or catheters or has aggressive behavior toward staff~~
~~2~~	~~Agitated~~	~~Frequent non-purposeful movement or patient-ventilator dyssynchrony~~
~~1~~	~~Restless~~	~~Anxious or apprehensive but movements not aggressive or vigorous~~
~~0~~	~~Alert and calm~~	
~~-1~~	~~Drowsy~~	~~Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice~~
~~-2~~	~~Light Sedation~~	~~Briefly, less than 10 seconds, awakening with eye contact to voice~~
~~-3~~	~~Moderate Sedation~~	~~Any movement, but no eye contact to voice~~
~~-4~~	~~Deep Sedation~~	~~No response to voice, but any to movement to physical stimulation~~
~~-5~~	~~Unresponsive~~	~~No response to voice or physical stimulation~~

~~2.~~**1.** Minimal Sedation: A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. This level of sedation is associated with the **Richmond Agitation Sedation Scale (**RASS**)** score of - 2.

~~3.~~**2.** Moderate Sedation/Analgesia (Previously referred to as "Conscious Sedation"): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. (Note: Reflex withdrawal from painful

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/06, 10/08, 06/11, 02/12, 11/15; 03/18; **09/20; 12/20**	08/12, 02/16, 05/16, 4/18, **08/21**	08/12, 05/16, 07/18, **10/21**	03/17, 09/18, **05/22**	03/17, 11/18, **07/22**	10/12, 04/17, 11/18, **09/22**	01/19, **11/22**	10/12, 06/17, n/a	10/12, 06/17, 01/19

stimulus is not considered a purposeful response.) No interventions are required to maintain a patent airway, spontaneous ventilation is adequate, and cardiovascular function is usually maintained. Moderate sedation/analgesia may only be administered during therapeutic, diagnostic or surgical procedures. This level of sedation is associated with the RASS score of –3.

a. Medications used for Moderate Sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g. propofol, etomidate, ketamine, and thiopental) are not appropriate for moderate sedation and must not be used for this purpose.

~~4.~~**3.** Deep Sedation/Analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. This level of sedation is associated with the RASS score of - 4.

a. A Registered Nurse (RN) may not administer medications for deep sedation (propofol, ketamine, or etomidate) or provide monitoring for deep sedation.
b. Medication administration for deep sedation may only be performed by a physician who has been privileged in deep sedation.
c. Monitoring for deep sedation may be performed by a physician/AHP.

~~5.~~**4.** Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia.

a. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

~~6.~~**5.** Rescue: Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiological consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

~~7.~~**6.** Allied Health Professional (AHP): An individual credentialed/privileged to provide specified patient care, treatment and services.

~~8.~~**7.** End tidal CO_2 ($EtCO_2$): The measuring of End tidal CO_2 ($EtCO_2$) via the Capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline $EtCO_2$ before sedation is given.

~~9.~~**8.** Respiratory depression~~:~~ can be defined as:

a. $EtCO_2$ values 10mmHg higher or lower than the patient's baseline with an absolute maximum of 50mmHg
b. 10% change in $EtCO_2$ values above or below a patient's baseline
c. Apnea that last for fifteen (15) seconds or longer

B. **POLICY**:

1. Tri-City Medical Center (TCMC) provides for the safe administration of sedatives to minimize clinical risks to patients and assure comparability of care throughout the organization.
2. This policy is intended to discuss the care of patients receiving ~~a specific level of~~ sedation~~/ analgesia~~ under the care of non-anesthesiologists privileged to administer sedation/analgesia. It has been designated to be applicable to procedures performed in a variety of settings and by various disciplines. These settings may be inpatient or outpatient and include but are not limited to:

a. Moderate Sedation: Cardiac Catheterization Lab, Critical Care, Telemetry, Diagnostic Imaging, Emergency Department, Operating Room/ Endoscopy/ Bronchoscopy, Post Anesthesia Care Unit, Interventional Radiology.
b. Deep Sedation: Emergency Department

3. This policy excludes:
   a. Patients who are NOT undergoing therapeutic or diagnostic procedures (i.e., preoperative or postoperative sedation, pain management, sedation for insomnia, or seizure management)
   ~~b. Emergent procedures~~
   ~~c.~~**b.** Patients undergoing major regional anesthesia or general anesthesia.
   ~~d.~~**c.** Situations where it is anticipated that the required sedation analgesia will eliminate purposeful response to verbal commands or tactile stimulation accompanied by partial or complete loss of protective reflexes; such patients require a greater level of care than covered in this policy.
   ~~e.~~**d.** Otherwise healthy patients receiving peripheral nerve blocks, local or topical anesthesia.
   ~~f. Minimal Sedation/Anxiolytic - *note*: if patient slips into the moderate sedation level, this sedation/analgesia procedure must be implemented.~~
   ~~g.~~**e.** Drug or alcohol withdrawal or prophylaxis.
   ~~h.~~**f.** The use of any level of sedation/analgesia in any area of the hospital where an anesthesiologist is present.
   ~~i.~~**g.** Single doses of sedatives and narcotics (oral [PO], intramuscular [IM], or intravenous [IV]) given in usual and customary doses for routine **non-invasive** care of patients during procedures such as dressing changes, etc., do not require the provider to follow the sedation policy as long as the RASS score remains at a – 1 or below.
   ~~j. The decision to use a single dose of medication for anxiolysis or pain control or to use the sedation policy should be based on the patient's history and planned procedure.~~
4. Patient Consent:
   a. Pre-procedural education, treatments, and services are provided according to the plan of care.
   b. Physician/AHP shall be responsible for discussing alternatives and risks prior to administration of medication as in any other procedure.
   c. Procedural/Informed consents are required to be signed by all patients before any invasive procedure. See Patient Care Services Policy: Consent for Operative or Other Procedures for complete details.
5. **Emergency procedures: The pre-sedation assessment shall be completed based on the needs and clinical condition of the patient in cases of emergency. The pre-sedation assessment may be waived if the patient's condition is prohibitive of completing the assessment, or if risk outweighs the benefit to the patient in cases of life-threatening emergency.**
6. **Consider anesthesia consult for patients with an ASA physical status classification of ASA IV or above.**
~~5.~~**7.** The Registered Nurse (RN) will monitor the patient for the presence of pain. Any patient undergoing a procedure who expresses concern regarding unresolved pain management has the right to request pain relief. Any patient request for temporary cessation or termination of the procedure will be honored as expeditiously as possible.
~~6.~~**8.** Medical Staff Credentialing Requirements:
   a. In order to prescribe and administer moderate or deep sedation/analgesia a physician/AHP must have requisite privilege (physician/AHP privileges available on TCMC Intranet). See Medical Staff Policy: Criteria for Granting Moderate and Deep Sedation/Anesthesia Privileges to Non-Anesthesiologists.
~~7.~~**9.** RN Training Requirements:
   a. ~~Moderate s~~**S**edation ~~self-study and test~~**computer-based learning module (annually)**.
   b. Demonstrate competency in basic dysrhythmia recognition

c. **Current** BLS~~, training including airway management, recognition of cardiovascular and respiratory side effects of sedatives and variability of patient responses with re-certification every two (2) years is required~~.

d. ACLS **required for adult patient population**

~~d.~~**e.** ~~,~~PALS, ENPC, NRP required ~~(~~as appropriate to patient population~~)~~.

~~i. Healthcare providers shall use child CPR guidelines for children from one (1) year of age to puberty.~~

~~1) Signs of puberty include breast development on the female and underarm, chest, and facial hair on the male. Once a child reaches puberty, healthcare providers shall use adult CPR guidelines for resuscitation.~~

~~8.~~**10. General principles of sedation medication administration:**~~Administering medications:~~

~~a. Medication administration for deep sedation may only be performed by a physician who has been privileged in deep sedation.~~

~~b.~~**a.** The physician/AHP ~~is~~**must be** present prior to administering any ~~moderate~~ sedation/analgesia medication.

~~c.~~**b.** IV sedation/analgesia drugs should be given in small incremental doses that are titrated to the desired endpoints of analgesia and sedation. Sufficient time must elapse between doses to allow the effect of each dose to be assessed before subsequent drug administration. When drugs are administered by non-IV routes (PO, rectal, IM, intranasal), allowance should be made for the time required for drug absorption before supplementation is considered.

~~d.~~**c.** All medications commonly used in ~~moderate~~ sedation, regardless of their safety profile, **may** produce **unintended** general anesthesia and may cause cardio-respiratory arrest.

~~e.~~**d.** See resource on TCMC Intranet for the list of medications commonly used for ~~moderate~~ sedation/analgesia, reversal agents, and typical dosages for all ages.

e. Mild/moderate sedation medication administration:

~~f. The RN who is directly responsible to administer medications, monitor and observe the patient's response to medications shall be with the patient at all times and may not engage in tasks that would compromise continuous monitoring during the procedure.~~

i. Medication administration for mild/moderate sedation may be performed by an RN with the appropriate training (see RN Training Requirements).

~~g.~~**ii.** Medications used for ~~Moderate~~ **mild or moderate** ~~S~~sedation should be those easily titrated for this purpose. Rapid onset anesthetics (e.g., propofol, etomidate, ketamine, and thiopental) are not appropriate for **mild or** moderate sedation and must not be used for this purpose.

f. Deep sedation medication administration:

~~h.~~**i.** Medication administration for deep sedation may only be performed by a physician who ~~has been~~**is** privileged in deep sedation.

~~i.~~**ii.** A Registered Nurse (RN) may not administer medications for deep sedation (e.g., propofol, ketamine, or etomidate) or provide monitoring for deep sedation.

~~9.~~**11.** ~~Required Staff, Equipment and Supplies~~**Staffing requirements:**

a. Mild/Moderate Sedation

i. Physician/AHP to perform procedure

ii. RN dedicated solely to the administration of medication(s) and patient monitoring

1) The RN caring for the patient receiving mild or moderate sedation/analgesia should have no competing responsibilities that would compromise continuous monitoring and assessment of the patient during the administration of sedation.

2) The nurse providing mild or moderate sedation should be in constant attendance with unrestricted immediate visual and physical access to the patient.

a) **The nurse may perform short, interruptible tasks (e.g., opening suture, tying a gown) while remaining in the procedure room.**

iii. **If applicable, healthcare provider/technical assistant (e.g., RN, Respiratory Therapist, technician) to assist the physician/AHP with the procedure.**

b. Deep Sedation

i. Physician/AHP to perform the procedure

ii. Physician/AHP to monitor the patient

iii. If applicable, healthcare provider/ technical assistant (e.g., RN, Respiratory Therapist, technician) to assist the physician/AHP with the procedure.

iv. If requested by the physician/AHP, the RN may document vital signs.

~~a. Sufficient numbers of qualified staff (in addition to the person performing the procedure) are present to evaluate the patient, assist with the procedure, provide sedation and/or anesthesia, monitor, and recover the patient.~~

~~b. Minimum Staffing Requirements~~

~~i. Moderate Sedation~~

~~1) Physician/AHP to perform procedure~~

~~2) RN to monitor patient~~

~~3) Healthcare provider (e.g., RN, Respiratory Therapist, technician) to assist the physician/AHP with the procedure~~

~~ii. Deep Sedation~~

~~1) Physician/AHP to perform the procedure~~

~~2) Physician/AHP to monitor the patient~~

~~3) RN to assist physician/AHP~~

C. **PROCEDURE PRE-SEDATION:**

1. Pre-procedure RN **shall**:

a. ~~Reviews the anticipated needs of the patient are assessed to~~**Assess and** plan for the appropriate level of post-procedure care.

b. Ensures~~s~~ a pre-~~anesthesia/~~sedation assessment is performed by the physician/AHP and documented in the health record. **Elements of pre-sedation assessment include:**

i. Time and nature of last oral intake. Refer to NPO recommended guidelines in Appendix CA.

ii. American Society of Anesthesiologists (ASA) classification. Refer to Appendix DB for ASA Physical Status (PS) Classification System.

i. Airway Assessment: Patient's ability to hyperextend neck, maintain airway and open mouth without difficulty, if teeth are intact and Mallampati score.

~~a.~~**ii. Plan for sedation.**

c. Ensures **a current History and Physical (H&P) is documented in the medical record (must be within 30 days prior to procedure).**

i. The H&P shall include current medications and drug allergies and/or adverse experience with sedation/analgesia and anesthesia.

~~c.~~**d. Ensure the** ~~the physician/AHP documents patient's unchanged condition from last History and Physical (H&P)~~**H&P Update is documented, according to Medical Staff Policy #8710-518 Medical Record Documentation Requirements.** ~~or performs a pertinent pre-anesthesia/sedation assessment, to include, but not limited to:~~

~~i. Cardiac, respiratory and/or other major system abnormalities~~

~~ii. Current medications and drug allergies and/or adverse experience with sedation/analgesia and anesthesia.~~

~~iii. Airway Assessment: Patient's ability to hyperextend neck, maintain airway and open mouth without difficulty, if teeth are intact and mallampati score.~~

~~iv. Time and nature of last oral intake. Recommended guidelines~~

~~1) Patients should be NPO prior to procedure time for:~~

a) Two (2) hours after clear liquids
b) Eight (8) hours after solids

2) Oral medications may be taken with small amounts of clear liquids.
3) Patients under ten (10) years of age must be NPO for a period of time as indicated below:
   a) Infants 0 to 2 years of age:
      i) No solids the day of procedure
      ii) Formula until six (6) hours before procedure
      iii) Breast milk until four (4) hours before procedure
      iv) Clear liquids until two (2) hours prior to procedure
      v) NPO thereafter until the procedure.
   b) Ages 3 to 10 years:
      i) No solids the day of procedure
      ii) Clear liquids until two (2) hours prior to procedure
      iii) NPO thereafter until the procedure

v. American Society of Anesthesiologists (ASA) Physical Status Classification System

ASA PS Classification	**Definition**	**Examples, including but not limited to:**
ASA I	A normal healthy patient.	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with a mild systemic disease.	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease.	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life.	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation.	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	Patient declared brain dead whose organs are being removed for donor purposes.	

~~d.~~**e.** Verify physician/AHP orders for sedation.
~~e.~~**f.** Verify the procedural consent form is accurate and complete.
~~f.~~**g.** Verify procedure with patient.
~~g.~~**h.** Ensure IV access **is** in place (as ordered by physician/AHP):
  i. Appropriate equipment to administer intravenous fluids and drugs including blood and blood components is available.
~~h.~~**i.** Review/initiate individualized plan of care **as appropriate to patient setting**.

2. Immediately Pre-Procedure, RN monitoring or assisting the physician/AHP shall:
  a. Verify the procedural consent form is accurate and complete
  b. Verify procedure with patient
  c. Obtain baseline vital signs: BP, heart rate, respiratory rate, $EtCO_2$, Aldrete, RASS, oxygen (O_2) saturation, pain score and document on the Sedation Flowsheet or electronic medical record. **Note the supplemental oxygen delivery method and oxygen flow rate, if applicable.**
    i. For pediatric patients, include height and weight. Calculate correct dosage of reversal agent for potential administration prior to procedure.
  d. Ensure a "time out" is completed before starting the procedure as described in the Patient Care Services Procedure: Universal Protocol.

B. **INTRA-PROCEDURE FOR PLANNED ~~MODERATE SEDATION~~:**

~~2.~~**1.** Measure/assess on an ongoing basis and document every five (5) minutes or more often if significant changes in the patient's condition occurs during the procedure:
  a. BP
  b. Heart rate
    i. Continuous EKG rhythm is recommended for all patients receiving **mild or** moderate sedation/analgesia, and REQUIRED for patients with ASA score of III or greater.
  c. Respiratory rate
  d. Adequacy of ventilation
  e. $EtCO_2$ (except for mechanically ventilated patients)
  f. O_2 Saturation **(%)**
  g. Supplemental oxygen delivery method (e.g., nasal cannula, simple facemask)
  h. Oxygen flow rate (L/min)
  ~~g.~~**i.** Level of sedation for adults using the RASS.:

~~4~~	~~Combative~~	~~Overly combative or violent, immediate danger to staff~~
~~3~~	~~Very Agitated~~	~~Pulls on or removes tubes or catheters or has aggressive behavior toward staff~~
~~2~~	~~Agitated~~	~~Frequent non-purposeful movement or patient-ventilator dyssynchrony~~
~~1~~	~~Restless~~	~~Anxious or apprehensive but movements not aggressive or vigorous~~
~~0~~	~~Alert and calm~~	
~~-1~~	~~Drowsy~~	~~Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice~~
~~-2~~	~~Light Sedation~~	~~Briefly, less than 10 seconds, awakening with eye contact to voice~~
~~-3~~	~~Moderate Sedation~~	~~Any movement, but no eye contact to voice~~
~~-4~~	~~Deep Sedation~~	~~No response to voice, but any to movement to physical stimulation~~
~~-5~~	~~Unresponsive~~	~~No response to voice or physical stimulation~~

~~h.~~**j.** Level of sedation for pediatrics using the Aldrete Score.:

~~Activity:~~	~~Able to move 4 extremities voluntarily or on command~~	~~Score: 2~~

	~~Able to move 2 extremities voluntarily or on command~~	~~Score: 1~~
	~~Able to move no extremities on command~~	~~Score: 0~~
~~Breathing~~	~~Able to breathe deeply and cough freely~~	~~Score: 2~~
	~~Dyspnea~~	~~Score: 1~~
	~~Apneic~~	~~Score: 0~~
~~Circulation:~~	~~BP less than or equal to (≤) 20% of pre-anesthetic level~~	~~Score: 2~~
	~~BP is 20% to 50% of pre-anesthetic level~~	~~Score: 1~~
	~~BP greater than or equal to (≥) 50% of pre-anesthetic level~~	~~Score: 0~~
~~Consciousness:~~	~~Fully awake~~	~~Score: 2~~
	~~Arousable~~	~~Score: 1~~
	~~Not responding~~	~~Score: 0~~
~~Oxygen Saturation (Pulse Oximetry):~~	~~Greater than (>) 92% on room air~~	~~Score: 2~~
	~~Needs supplemental oxygen to maintain greater than (>) 90%~~	~~Score: 1~~
	~~Less than (<) 90% with oxygen~~	~~Score: 0~~

~~i.~~**k.** Pain level

~~j.~~**l.** O_2 saturation and heart rate are monitored continuously throughout the procedure. If O_2 saturation is not maintained at or above 90%, (unless baseline was below 90%), obtain an order for supplemental oxygen and/or anesthesia consult. Supplemental oxygen is also recommended during the procedure for the following:

i. ASA class III or greater patients
ii. Patients whose O_2 saturation reading is less than 90% pre-procedure while on room air

~~k.~~**m.** ~~The measuring of $EtCO_2$ via the capnography machine is not a diagnostic measurement. Rather, $EtCO_2$ measurements are to give a non-invasive trending measurement. Therefore, it is important to establish a patient's baseline~~ $EtCO_2$ **(establish baseline** before sedation is given**)**.

i. If during the procedure hypoventilation or respiratory depression occurs, intervene immediately by:
   1) Repositioning the patient's head to open up the airway
   2) Verbally or physically stimulate the patient to breathe
   3) If the patient is apneic, start bag/mask ventilation.

~~ii. Respiratory depression can be defined as:~~
~~1) $EtCO_2$ values 10mmHg higher or lower than the patient's baseline with an absolute maximum of 50mmHg~~
~~2) 10% change in $EtCO_2$ values above or below a patient's baseline~~
~~3) Apnea that last for 15 seconds or longer~~

~~iii.~~**ii.** Important: Respiratory depression may occur after the procedure is complete. That is, before the patient returns to a level of consciousness. Continue to monitor the patient with $EtCO_2$ until the patient is fully awake and alert or returns to baseline.

~~l.~~**n.** Medications and fluids including drugs, dosages, route, times and personnel administering drugs are documented in the medical record.

~~m.~~**o.** Any unusual occurrences are documented.

~~C. **INTRA-PROCEDURE PLANNED FOR DEEP SEDATION:**~~
~~2. The RN shall document vital signs as requested by physician/AHP.~~

~~D.~~**C. POST PROCEDURE CARE, DOCUMENTATION AND DISCHARGE:**

1. Patient status ~~is~~**shall be** assessed immediately after the procedure and/or administration of **mild,** moderate or deep sedation.

~~2.~~**a.** **Vital signs are to be completed and documented post-procedurally every five (5) minutes times three (3), then every fifteen (15) minutes until return to baseline.** ~~and vital signs and pain level are continuously monitored and documented every 5 - 15 minutes according to the patient's condition or until the vital signs return to the pre-procedure baseline (minimum recovery time is 30 minutes), and the following criteria are met:~~

~~a.~~**b.** Patient achieves a score of 8 or greater (or pre-sedation baseline), on the Aldrete scoring system.~~:~~

~~Activity:~~	~~Able to move 4 extremities voluntarily or on command~~	~~Score: 2~~
	~~Able to move 2 extremities voluntarily or on command~~	~~Score: 1~~
	~~Able to move no extremities on command~~	~~Score: 0~~
~~Breathing~~	~~Able to breathe deeply and cough freely~~	~~Score: 2~~
	~~Dyspnea~~	~~Score: 1~~
	~~Apneic~~	~~Score: 0~~
~~Circulation:~~	~~BP less than or equal to (<) 20% of pre-anesthetic level~~	~~Score: 2~~
	~~BP is 20% to 50% of pre-anesthetic level~~	~~Score: 1~~
	~~BP greater than or equal to (>) 50% of pre-anesthetic level~~	~~Score: 0~~
~~Consciousness:~~	~~Fully awake~~	~~Score: 2~~
	~~Arousable~~	~~Score: 1~~
	~~Not responding~~	~~Score: 0~~
~~Oxygen Saturation (Pulse Oximetry):~~	~~Greater than (>) 92% on room air~~	~~Score: 2~~
	~~Needs supplemental oxygen to maintain greater than (>) 90%~~	~~Score: 1~~
	~~Less than (<) 90% with oxygen~~	~~Score: 0~~

c. **Assess and document patient response to sedation. Refer to attachment for definitions of patient response, including Good, Fair and Poor.**

~~b.~~**d.** If the patient does not meet the above criteria, the physician/AHP is notified for further orders.

~~c.~~**e.** If a reversal agent has been used the patient shall be recovered for an additional ninety (90) minutes.

~~d.~~**f.** Patients must meet the following discharge criteria prior to being discharged home:

i. Pre-procedure LOC
ii. Pre-procedure activity
iii. Vital signs within pre-procedure values
iv. Oral fluids tolerated
v. Pain controlled
vi. Voided
vii. Evaluate procedure site
viii. Dressing clean & dry

~~e.~~**g.** Obtain a Physician/AHP order for discharge when all criteria are met.

~~f.~~**h.** The patient and/or designated adult receives discharge instructions if outpatient and accompanied home by a responsible adult.

~~3.~~**2.** Monitoring Outcomes:

a. Outcome data shall be collected in all areas where ~~moderate or deep~~ sedation~~/analgesia~~ is performed. Data shall be aggregated by department/service and practitioner specific.

~~The anticipated needs of the patient are assessed to the plan for the appropriate level of post-procedure care.~~

~~a.~~**b. Medical Staff department collects sedation outcome data and forwards to the Department of Anesthesia for action as necessary.**

~~4. Pre-procedure education, treatments, and services are provided according to the plan of care, treatment, and services.~~

~~5.~~**3.** Patient Discharge:

a. Patients are discharged from the recovery area and the hospital by a qualified physician/AHP when they meet discharge criteria.

b. Patients who have received sedation in the outpatient setting are discharged in the company of a responsible, designated person per Patient Care Services Policy: Outpatient Post Anesthesia/Procedure Discharge/Transportation Guidelines.

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

~~2.~~**1.** Agents Commonly Used for Procedural Sedation

~~3.~~**2.** Sedation Flow Sheet 8720-1030 - Sample

3. Patient Care Services Policy: Outpatient Post Anesthesia/Procedure Discharge/Transportation Guidelines

4. **Procedural Sedation Patient Response Fields Definitions**

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

~~2. Conner, R. (2017). Guidelines for Perioperative Practice, 2017 Edition. Denver, CO: Association of PeriOperative Registered Nurses.~~

1. AORN, Inc. (2020). *Guidelines for Perioperative Practice.* Denver.

~~3.~~**2.** *ASA Physical Status Classification System.* (~~2014~~**2019**). Retrieved ~~January 11th, 2016~~**September 17, 2020**, from American Society of Anesthesiologists: https://www.asahq.org/~~resources/clinical-information~~**standards-and-guidelines**/asa-physical-status-classification-system

~~4.~~**3.** In, U. L, S. K, & L. M (2006). *Thelan's Critical Care Nursing Diagnosis and Management* (5th Edition ed., p. 153). St. Louis, Missouri: Mosby Elsevier.

4. Nicholau, T. K. (2015). Postanesthesia Scoring System. In R. D. Miller, *Miller's Anesthesia* (8th Edition, p.2942). St. Louis, Missouri: Saunders Elsevier

5. Rothrock, J. C. & McEwen, D. R. (2019). *Alexander's Care of the Patient in Surgery, 16th Edition.* St. Louis, MO: Elsevier.

~~5.~~

~~6. Rothrock, Jane C. (2015) Alexander's Care of the Patient in Surgery, 15th Edition.~~

Appendix A

Richmond Agitation-Sedation Scale (RASS)

4	Combative	Overly combative or violent, immediate danger to staff
3	Very Agitated	Pulls on or removes tubes or catheters or has aggressive behavior toward staff
2	Agitated	Frequent non purposeful movement or patient-ventilator dyssynchrony
1	Restless	Anxious or apprehensive but movements not aggressive or vigorous
0	Alert and calm	
-1	Drowsy	Not fully alert, but has sustained, more than 10 seconds, awakening with eye contact to voice
-2	Light Sedation	Briefly, less than 10 seconds, awakening with eye contact to voice
-3	Moderate Sedation	Any movement, but no eye contact to voice
-4	Deep Sedation	No response to voice, but any movement to physical stimulation
-5	Unresponsive	No response to voice or physical stimulation

Appendix B

Aldrete Scale

Activity	Able to move 4 extremities voluntarily or on command	Score: 2
	Able to move 2 extremities voluntarily or on command	Score: 1
	Able to move no extremities on command	Score: 0

Breathing	Able to breathe deeply and cough freely	Score: 2
	Dyspnea	Score: 1
	Apneic	Score: 0

Circulation	BP less than or equal to (≤) 20% of pre-anesthetic level	Score: 2
	BP is 20% to 50% of pre-anesthetic level	Score: 1
	BP greater than or equal to (≥) 50% of pre-anesthetic level	Score: 0

Consciousness	Fully awake	Score: 2
	Arousable	Score: 1
	Not responding	Score: 0

Oxygen Saturation (Pulse Oximetry)	Greater than (>) 92% on room air	Score: 2
	Needs supplemental oxygen to maintain greater than (>) 90%	Score: 1
	Less than (<) 90% with oxygen	Score: 0

Appendix C

Pre-Procedure NPO Guidelines

1) Patients should be NPO prior to procedure time for:
   i) Two (2) hours after clear liquids
   ii) Eight (8) hours after solids
2) Oral medications may be taken with small amounts of clear liquids.
3) Patients under ten (10) years of age must be NPO for a period of time as indicated below:
   a) Infants 0 to 2 years of age:
      i) No solids the day of procedure
      ii) Formula until six (6) hours before procedure
      iii) Breast milk until four (4) hours before procedure
      iv) Clear liquids until two (2) hours prior to procedure
      v) NPO thereafter until the procedure.
   b) Ages 3 to 10 years:
      i) No solids the day of procedure
      ii) Clear liquids until two (2) hours prior to procedure
      iii) NPO thereafter until the procedure

Appendix D

American Society of Anesthesiologists (ASA) Physical Status (PS) Classification

ASA PS Classification	Definition	Examples, including but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	
The addition of "E" to the ASA PS Classification denotes Emergency surgery. An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.		

Definitions to the Procedural Sedation Patient Response Fields

Good = All of the following apply:

O2 sat maintained greater than 92% or higher
BP within 20% of pre-anesthetic level
Able to breathe deeply and cough freely
Remained hemodynamically stable
No complications, case completed as planned
No unplanned escalation to higher level of sedation
No unplanned respiratory support required
Reversal medications not required (i.e. Naloxone, Flumazenil)

Fair = One or both of the following apply:

Required supplemental O2 or minimal respiratory support to maintain O2 sat greater than or equal to 90% (e.g. chin lift/jaw thrust)
BP within 20%-50% of pre-anesthetic level

Poor = One or more of the following apply:

O2 sat < 90% with O2
BP within 50% of pre-anesthetic level
Respiratory support required (i.e. placement of nasal trumpet/oral airway, supraglottic airway, ET tube, assisted ventilation with bag-valve-mask)
Not responding to voice or physical stimulation
Unplanned escalation to deeper level of sedation
Unplanned transfer to higher level of care
Reversal Medications Required (i.e. Naloxone, Flumazenil)
Serious adverse event (Hemodynamic instability requiring intervention, apnea, anaphylaxis, aspiration, cardiac arrest, death)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES ~~POLICY MANUAL~~

ISSUE DATE: 06/12

SUBJECT: Self-Administered Continuous Subcutaneous Infusion of Insulin (Insulin Pump Therapy) for the Acute Care Patient

REVISION DATE~~(S)~~: 02/14

~~Department~~ Patient Care Services Content Expert Approval:	~~09/16~~06/19
Clinical Policies & Procedures Committee Approval:	~~10/16~~03/~~19~~10/19
Nurse Executive ~~Council~~ Committee Approval:	~~10/16~~10/19
Diabetes Task Force Approval:	12/16
~~Medical Staff Department or Division Approval:~~	~~n/a~~
Department of Anesthesiology Approval:	05/22
Pharmacy & Therapeutics Committee Approval:	~~03/17~~, 07/22
Medical Executive Committee Approval:	~~04/17~~, 09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~05/17~~ n/a
Board of Directors Approval:	05/17

A. **POLICY:**

1. Continuous subcutaneous infusion of insulin (CSII) or insulin pump therapy is an option for hospitalized adult patients who desire intensive insulin management. CSII is not initiated in the hospital. ~~This policy includes self-management of a Continuous Glucose Monitor, if applicable.~~

B. **CONTRAINDICATIONS:**

1. Altered level of consciousness or change in judgment.
2. Receiving medications with the potential of inducing altered mental awareness or level of consciousness as determined by attending/consulting physician.
3. Mental and/or physical inability to independently manage the pump (dosing changes and boluses, settings, **changing** infusion sets, tubings, ~~changes~~, reservoirs **with** ~~and~~ insulin, etc. **NOTE: supplies dependent on specific pump**)
4. Risk for suicide.
5. Other circumstances identified by the attending/consulting physician.

C. **PROCEDURE: PATIENT ASSESSMENT:**

1. Verify that the patient's attending physician has initiated the **appropriate orders** ~~"Insulin Pump (CSII) – Subcutaneous Self-Administered" PowerPlan~~.
2. Notify Biomedical Engineering to evaluate the pump **or pump/** ~~and G~~continuous ~~G~~glucose ~~M~~meter **(CGM) combination** for safety and obvious damage per Patient Care Services Policy: Medical Equipment Brought Into the Facility.
3. Complete **an** ~~the~~ ~~"I~~initial ~~A~~assessment for ~~I~~insulin ~~P~~pump ~~P~~patients~~"~~ .Verify that patient:
   a. Is alert to time, person and place on admission and then at least once per shift.
   b. Is able to independently perform psychomotor tasks to manage the insulin infusion as follows:
      i. Knows and can change basal rate(s).
      ii. Knows and can manage mealtime insulin ~~infusions~~ **boluses** based on insulin to carb ratio(s).

iii. Knows and can manage correction ~~infusions~~ **boluses** based on insulin sensitivity factor(s).

iv. Can change insertion site, infusion set, tubing, and reservoir with insulin every 72 hours and prn~~.~~ **or according to specific pump protocol.**
NOTE: ~~there might be slight differences in~~ Supplies depend~~ing~~ on ~~the~~ **specific** pump.

~~v. For a Continuous Glucose Monitor (CGM), can change the sensor at appropriate intervals.~~

c. Has his/her own **necessary** supplies at the bedside ~~necessary~~ for self-management: infusion sets, tubing, reservoirs, insulin, etc.
   i. Note: Insulin brought in from home for use in the hospital must be ordered by the physician and verified by the pharmacy according to Patient Services **Policy** (PCS) Medications Brought in by the Patient Policy.

d. Has signed the **Patient Agreement for Self-Administered Continuous Subcutaneous Infusion of Insulin** ~~Insulin Pump Therapy Patient Agreement~~

e. Is willing to keep written records of insulin infusions using the Patient Insulin Pump Record

4. Check point of care (POC) blood glucose levels as ordered by the physician using the hospital meter **and use reading to determine insulin dose** ~~or readings from the patient's continuous glucose monitor~~. **Patients may use their own Continuous Glucose Meters, but readings are not used to determine insulin dosing.**
   a. **If patient has Type 1 diabetes and** ~~If~~ 2 consecutive POC blood glucose readings are above 250 mg/dL (200 mg/dL, if pregnant) within a 4-6 hour interval, obtain order for a urine specimen to check for ketones and instruct the patient to change the infusion set, insertion site, and reservoir with insulin.
   b. Call the physician for a correction dose of lispro insulin to be administered subcutaneously by the nurse ~~when the POC blood glucose is above 250 or~~ if the pump is disconnected for more than 30 minutes.
5. Discontinue the pump when ordered by the physician or if the patient's level of consciousness suddenly changes.

D. **RESPONSIBILITIES:**

1. Patient must change entire pump set-up including insertion site, infusion set, and reservoir with insulin at least every 72 hours and PRN **as applicable** ~~**or according to specific pump protocol**~~.
2. Nurse will assess insertion site every shift for redness, signs of infection, purulent drainage, or leakage.
3. Patient will change infusion set, tubing, and insertion site if:
   a. Tubing is clogged or infusion set is leaking
   b. Site is red, painful, irritated, and/or there are signs of infection
   ~~c. Two consecutive POC blood glucose readings are above 250 mg/dL (200mg/dL if pregnant) within a 4-6 hour interval.~~

~~c.~~ **4. Patient must agree to keep blood glucose levels 140-180 mg/dL. Consideration may be given to tighter control, i.e. 100-140 mg/dL, if patient desires.**

E. **MEDICATION INTERVENTIONS:**

1. If patient is no longer alert or any of the other assessment criteria have changed:
   a. Explain to patient and/or patient's family that the pump will be removed for patient's safety.
   b. Obtain orders for basal insulin, mealtime insulin, and correction insulin. Alternatively, begin continuous infusion of IV regular insulin according to physician orders.
      ~~c.~~**i.** A pump should not be discontinued without starting either subcutaneous or intravenous insulin at least 60 minutes before the subcutaneous pump infusion is removed.

~~d.~~**c.** Remove the pump and infusions set and instruct a family member to take the pump home. If family member is not available, send pump to Pharmacy for safe-keeping.
~~e.~~**d.** Continue to measure POC blood glucose levels as ordered.
~~f.~~**e.** Continue subcutaneous or IV insulin orders until patient is assessed by physician to be able to once again, independently, self-manage the pump.

F. **SPECIAL PROCEDURES:**

1. For procedures requiring sedation (surgery, cardiac catheterization, bronchoscopy, endoscopy, etc.), the pump will be disconnected. Contact the physician for specific orders for starting IV or SC insulin therapy.
2. Pumps should never be exposed to x-ray beams which may cause the pump to empty its entire reservoir of insulin and potentially cause severe hypoglycemia and death.
3. For CT scans and general x-rays, it is not necessary to disconnect the pump if the pump is not in the area of interest. It can be covered with a lead apron.
4. For MRIs, disconnect the pump. Remove the insertion set only if it is metal.
5. For mammograms and bone density tests, it is not necessary to disconnect the pump.
6. For ultrasound, it is not necessary to disconnect the pump.
7. If the pump is stopped for ~~over~~ 30 minutes **or longer, monitor POC blood glucose and administer insulin per physician orders (recommend monitoring POC blood glucose every 30 minutes until insulin pump resumed or appropriate provider orders initiated)**~~the pump may need to be reconnected for a dose of insulin prior to continuing the radiology procedure~~ to prevent rapid onset DKA ~~**or a subcutaneous dose of rapid-acting insulin should be administered.**~~
8. In case of hypoglycemia, treat per PCS Hypoglycemia Management in the Adult Patient Standardized Procedure.

G. **PUMP INFORMATION:**

1. An external insulin pump is about the size of a pager and contains a reservoir filled with rapid acting insulin (lispro, aspart, or glulisine), has a computer chip, and a battery-operated pump. Many pump models exist; some have visible tubing, others are self-contained and disposable. An insulin pump **generally** does not automatically control blood glucose levels**; however, this is an area of intense innovation and at least one pump is able to do this, others will soon be on the market**. Pump users check their blood glucose levels 4-10 times/day (8-12 times/day when pregnant), calculate doses of insulin based on the blood glucose level and/or carbohydrate intake and program the pump to deliver a dose (bolus) of insulin. The pump is also programmed to deliver continuous basal insulin.
   a. All insulin is delivered through an infusion set
   b. The patient changes the insertion site, infusion set, and reservoir with insulin every 72 hours, or more often as needed **as applicable**~~**or according to specific pump protocol,**~~, to prevent infection and to promote good insulin delivery.
2. Refer to the 800 number on the back of the pump **or pump**/CGM **combination** if needed for technical support.
3. Diabetic Ketoacidosis (DKA)
   a. Caution: The effect of rapid acting insulin lasts about 4 hours; therefore, if insulin delivery is interrupted, DKA can develop rapidly in both non-pregnant and pregnant patients. If the insulin pump is removed, physician orders for either subcutaneous (SC) or intravenous (IV) insulin should start immediately.
   b. Note: DKA is not likely to occur in patients with type 2 diabetes
4. The most common causes of DKA in pump users:
   a. Insertion set/tubing is clogged, kinked or leaking
   b. Site has not been changed recently and site is irritated
   c. Failure to treat hyperglycemia appropriately
   d. Insulin has lost potency in the vial of insulin currently in use (check expiration date).
5. Correction doses:

a. Most pumps have a built-in feature to limit the amount of insulin delivery for correction doses.
b. Correction dosing is not advised more than once every two hours

6. **After** ~~When~~ the pump is discontinued, the patient may resume pump therapy with a physician order.

H. **KEY POINTS:**

1. Insulin is delivered either by pump or injection— Not Both
2. Patient **is expected** ~~-~~to self-maintain **the** fasting and pre-meal blood glucose range **of** 140-180 mg/dL. **while in the hospital.** POC blood glucose levels will be checked by RN using the hospital meter. ~~-or readings from the patient's continuous glucose meter~~. **Patients may use their own Continuous Glucose Meters, but readings are not used to determine insulin dosing.**
3. **F**~~F~~or pregnant patients, POC blood glucose targets are as follows:
   a. Antepartum targets: Fasting ~~70-99~~ **60-89** mg/dL; one hour after first bite of a meal 100-129 mg/d ~~L,~~ **two hours after first bite of meal 100-119 mg/dL, and at HS and overnight 60-99 mg/dL.**
   b. Intrapartum (during labor): 70-110 mg/dL
   c. Postpartum and breastfeeding: ~~Fasting 70-99 mg/dL, one hour after the first bite of a meal 100-150 mg/dL. Higher targets may be set for individual patient needs~~**Blood glucose target ~~-~~varies depending on pre-existing diabetes, diabetes diagnosis after GDM and~~,~~ insulin dependence.~~ or required, but~~ ~~h~~Higher target levels tolerated in insulin-taking breastfeeding mothers.**
4. ~~The bedside glucose monitor allows for necessary actions to be taken quickly along with follow-up care. However, for accurate Nova StatStrip readings, the hematocrit range must be 25-60%. If HCT is less than 25% the blood glucose may be inaccurately high; if greater than 60%, blood glucose may be inaccurately low.~~ **If the hematocrit is below 20% or above 65%, ~~may get~~ a flow or bad sample error may display on the Nova Stat Strip device; if ~~you get~~ a blood glucose value displays when the hematocrit is below 20% and above 65%, ~~you can~~the result is considered ~~it~~ to be accurate.**

I. **DOCUMENTATION:**

1. Assure patient has signed the Patient Agreement for Self-Administered Continuous Subcutaneous Infusion of Insulin
2. Complete the ~~I~~initial ~~A~~assessment for ~~I~~insulin ~~P~~pump ~~P~~patients
3. Document insertion site location **in the health record**~~on the Patient Insulin Pump Record~~
4. Provide ~~P~~patient with a supply of the Patient Insulin Pump Record.
5. Document POC blood glucose readings on the Patient Insulin Pump Record and in the ~~E~~electronic **health**~~medical~~ ~~R~~record.
6. The Patient Insulin Pump Records are ~~**inlcuded**~~**included**~~-scanned~~ ~~into~~ the **health**~~medical~~ record at discharge.
7. Ensure that the patient records all self-administered mealtime and correction doses of insulin; the basal rate and changes to the basal rate, and the grams of carbohydrate consumed at each meal.
8. Documentation on the Patient Insulin Pump record must include the date of each infusion set change and insertion site change (if not the same as set change date).

J. **FORM(S):**

1. Initial Assessment for Insulin Pump Patients **- Sample**
2. **Inulin Pump** Patient Agreement for Self-Administered Continuous Subcutaneous Infusion of Insulin **- Sample**
3. ~~Patient-~~Insulin Pump **Patient** Record **- Sample**

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

1. Patient Care Services Standardized Procedure: ~~H~~ypoglycemia Management in the Adult Patient

2. Patient Care Services Policy: Medical Equipment Brought Into the Facility
3. Patient Care Services Policy: Medications Brought in by the Patient

L. **REFERENCE(S):**

1. American Association of Diabetes Educators, Inpatient Position Statement. The Diabetes Educator, In Press, 2009.
2. American Diabetes Association, Clinical Practice Recommendations – 2002, Continuous Subcutaneous Insulin Infusion; Diabetes Care 25: S116
3. ~~*American Diabetes Association, Standards of Medical Care – 2006, Diabetes Care in the Hospital; Diabetes Care 29: S4–42S.*~~ **Diabetes Care vol. 40, supplement 1, Standards of Medical Care in Diabetes--2018, (pp.S144-S151).**
4. American Diabetes Association: Managing Preexisting Diabetes for Pregnancy. Diabetes Care, Volume Number 5, May 2008
5. Cook, et al. Use of Subcutaneous Insulin Infusion (Insulin Pump) Therapy in the Hospital Setting – Proposed Guidelines and Outcomes Measures; The Diabetes EDUCATOR; Volume 31, Number 6, November/December 2005
6. Pickup, J and Keen, H. Continuous Subcutaneous Insulin Infusion at 25 years: Evidence base for the expanding use of insulin pump therapy in Type 1 Diabetes; Diabetes Care 25: 1079-1087
7. The Diabetes Educator. Vol. 31 No. 6, November/December 2005. The use of Subcutaneous Insulin Infusion (Insulin Pump) in the Hospital Setting: Proposed Guidelines and Outcome Measures.
~~7.~~**8. diabetesforecast.org, Consumer Guide for Continuous Glucose Monitors**

SAMPLE

1. Has the attending physician completed the Power Plan *Insulin Pump (CSII) – Subcutaneous Self-Administered?*
   a. Yes ☐ No
2. Is the patient alert to time, place, and person? ☐ Yes ☐ No
3. The patient has the requisite knowledge to be able to self-manage the pump if he/she can provide the information for the following:
   a. Type of insulin used in the pump:
      ☐ Humalog® (lispro) ☐ Novolog® (aspart) ☐ Apidra® (glulisine)
   b. Basal rates (note: patient may have one or more):
      Basal rate 1 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
      Basal rate 2 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
      Basal rate 3 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
      Basal rate 4 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
      Basal rate 5 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
      Basal rate 6 _____ units/hour from _____ a.m./p.m. to ____ a.m./p.m.
   c. Insulin to carb ratio (note: patient may have a different rate for each meal or may only have a fixed amount that is taken for each meal):
      Insulin to carb ratio breakfast _____ units of insulin per _____ grams of carb
      Insulin to carb ratio lunch _____ units of insulin per _____ grams of carb
      Insulin to carb ratio dinner _____ units of insulin per _____ grams of carb
      Insulin to carb ratio snack _____ units of insulin per _____ grams of carb
      _____units at breakfast; _____units at lunch; _____units at dinner
   d. Correction Factor (note: patient may have a correction scale that is used based on pre-meal blood glucose levels):
      _____ Units for every _____ mg/dL over _____ mg/dL (target glucose)
      or one unit will bring blood glucose down _____ mg/dL
      or make copy of written correction scale supplied by patient and add to chart
4. Does the patient have the physical ability to manage the pump, deliver the doses and make setting changes? ☐ yes ☐ no
5. Does the patient have pump supplies and insulin at bedside? ☐ yes ☐ no
6. Has the pharmacy verified the insulin? ☐ yes ☐ no
7. Has Biomedical Engineering evaluated the pump for safety? ☐ yes ☐ no
8. Has the patient signed the *Patient Agreement for Self-Administered Continuous Subcutaneous Infusion of Insulin?* ☐ yes ☐ no
9. Can patient change basal, prandial and correction settings/doses? ☐ yes ☐ no
10. Can patient count carbohydrates ☐ yes ☐ no

NOTE: all yes/no questions must be answered "yes" before patient may use pump.

Pump model and manufacturer _____
Serial number _____

Pump/CGM combination device model and manufacturer
Serial number _____

Pump customer service number (found on back of pump) _____

Affix Patient Label

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

Initial Assessment for Insulin Pump Patients

Page 1 of 1

8720-NEW

(Rev xx/xx)

Example - Patient Copy Example - Front Office Example - Billing

SAMPLE

For your safety and optimal medical care during this hospitalization, we request that you agree to the following recommendations. If you believe that you cannot agree to these recommendations, we would like to treat your diabetes with insulin injections and request that you discontinue the use of your insulin pump.

1. I agree to hold harmless Tri-City Healthcare District from any recalls, alerts and preventive maintenance brought to my attention for my insulin pump and continuous glucose meter, if applicable.
2. I agree to accept total responsibility for maintaining the pump and related equipment as well as self-administered insulin boluses and basal rates.
3. My insulin pump or insulin pump Continuous Glucose Meter (CGM) combo is approved by the Federal Drug Administration (FDA).
4. I agree to allow Biomedical Engineering to evaluate my pump/pump CGM combo for safety and possible damage.
5. The make, model, and serial number (usually found on the back of the pump) are as follows:
6. Insulin Pump make & model _____ Serial Number_____

During my hospital stay, I agree to

1. Try to keep my blood glucose levels in the hospital target range of 140-180 mg/dL.
2. Use the blood glucose test results from the hospital meter for determining insulin rates and doses. The CGM readings will not be permitted for rate and dose adjustments.
3. Write my basal rate, mealtime and correction insulin boluses on the **Patient Insulin Pump Record** so the nurse can monitor my care.
4. Write the carbohydrate grams or servings consumed for each meal on the **Patient Insulin Pump Record.**
5. Write the insertion site, infusion set, and reservoir with insulin changes on the **Patient Insulin Pump Record.**
6. Change my basal rate if determined necessary by my physician.
7. Change the insertion site, infusion set, and reservoir with insulin every 72 hours or more often if
   a. The insertion site is red, irritated, painful, or if there are signs of infection
   b. The infusion set is leaking or the tubing is clogged
   c. Two consecutive capillary blood glucose readings are greater than 250 mg/dL (200 mg/dL if pregnant) or less than 50 mg/dL in a 24 **hour** period for 2 days. (200 mg/dL if pregnant)
   d. A "no delivery" alarm occurs on the pump
8. Provide my own insulin pump supplies including insulin, which I agree to allow the pharmacy to verify
9. Allow the nurses and physicians caring for me to view the **Patient Insulin Pump Record** as needed
10. Allow the nurse to check my pump insertion site for irritation, redness or leaks
11. Report any symptoms of low blood sugar
12. Report any pump problems immediately to my nurse.
13. Ask questions if I do not understand my doctor's orders for my insulin pump
14. Have my pump disconnected if I can no longer, independently, manage my pump and I agree, then, to an alternate insulin delivery method
15. Send my pump and supplies home with a family member for safekeeping if my pump is disconnected or have Tri-City Medical Center's Pharmacy department store my pump for safe-keeping.

I also understand that my insulin pump may be discontinued or disconnected (either temporarily or longer) and an alternate method of insulin delivery used for any of the following situations.

1. Changes in my level of consciousness, awareness, or judgment
2. Changes in my physical ability to manage my pump.
3. Radiological procedure such as x-rays, CT scans, MRIs or other procedures.
4. Other reasons determined to be medically necessary by my doctor.

Patient Signature:_____Date:_____

WitnessSignature._____Date._____

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

PATIENT AGREEMENT FOR SELF-ADMINISTERED CONTINUOUS SUBCUTANEOUS INFUSION OF INSULIN

Page 1 of 1

Affix Patient Label

8720-NEW

(Rev xx/xx)

Example - Patient Copy Example - Front Office Example - Billing

SAMPLE

To be kept at the bedside for the patient to complete during hospitalization. Start a new record each day

DATE:_____ **PATIENT NAME:**_____

Patient to record the following:

- Date of last infusion set change and insertion site change: _____ (must change every 72 hours)
- Location of insertion site: _____
- Type of insulin currently in your pump: ☐Humalog (lispro) ☐ Novolog (aspart) ☐ Apidra (glulisine)
- Estimated total carbohydrate grams or servings for each meal
- Nurse will record the Point of Care Blood Glucose (BG) readings that are obtained from the hospital meter, which you must use to make any rate changes or bolus doses, before each meal and at bedtime.

Tell your nurse if:

- Something is wrong with your pump, or you do not feel capable of managing your pump
- You notice redness at the insertion site, or you just changed your insertion site
- You have symptoms of low blood sugar or high blood sugar
- Your pump is unplugged for more than 30 minutes

TIME	POC BG done by nurse	CARBS consumed (grams or servings)	BOLUS amount		BASAL rate	Comments
			Mealtime	Correction		

Basal rate is the "background" insulin, delivered by the pump continuously, to maintain glucose levels when not eating.

Bolus dose is the "mealtime" insulin taken before meals and/or "correction" insulin used to manage spikes in glucose.

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

PATIENT INSULIN PUMP RECORD
Page 1 of 1

8720-NEW

(Rev. xx/xx)

Affix Patient Label

Example - Patient Copy Example - Front Office Example - Billing

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/06**	**SUBJECT: Skin and Wound Care Policy**
REVISION DATE:	**09/06, 12/08, 07/09, 12/09, 06/10, 10/13, 04/15, 10/17**	**~~POLICY NUMBER: IV.D~~**

Patient Care Services Content Expert~~Department~~ Approval:	**~~04/17~~10/20**
Clinical Policies and Procedures Approval:	**~~05/17~~06/22**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~05/17~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/17~~09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**10/17, n/a**
Board of Directors Approval:	**10/17**

A. **PURPOSE:**

1. ~~The purpose of this policy is t~~**T**o define healthy maintenance of skin integrity, alteration in skin integrity and the process for assessment, treatment and documentation. For the purpose of this policy surgical wounds are considered acute wounds which proceed through an orderly and timely healing process not requiring interventions to heal. The surgeon provides orders for the care of the acute wound.
2. To ~~prevent pressure injuries a comprehensive visual and tactile skin inspection upon admission, regularly, and as needed. I~~identify risk factors of pressure injury development utilizing the Braden Risk Assessment.
~~2.~~**3.** **To** identify alterations in skin integrity and implement pressure injury prevention and nursing interventions to protect patient~~.~~ **by:**
   a. Remove**ing** all garments, protectors, dressings (including ~~**negative pressure**~~ wound vac dressings), and removable devices, as medically stable, to assess the skin.
   ~~b.~~**a.** Assess**ing** splints, casts, tubes and other devices as potential sites for pressure injury development.
   ~~c.~~**b.** **Ensuring** ~~M~~**m**aintenance of healthy skin integrity through clean and dry skin using non friction bathing standards with slightly warm non-irritating, non-sensitizing, ph- balanced every day and after each incontinence episode. Keep skin well hydrated and moisturized.

B. **DEFINITION(S):**

1. Arterial Ulcer – a wound which fails to heal secondary to insufficient arterial perfusion, commonly located on areas exposed to repetitive trauma (i.e. lateral malleolus, phalangeal heads, between the toes, or on tips of toes) and typically has a "punched" out appearance.
~~1.~~**2.** ~~-~~**Biofilm – complex microbial communities containing bacteria and fungi. The microorganisms synthesize and secrete a protective matrix that attaches the biofilm firmly to a living or nonliving surface**
3. **Blanchable – quickly regains redness when pressure is lifted from skin (2-3 seconds)**

~~2.~~**4.** Diabetic Ulcer – a wound which fails to heal as a result of elevated glucose levels resulting in altered nerve function in the lower extremities. Commonly located on pressure points of the feet such as the plantar surface and the metatarsal heads.

5. Eschar – black or brown necrotic devitalized tissue (scab-like covering).

6. Erythema – redness of the skin or mucous membranes, caused by hyperemia (increased blood flow) in superficial capillaries.

7. Fascia – band or sheet of connective tissue, primarily collagen, beneath the skin that attaches, stabilizes, encloses, and surrounds and separates muscles and internal organs.

~~3.~~**8. Fluctuance – a tense area of skin with a wave-like or boggy feeling upon palpation, this is the pus which has accumulated beneath the epidermis.**

9. Friction – sanding away of surface layer of skin occurring with repetitive rubbing, often seen under restraints or on elbows/heels, or where skin is fragile and macerated.

10. Full Thickness – tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly muscle excluding pressure injuries.

11. Incontinence-associated dermatitis (IAD) - is characterized by erythema and edema of the surface of the skin, sometimes accompanied by serous exudate, erosion, or secondary cutaneous infection. It is also classified as a form of moisture-associated skin damage that occurs when the skin is exposed to urinary, fecal, or dual urinary and fecal incontinence

~~3.~~**12. Intertriginous dermatitis (ITD) – a superficial inflammatory skin condition of the skin's flexural surfaces, prompted or irritated by warm temperatures, friction, moisture, maceration and poor ventilation. Frequently affected areas being the axilla, abdominal folds, and perineum**

13. Ischemic – a wound caused by vasoconstriction (contraction of smooth muscle in blood vessels) and increase in blood pressure. Do not stage an ischemic, traumatic or dermatologic condition as a deep tissue pressure injury (DTPI).

14. Maceration – erythematous or "water-logged" skin secondary to diaphoresis or incontinence, may also be seen around a percutaneous tube that is leaking.

15. Medical-adhesive-related skin injuries (MARSI). Erythema, epidermal stripping or skin tears, erosion, bulla, or vesicle observed after removal of an adhesive ostomy pouching system.

16. Medical Device Related Pressure Injury: This describes an etiology. Medical device related pressure injuries result from the use of devices designed and applied for diagnostic or therapeutic purposes. The resultant pressure injury generally conforms to the pattern or shape of the device. The injury should be staged using the staging system.

17. Microclimate – temperature, humidity and airflow at patient/ support surface

~~4.~~**18. Moisture-associated skin damage (MASD). Injury characterized by the inflammation and erosion (or denudation) of the epidermis resulting from prolonged exposure to various sources of moisture and potential irritants (e.g., urine, stool, perspiration, wound exudate and ostomy effluent).**

~~5.~~**19. Mucosal Membrane Pressure Injury: Mucosal membrane pressure injury is found on mucous membranes with a history of a medical device in use at the location of the injury. Due to the anatomy of the tissue these ulcers cannot be staged.**

~~6.~~**1.** Full Thickness – tissue damage involving total loss of epidermis and dermis and extending into the subcutaneous tissue and possibly muscle excluding pressure injuries.

~~7.~~**20.** Partial Thickness – tissue damage to the epidermis and part of the dermis excluding pressure injuries. Abrasions, skin tears, blisters and shallow craters are examples of partial thickness wounds~~.~~.

~~8.~~**21.** Pressure injury – localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.

a. Suspected Deep Tissue Injury (DTI) Depth Unknown- Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or ***shear.*** The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

b. ~~Category/~~Stage I **Pressure Injury**: Non-blanchable erythema **-- Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.**~~Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" persons.~~

c. **Stage 2 Pressure Injury: Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)**

~~c. Category/Stage II: Partial thickness – Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled or sero sanginous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising*. This category should not be used to describe skin tears, tape burns, incontinence associated dermatitis, maceration or excoriation.~~

~~*Bruising indicates deep tissue injury.~~

d. **Stage 3 Pressure Injury: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.**

~~d. Category/Stage III: Full thickness skin loss – Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is~~**~~are~~** ~~*not* exposed. Slough may be present but does not obscure the depth of tissue loss. *May* include undermining and tunneling. The depth of a Category/Stage III pressure injury~~**~~ulcer~~** ~~varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure injuries~~**~~ulcers~~**~~. Bone/tendon is not visible or directly palpable~~

e. **Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or**

tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.

~~e. Category/Stage IV: Full thickness tissue loss – Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage IV pressure injury**ulcer** varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable~~

f. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss. Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e., dry, adherent, and intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

~~f. Unstageable/Unclassified: Full thickness skin or tissue loss – depth unknown – Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed.~~

22. Re-epithelialization – restoration of epithelium over a wound

23. Skin Failure – Tissue necrosis associate with multisystem organ failure.

~~4.~~**24.** Shear – the mechanical force that is parallel to the skin which can damage deep tissue such as muscle. Tissues attached to the bone are pulled in one direction, whereas surface tissues remain stationary. Shearing occurs when the head of the bed (HOB) is elevated and the patient slides downward in bed.

~~5.~~**25.** Sinus Tract – may also be referred to as tunneling; course or path of tissue destruction occurring in any direction from the surface or edge of wound resulting in dead space with potential for abscess formation.

~~6.~~**26.** Skin Tear – a traumatic wound resulting from separation of the epidermis from the dermis. Skin tears without tissue loss may be linear type or flap type. Skin tears with tissue loss may be partial or complete.

~~9.~~**27.** Slough – **dead, nonviable tissue; loose, stringy, moist and soft. May be cream colored, white, tan, or yellow. Composed of proteinaceous tissue, fibrin, neutrophils and bacteria.** ~~loose, stringy, non-viable tissue, may be white, tan, or yellow.~~

~~10.~~**28.** Undermining – area of tissue destruction extending under intact skin along the periphery of a wound, commonly seen in shear injuries.

29. Venous Ulcer – a wound that has failed to heal secondary to venous insufficiency, commonly located on the medial aspect of lower leg and ankle or superior to the medial malleolus, will typically appear with irregular margins and surrounding skin will have brown/black discoloration, there may be evidence of healed ulcer.

~~11.~~**30. Viable dermis – living dermal tissue**

~~7.~~**31.** Wound – a disruption of normal structure and function of the integumentary system. Wounds are classified as acute, chronic, or refractory.

a. Acute – a wound which occurs suddenly (i.e. trauma or surgery) and heals in an orderly and predictable cascade of events.

b. Chronic – an acute wound which fails to heal normally (i.e. dehisced surgical wound) or a wound that is not healing secondary to a loss of perfusion or some other breakdown in tissue integrity (i.e. nutritional status, infections, or elevated glucose levels).

c. Refractory – a wound which shows no measurable progress for two consecutive weeks despite appropriate management.

C. **POLICY:**

1. Skin (Integumentary) Assessment~~:~~

a. **Skin shall be assessed with all nursing department admission assessments, each shift and upon transfer ~~this~~ includinges Emergency Department and inpatient areas.**~~Skin condition shall be assessed **in coordination with the Braden Risk Assessment** with all hospital department nursing assessments.~~

~~**Skin condition shall be assessed for all inpatient shift assessments transfers and PRN.**~~

b. Braden Risk Assessment shall be completed with all ~~hospital~~ department nursing **admission** assessments~~, , upon orders for~~ inpatient **shift** ~~admission,~~**assessment, transfer, and as needed (PRN).**~~ and admission. Reassessments will be upon unit specific standards and PRN~~.

i. Neonatal Intensive Care Unit (NICU)/Women and Newborn Services (WNS) shall complete newborn skin condition scale

~~b.~~**c. Operating Room (OR)/Peri-Operative Areas assess high risk patient population for skin integrity at pressure points which will be affected by patient positioning**~~, upon orders for inpatient admission, and admission. Reassessments will be upon unit specific standards and PRN.~~**.**

~~1) Outpatient Areas: (Emergency Department and Procedural Areas) should assess**complete both Braden Risk Assessment in conjunction with a skin assessment. Patients that are evaluated as** high risk patient populations for the skin integrity at pressure points which will be affected by patient positioning during the procedure. Application**injury development shall have the application** of prophylactic Composite**a foam composite** dressing, i.e. sacral dressing, heel dressing should be considered. **(heels, sacrum, elbows).**~~

~~ii. For any area that has dressing (including wound vac) upon admission, the dressing should be removed, area assessed, skin condition documented and appropriate dressing applied.~~

~~1)~~**d.** ~~VAC dressings should be removed and a saline dressing can be used until the Wound Team can be consulted to replace.~~

~~a.~~**e.** Skin **a**Assessment shall be comprehensive (visual and tactile) including but is not limited to:

i. Skin Turgor
ii. Mucous Membranes Color and Description
iii. Skin Color
iv. Skin Temperature
v. Skin Moisture
~~iii.~~**vi.** Presence of :
1) Any skin abnormality including partial or full thickness wounds
2) Pressure Injuries (DTI / Stage I / 2 / 3 / 4 or Unstageable)
3) Skin Tear
~~1)~~**4) Skin Failure**
~~2)~~**5)** Surgical Incision

i. Location of ~~all~~ any skin abnormality including partial or full thickness wounds, pressure injuries, skin tears**, skin failure** or surgical incisions and description of skin abnormality and surrounding tissue, description and drainage.

~~iv.~~**ii. For any area that has a dressing (including Wound Vacuum) upon admission the dressing should be removed, area assessed, skin condition documented and appropriate dressing applied.**

~~e.~~**f.** Assess skin abnormality for signs and symptoms of infection. If any new infection is identified, notify physician.

~~d.~~**g.** Photograph all skin injuries including partial or full thickness wounds, pressure injuries , skin tears**, skin failure** or non-surgical wounds on admission, at least once every 7 days, with changes and new discovery **and day of discharge or 24 hours prior to the day of discharge** . Photos shall include:

i. Measuring guide with the following information: patient initials and location of wound~~.~~

ii. If a patient refuses a skin assessment~~s~~, perform the following:

1) Identify why patient is refusing to allow assessment, ~~and mitigate refusal,~~ educate the patient on the rationale ~~importance~~ of assessment and the risk of developing a pressure injury,

2) If patient continues to refuse after re-education, notify the physician.

2. Repositioning Patients

a. Stable Patients

iii. Maintain mobility to reduce pressure areas on patient.

iv. Reposition immobile patients at least every two (2) hours when unable to turn self.

v. Float / elevate heels from the surface of the bed ensuring heels are free from any tubes or medical devices.

vi. Encourage/assist ambulatory patients to change positions in bed.

vii. Reposition patients in chair every 30 minutes.

viii. Consider obtaining a chair cushion.

ix. Do not place patient on reddened areas until redness has completely resolved.

b. Hemodynamically Unstable Patients

i. Provide mini-turns.

ii. Weight shift patient with pillow(s).

iii. Float / elevate heels from surface of bed ensuring heels are free of any tubes or medical devices.

iv. Pelvis injury - log roll patient only with approval of the physician.

~~ii.~~v. Cervical fracture – patient must have appropriate fitted cervical collar in place then log roll patient and wedge in proper alignment

vi. For additional information see VCU Hemodynamic Instability Guide

~~2.~~**3.** Documentation:

a. Braden Risk Assessment and nursing interventions to protect patient~~.~~

b. Integumentary skin assessment including any skin injuries~~.~~

c. Dressing changes~~:~~

i. Write date, time, initials, and stage **"T" for treatment** on the dressing prior to application.

~~b. Skin Care treatment plans.~~

d. Initiate appropriate orders and Interdisciplinary plan of

e. Documentation of Skin Bundle within EMR

~~3.~~**4.** Identify patients at risk for skin breakdown~~:~~

a. Braden Risk Assessment Score **less than or equal to (<)**18

i. Implement interventions in areas of deficit

b. Immobility
c. Dry ~~C~~**c**happed ~~S~~**s**kin
d. Over ~~H~~**h**ydrated ~~S~~**s**kin
e. Renal / ~~H~~**h**epatic ~~I~~**i**mpairment
f. Low ~~A~~**a**lbumin ~~L~~**l**evels
~~g.~~**c.** Surgery Lasting **four (4)** ~~Or More Hours~~**or more hours**
~~h.~~**d.** Diabetic
~~i.~~**e.** Sepsis / ~~I~~**i**nfection
~~j.~~**f.** Patients ~~With Really Low~~**with really low** a **decreased body mass index** (BMI) **e.g., 19 or less** ~~(for example less than 19)~~
~~k.~~**g.** Spinal Cord Injury

~~4.~~**5.** Skin protection / wound prevention guidelines and intervention options~~:~~
a. Maintain healthy skin moisture (strengthen skin integrity~~):~~**)**
i. Clean incontinent episodes quickly to keep skin dry~~.~~
ii. Use **peri-wipes**~~Shield pads~~ to clean perineum after stool **and**~~&~~ urine.
iii. Use protective barrier moisture lotion to prevent chaffing.
iv. Keep irritating substances off the skin i.e. acidic stool.
v. Use a single **moisture wicking pad** ~~underpad~~ for incontinent patients to absorb moisture.
i. Use female external containment device for ~~incontinent~~**incontinence** ~~females~~, as appropriate.
ii. Avoid adult diapers on incontinent patients; except during transport or during ambulation.
iii. Use condom catheter for incontinence on male patients as appropriate
~~vi.~~**iv. Use pH balance non-rinse cleanser**
~~vii. Avoid adult diapers except on incontinent patients except during transport or during ambulation.~~
~~viii.~~**vi.** ~~Use pH balanced non-rinse cleanser (Sage Comfort wipes).~~

~~5.~~**6.** Reduce friction and shearing~~:~~
~~c.~~**a.** Use ~~draw~~**slide** sheet when repositioning patient in bed.
~~d.~~**b.** Lift patients off bed when repositioning (to reduce drag).
~~a.~~**c.** ~~-~~Evaluate for appropriate assist devices (trapeze bar).
~~e.~~**d.** Consider use of specialty mattresses for patients at high risk, in addition to turning, position and offloading patient every **two (2)** hours **(See Mattress Selection Guide)**.
~~i. Pressure redistribution standard mattress (NPT3, Isoflex or Sizewise).)~~
~~ii. Pressure redistribution mattress with a blower **Low Air Loss** – for patients with moisture problems, incontinence and only 2 intact turning surfaces.. (Pulsate Mattress).)~~
~~iii. Pressure Relieving~~**Air fluidized** ~~Mattress – for patients with flaps/grafts or with only 1 intact turning surface., **patients that have been "found down" or DTI.** Paraplegic and Quadriplegic patient shall be place on a pressure relieving~~**air fluidized** ~~surface (Immerse Mattress and Evolution bed). Unstable spine patients should not be placed on this surface.~~
~~iv. Bari Bed – for patients greater than 350 pounds or difficulty turning and positioning.~~

~~6.~~**7.** Reduce pressure and shearing~~:~~
a. Maintain proper alignment / body position.
b. HOB less than 30 degrees if not contraindicated for patient.
c. ~~Latch~~**Gatch** knee of bed to prevent sliding down in bed.
d. Consider floating/elevating heels with pillow or heel protectors under ankles.
e. Off load pressure areas~~.~~

f. Avoid foam rings or donuts~~.~~
g. When ~~side lying,~~**side lying** avoid positioning on trochanter and turn off the back at 30 degree angle.
h. Consider applying preventative ~~silicone~~**foam** composite dressing to high risk areas.

~~7. Maintain mobility to reduce pressure areas on patient:~~
~~a. Reposition immobile patients at least every 2 hours.~~
~~b. Encourage/assist ambulatory patients to change positions in bed.~~
~~c. Reposition patients in chair every 30 minutes.~~
~~d. Do not place patient on reddened areas until redness has completely resolved.~~

8. Care for incontinent patients~~:~~
a. Offer frequent toileting, cued voiding or timed voiding~~.~~
b. Every **one (1)** hour observation of incontinent episodes and immediate cleansing of area after each episode~~.~~
c. Cleanse with **peri-wipes**~~comfort shield perineal care.~~
d. Avoid diapering except when ambulating and during transport~~.~~
e. Use one incontinent pad (avoid chux) on top of draw sheet~~.~~
f. Use incontinence skin barriers / creams / ointments and skin protectants to protect and maintain intact skin~~.~~
g. Consider using containment device to contain urine~~/~~ / stool~~.~~

9. Nutrition~~:~~
a. Initiate nutrition consult for patients at high risk~~.~~
b. Consider nutrition supplement per physician's order if at high risk~~.~~
c. Offer fluids with each turn unless contraindicated~~.~~
d. Multi-vitamins per physician's order~~.~~

~~10.~~**D. PROCEDURE TREATMENT~~:~~**

~~12.~~**1. Apply ~~P~~prophylactic foam composite dressings to identified high risk pressure injury areas** with low moisture **pressure points**
~~a.~~**g. Apply silicone composite dressing** (i.e.: **sacral dressing, heel dressing) to low moisture high risk areas**~~. or under medical devices.~~
~~b.~~**a. Reassess high risk skin areas by peeling back ~~P~~prophylactic silicone composite dressing every shift**
~~c.~~**b. Change prophylactic silicone~~foam~~ composite dressings every three (3) days and prn if soiled.**
~~d.~~**c. Mark prophylactic prevention dressing with a "P" and the date and time**
~~e.~~**d. ~~Frequent positioning and off-loading every 1-2 hours will assist in the prevention of pressure injuries~~.**

~~11.~~**2.** Stage 1, Stage 2, and Suspect Deep Tissue Injury~~:~~
a. Apply silicone composite dressing~~, i.e. ie: sacral dressing, heel dressing~~ to ~~L~~low moisture Stage 1 area.
b. Reassess Stage 1, Stage2, or **s**~~S~~uspect **d**~~D~~eep **t**~~T~~issue **i**~~I~~njury ~~A~~area by peeling back silicone composite dressing~~, i.e. ie: sacral dressing, heel dressing with assessments per standards of care.~~
c. **If**~~For~~ **p**~~P~~ressure **i**~~I~~njuries **is in a** high moisture areas utilize an external urinary containment device, ~~and~~ apply a protective barrier and leave open to air~~.~~
d. Position ~~patients~~**patient** off area of **p**~~P~~ressure ~~injury.~~**injuries**
~~d.~~**e. Enter a Wound Team Consult via Cerner**

~~12.~~**3.** Stage 3~~:~~
a. Cleanse wound with normal saline.
b. Assess for tunnels, tracts, or undermining~~.~~
c. Culture wound after cleansing if ordered~~.~~

d. If clean and shallow, fill visible wound bed with calcium alginate~~.~~
e. If infected, cleanse , culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate~~).~~) **If dry, silver impregnated calcium alginate may stay in place seven (7) days.**
f. If tracts, tunnels or undermining moisten **wrap** ~~kerlix~~**/stretch gauze with antimicrobial wound gel** ~~roll with anasept gel~~ and fill cavity, tracts, tunnels, **with**~~or~~ **wrap/stretch gauze.** ~~undermining with kerlix~~.
g. Cover wound with silicone composite dressing~~.~~
h. Change daily and if dressing becomes saturated with drainage~~.~~
~~h.~~**i. Consult Wound Team**
~~i. Enter a referral to the Wound Team~~ **Consult** ~~via Cerner.~~

~~13.~~**4.** Stage 4~~:~~
a. Cleanse wound with normal saline~~.~~
b. Assess for tunnels, tracts, or undermining and supporting structures: muscle, bone, tendon, or joint capsule~~.~~
c. Culture wound after cleansing~~.~~
d. If clean and shallow, fill visible wound bed with calcium alginate. If infected, cleanse, culture and fill cavity with silver impregnated calcium alginate (silver) vs (calcium alginate~~).~~)
e. If tracts, tunnels, undermining, or non- visible wound bed moisten **wrap/stretch gauze with antimicrobial wound gel** ~~kerlix roll with anasept gel~~ and fill cavity, tracts, tunnels, or undermining with ~~kerlix.~~**wrap/stretch gauze**
f. Cover wound with silicone composite dressing~~.~~
g. For wounds with high moisture related to incontinence, avoid foam composite dressing and apply barrier paste.
~~g.~~**h.** Change every 12 ~~hours~~**hours**~~rs~~ and if dressing becomes saturated with drainage~~.~~
i. Low wound drainage Stage 4 Pressure Injuries - Foam composite dressing with Silver can stay in place for up to seven (7) days. Change if dressing becomes saturated with drainage
h. Order pressure relieving mattress, i.e., air fluidized bed, immerse, or low air-loss~~.~~
~~i.~~**j.** ~~Enter a referral to the~~ **Consult** Wound Team **Consult** ~~via Cerner.~~

~~14.~~**5.** Unstageable – unable to determine staging of pressure injury~~:~~
a. Relieve excessive moisture, pressure and/or shear~~.~~
b. **Consult**~~Enter a referral to the~~ Wound Team **Consult** ~~via Cerner.~~
c. If only necrotic tissue (eschar) is present, cover the wound with dry gauze dressing until specific orders are given, or consult is obtained from Wound Team~~.~~**WOCN**
d. For wounds with ~~a~~ draining necrotic tissue (eschar/slough), follow Stage IV treatment
~~d.~~**e.** options, silver or calcium alginate, changing every 12 ~~hours~~**hours** and if dressing becomes saturated with drainage, until specific orders are given, or consult is obtained from Wound Team.

~~15.~~**6.** Skin Tear~~:~~
a. Cleanse wound area gently with normal saline.
b. Approximate skin edges~~.~~
c. Apply ~~silicon~~**silicone** contact layer~~.~~
i. Change ~~silicon~~**silicone** contact layer every seven days~~.~~
d. If bleeding, consider calcium ~~alginate~~**alignate** or calcium ~~alginate~~**alginate**~~ignate~~ with silver on top of silicone contact layer~~.~~
e. Wrap area with **stretch gauze** ~~kerlix~~ and secure with tape. Avoid tape to skin.
i. Change **stretch gauze** ~~kerlix every twenty-four (24)~~ and as needed for saturation~~.~~
f. If unable to use **stretch gauze** ~~kerlix~~, apply silicone composite dressing~~.~~

i. Change silicone composite dressing every ~~twenty-four (24~~**3 days to 5 days**) and as needed **for** saturation~~.~~

~~16.~~**7.** Partial Thickness Wound~~:~~

a. Cleanse wound area gently with normal saline.

b. Apply silicone composite dressing:

i. Change dressing every three (3) days and as needed for saturation.

c. If dressing does not adhere or requires replacement more than every three (3) days, consult Wound Team. May apply a prophylactic silicone composite dressing and wrap/stretch gauze until Wound Team consult obtained. Change prophylactic silicone composite dressing daily.

~~a. Cleanse wound area gently with normal saline.~~

~~b. Apply silicone composite dressing:~~

~~Change **Foam Composite Dressing *QSATURDAY, Note Date and "T" on all dresssings***~~

~~i. **Remove Dressing *Any dressing*** every three (3) days and prn saturation. ***not dated***~~

~~a. If dressing does not adhere or requires replacement more than every three (3) days, consult Wound Team. May apply silicone composite foam and kerlix until Wound Team consult obtained. Change silicone composite foam daily.~~

~~17.~~**8.** ~~Full Thickness:~~**~~Position Patient Off Wound~~Full Thickness**

a. Cleanse wound area gently with normal saline.

b. Apply silver to wound void~~.~~

c. Apply silicone composite dressing~~.~~

i. Change silicone composite dressing every three (3) days and as needed **for** saturation~~.~~

1) Home Care patients change dressing every 3-5 days.

d. If wound appears infected, obtain order from physician to culture wound prior to silver application~~.~~

9. Skin Failure – tissue necrosis associated with multisystem organ failure.

a. Apply foam composite dressing to necrotic area with tissue ischemic changes – low moisture

b. Assess under foam composite dressing every shift.

c. Change foam composite dressing every three (3) days and as needed. Note date and "T" for treatment on all dressings.

d. Position patient off wound.

e. Order pressure redistribution mattress, air fluidized (Evolution with Immersion).

f. High moisture wounds related to incontinence avoid foam composite dressing, apply barrier paste.

g. Consult Wound Team

~~18.~~**10.** Medical Device Related Pressure ~~injury~~**Injury** Prevention~~:~~

a. Apply p~~P~~rophylactic **silicone**~~foam~~ composite dressing with ~~Medical~~**medical** device initiation.

b. Assess skin under medical device every shift ~~when medical device is removable or adjustable~~

~~b.~~**c.** Choose the correct size **/ shape** of medical device(s) to fit the individual.

~~c.~~**d.** ~~Cushion and p~~**P**rotect the skin with **thin hydrocolloid dressing, and/ or silicone**~~foam~~ composite dressings in high risk area (i.e., nasal bridge, **ears**).

i. Prophylactic silicone composite dressing application, i.e. sacral dressing, heel dressing to high risk area.

~~1)~~**i. Assess skin under dressing** ~~Peel back~~ every shift ~~and assess skin:~~

~~a)~~**1)** If skin is not intact consult Wound Team ~~via Cerner.~~

~~2)~~**ii.** Change silicone composite dressing every **three (3)**~~five (5)~~ days and **PRN**~~as needed~~ if saturated~~.~~

~~b.~~**e.** Avoid placement of device(s) over sites of prior or existing pressure injury~~.~~

f. Assess for edema under device(s) and potential for skin breakdown

~~c. Ensure staff knows~~**know** ~~the correct use of device(s) and prevention of skin breakdown.~~

~~d. Be aware of edema under device(s) and potential for skin breakdown.~~

~~d.~~**g.** Confirm that device(s) are not placed directly under an individual who is bedridden or immobile.

~~D.~~E. INCONTINENCE SKIN CARE~~:~~

1. Urinary~~:~~
   a. Preventive~~:~~
      i. Perform pericare daily and as ne**eded**~~cessary~~ with each incontinent episode using incontinence cleanser followed by application of external containment device for incontinent females and moisture barrier cream~~/ointment~~.
      ii. Use of an absorptive wicking pad or containment device (i.e., external catheter) may be necessary.
   b. Dermatitis/irritated red skin~~:~~
      i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by initiation of external urine containment device and application of moisture barrier cream~~/ointment~~.
      ii. Containment device may be indicated.
      iii. **Limit use of adult diaper unless patient is being transported or ambulating** ~~Optimal to avoid use of absorptive brief/diaper~~.
      ~~iv.~~**ii.** Consult Wound Team if no positive response to treatment in ~~forty-eight (~~48~~)~~ to ~~seventy-two (~~72~~)~~ hours.
   c. Fungal infection~~:~~
      i. Assess for presence of fungal infection. Signs and symptoms include erythema, maceration and satellite lesions; at times the infection presents as solid plaques of moist, read areas. The chief symptom is pruritus at the site.
      ii. Apply anti-fungal product~~.~~
      iii. Containment device may be indicated.
      iv. **Limit use of adult diaper unless patient is being transported or ambulating** ~~Optimal to avoid use of absorptive brief/diaper~~.
      v. **Order a low air loss** (Pulsate) **m**~~M~~attress to dry out perineal microclimate~~.~~
      ~~vi.~~**iii.** Consult Wound Team if no positive response to treatment in ~~forty-eight (~~48~~)~~ to ~~seventy-two (~~72~~)~~ hours.
2. Fecal~~:~~
   a. Preventive~~:~~
      i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier cream~~/ointment~~.
         1) For frequent loose stooling and enzymatic drainage, obtain order for use of a containment device ~~**(i.e.Dignicare Stool Management System / pouch) is indicated**~~ to protect skin ~~([see Patient Care Services Procedure:**PCS** Stool Management (Rectal Tube]) Dignacare Stool Management System). **Procedure.**~~
   b. Denuded/Excoriated Skin~~:~~

i. Perform pericare daily and as necessary with each incontinent episode using incontinence cleanser followed by application of moisture barrier **paste**~~cream/ointment every 1—2 hours~~.

~~i.~~**ii.** If skin is not broken, obtain order for use of a containment device ~~**i.e.Dignicare Stool Management System / pouch) is indicated**~~ to protect skin (see Patient Care Services Procedure: Stool Management [Rectal Tube] ~~Dignacare Stool Management System)~~

~~ii. **Procedure]**~~

~~ii.~~**iii.** If skin is broken, apply thick layer of **b**~~B~~arrier paste 1/8 inch thick **twice a day (BID) and blot clean and reapply as needed after stooling.** ~~Reapply paste every 1—2 hours and PRN stooling~~

~~iii.~~**iv.** Consult Wound Team if no positive response to treatment in ~~forty-eight (48)~~ to ~~seventy-two (72)~~ hours.

~~3.~~**2.** Consultation and referral to Wound Team:

~~a.~~**c.** Consult when the condition necessitates:

i. Chronic pressure injury history longer than **two (2)** weeks, hospital acquired pressure injury, any stage 3, stage 4, ~~suspect~~ deep tissue injury, **skin failure or** ~~**hospital acquired injury** or any~~ full thickness wounds.

~~4.~~**3.** Pressure redistribution surface/~~Specialty~~ **specialty** bed selection~~:~~

a. Assure the appropriate selection of pressure redistribution support surface. All mattresses require scheduled turning ~~and~~, positioning, ~~**and floating**~~ to prevent pressure injuries~~.**ulcers.**~~

b. Pressure redistribution **standard** ~~mattresses~~**mattress** are indicated for high risk patients, stage 1-3~~. (isoflex~~**.(IsoflexNWPT3** ~~-~~ and Sizewise~~).~~**)**

c. ~~Blower~~**Low Air loss** Mattress ~~(rental)~~ **with a blower, (Pulsate)** ~~are indicated~~**is indicated** for moisture related issues **(fecal and /or moisture).** ~~with pressure injuries~~**ulcers** ~~and high need of pressure re-distribution.~~**redistribution.** Avoid linens and padding on bed. ~~(Pulsate) **use airflow wicking pads for incontinence and patient lifting device as indicated.**~~

d. Air fluidized pressure redistribution mattress (Evolution with Immersion) is indicated for patients after a surgical flap/graph, paraplegic, quadriplegic, spinal cord injury, stage 3 and four (4) pressure injuries

e. Bariatric bed is indicated for patients greater than 350 pounds, difficulty turning and positioning.

f. Rotoprone therapy system (Intensive Care Unit (ICU) only) is designed to place a patient with acute pulmonary complications, acute respiratory distress syndrome (ARDS) in the prone position.

~~d. Bari Air (rental) are indicated for patients greater than 350 pounds, low air loss.~~

~~e. Pressure Relieving: Low Air Loss, Immerse and Air Fluidized Mattress (rental) are indicated for patients with **Ischemic injury related to vasoconstriction, deep tissue injury**,stage 3 and 4 pressure injuries**ulcers**, paraplegic and quadriplegic patients spinal cord injury patients, and patients after a surgical flap pressure injury repair.~~

~~5.~~**4.** Education:

a. Educate family and patient on pressure injury prevention and treatment per hospital polic**y**~~.ies; Educational Handout "How to Help Prevent and Manage Pressure Ulcers" and "It's Time To Take The Pressure Off!"~~

~~6.~~**5.** Call **P**~~p~~rovider:

a. With discovery of a pressure injury~~.~~

b. Immediately if the patient exhibit signs or symptoms of super infection related to pressure injury~~**ulcer**~~ or the following symptoms in the wound present.

c. Wound appears to be deteriorating~~.~~

d. Increased necrosis of tissue in or around the wound~~.~~
e. Increased drainage or odor~~.~~
f. Progressive or noted peri-wound erythemia~~.~~

~~7.~~**6.** Evaluate for possible referral to the TCMC Center for Wound **Care** ~~Healing~~ and Hyperbaric Medicine upon discharge.

~~B.~~F. RELATED DOCUMENTS:

1. Mattress Selection Guide (Bed Guide)
2. Patient Care Services Procedure: PureWick Female Urinary Incontinence Management
3. Patient Care Services Procedure: Stool Management (Rectal Tube) Dignacare Stool Management System Procedure
4. Pressure Ulcer Wound Dressing Selection (Includes Staging and Products)
5. ~~Tri-City Hospital Pressure Ulcer Wound Dressing Selection Guide~~
5. **~~Tri-City Medical Device Guide~~**
6. **Medical Devices and Minimal recommendations**
7. **VCU Hemodynamic Instability Guide**

~~E.~~G. REFERENCES:

1. **European Pressure Ulcer Advisory Panel (EPUAP), National Pressure Injury Advisory Panel (NPIAP), Pan Pacific Pressure Injury Alliance (PPPIA) (2019) *Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guidelines***
2. **www.npiap.org 2020 National Pressure Injury Advisory Panel**
3. **www.ncbi.nlm.nih.gov 2019 National Center for Biotechnology Information**
4. **Gray, M. and Giuliano, K. (2018). Incontinence-associated dermatitis, characteristics and relationship to pressure injury. *Journal of Wound, Ostomy and Continence Nursing*, 45(1): 63-67.**

1. ~~Hiser, B., et. al.,. (2006, February). *WOCN clinical practice guidelines: prevention and management of pressure ulcers*, 52 (2).~~
2. ~~Baranoski, S. & Ayello, E.A. (2004). *Wound care essentials: practice principles.* Philadelphia, PA: Lippincott Williams & Wilkins.~~
3. ~~Magnan, M.A. and Makelebust, J. (2009). Braden scale risk assessments and pressure ulcer prevention planning. *Journal of Wound, Ostomy and Continence Nursing, 36* (6), 622-634. 4. 3M Skin Health Program~~
4. ~~www.npuap.org~~**~~www.npiap.org~~** ~~2008~~**2020.** ~~www.ihi.org 2010.~~

Move to Related Document

VCU Hemodynamic Instability Guideline

Clinical Findings Which Prevent Patient Turning

1. Development of life threatening arrhythmia with symptomatic response (VFIB/VTACH/SVT) This does NOT include asymptomatic AFIB.

2. Active Fluid Resuscitation: (i.e. no volume going in= no systemic blood pressure).

3. Active Hemorrhaging:
   - Following Cardiac Surgery/Active Tamponade
   - Massive GI bleeding with use of Blakemore tube.
   - Active hemorrhage following Trauma.

4. Change in baseline hemodynamic parameters (BP, HR, Oxygen Saturation, RR, etc) that does not recover within 10 Minutes of position change and is not an expected result based on diagnosis.

Recommended Interventions for the Unstable Patient

IF PATIENT IS DEEMED TOO UNSTABLE TO TURN BY ABOVE PARAMETERS:

A TRIAL TURN SHOULD BE ATTEMPTED AT LEAST EVERY 8 HOURS TO DETERMINE ABILITY TO RESUME FREQUENT TURNING AT LEAST EVERY 2 HOURS

1. Provide mini-turns
2. Weight shift patient at least every 30 minutes
3. Elevate heels from surface of bed
4. Reposition patient's head, arms and legs at least every hour, consider passive ROM
5. Consider use of Continuous Lateral Rotation Therapy to prevent development of "gravitational equilibrium". Begin: SLOW AND LOW angles of turning to gauge patient response.
6. When turning patient: GO SLOW! Provide serial small turns from supine to lateral position to achieve linen changes, hygiene checks, and reposition with wedges and pillows.

UNSTABLE FRACTURES

1. **Patient's with unstable pelvis injuries LOG ROLL PATIENT ONLY with approval of Attending MD. Consider wedges or pillows placed between the legs to maintain proper alignment.**
2. **DO NOT use continuous loateral rotation therapy (CLRT) with unstable spinal fractures: these patients should be positioned with multiple wedges to maintain proper alignment**
3. **Cervical Fractures / UNSTABLE: Patient must have appropriately fitted cervical collar in place. Ensure security and proper positioning of collar, then log roll patient, and wedge in proper alignment.**

VCU Hemodynamic Instability Guideline

Strategies to Prevent Hemodynamic Changes in Response to Patient Turning

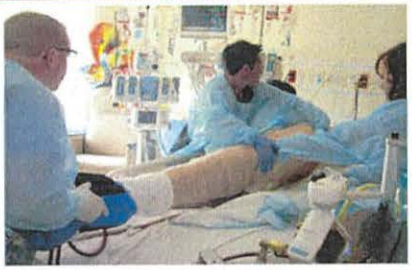
1. Consider use of Continuous Lateral Rotation Therapy to prevent development of "gravitational equilibrium". Begin: SLOW AND LOW angles of turning to gauge patient response.
2. When turning patient: GO SLOW! Provide serial small turns from supine to lateral position to achieve linen changes, hygiene checks, and reposition with wedges and pillows.
3. Consider use of vasopressive mediations to manage hypotension as approved by the Attending MD.
4. Monitor patient for signs of alterations in lung compliance based upon position, response, and known injuries or diagnosis.

TURNING THE UNSTABLE PATIENT:

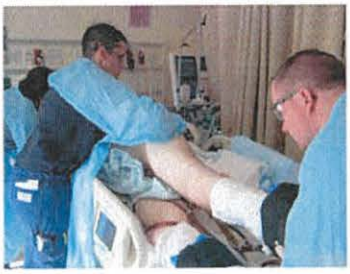
- GO SLOW
- GET HELP: Multiple staff to allow slow turning and management of equipment
- MONITOR RESPONSE
- INDIVIDUALIZE CARE BASED UPON RESULTS OF TRIAL TURNS.

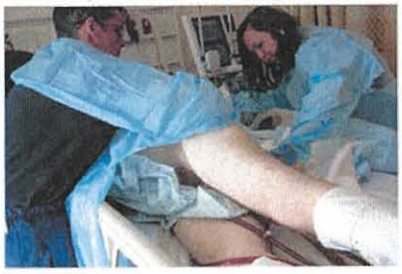
IT'S NEVER OK TO LET A PATIENT JUST "LAY THERE"

1. Secure Lines
2. Have Adequate Staff Present to provide turn
3. Turn patient 10-15 degrees and pause for 15 secs watching monitor
4. Continue turning incrementally to achieve full lateral position for skin care

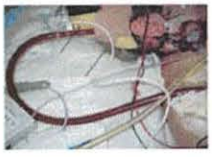


5. Slowly Return to 30 degree turn position using wedges and pillows to position.
6. Monitor response to turn over the next 10 minutes of recovery.
7. Individualize turning schedule based on changes in Braden Score and patient condition.





Manage Invasive Lines Such as ECMO: Have Staff to Secure and Monitor:
- **Note: The Patient Pictured Above Had 3 ECMO Cannulation sties and was still able to be turned.**



Tri-City Medical Center
Oceanside, California

Medical Devices and Minimal recommendations

Medical Devices	Protective Barrier Available	Minimal Recommended Frequency for Repositioning Medical Devices and/or Application of Protective Barrier (Includes Documentation for performing repositioning in Nursing Notes)
Secured central and arterial lines	Use stat lock securement device to create a barrier and securement for all PICC lines	Every 12 hours and PRN, reposition excessive tubing and secure. Do not reposition line at insertion site.
Sequential Devices	Ensure correct size. Discuss with MD regarding other possible alternatives to decrease utilization.	Every 12 hours remove at 0800/2000 and reapply at 1000/2200
Ted Hose	Choose correct size. Discuss with MD regarding other possible alternatives to decrease utilization	Every 12 hours remove at 0800/2000 and reapply at 1000/2200
Tracheostomy Plates	Fenestrated foam trach dressing and reinforce with gauze underneath and on the side of trach to absorb excessive secretions	Every 12 hours skin underneath should be assessed thoroughly and dressing changed more often as needed
EEG electrodes	Keep surrounding skin as clean and dry as possible. EEG tech to apply electrodes and securement cap (should be able to fit 1 finger under). Ensure cap is not excessively tight. Do not apply electrodes over damaged skin.	For patients that scored >18 (not at risk), EEG tech and nurse assess and document skin integrity and appropriate fit of the securement cap upon initiation of EEG. EEG tech reassesses 1-2 hours after initial placement- for comfort measures. Thereafter, EEG tech and nurse assess once per shift and prn (twice a day) for med-surg/tele OR every for 4 hours for ICU at beginning and end of EEG shift. Gently raise cap frontal area only/forehead, assess skin integrity under EEG electrodes and tightness of cap. For patients scoring ≤ 18, nurse will gently raise cap frontal area on/forehead and assess under EEG leads, for excessive tightness of cap every 4 hours and PRN on med-surg/tele OR every 2 hours for ICU. If at any time patient complains that cap is excessively tight or painful EEG electrodes, nurse can loosen cap, remove EEG electrodes and notify EEG tech immediately. Assessments should be conducted more often as needed and in response to complaints of pain.

Medical Devices	Protective Barrier Available	Minimal Recommended Frequency for Repositioning Medical Devices and/or Application of Protective Barrier (Includes Documentation for performing repositioning in Nursing Notes)
Duodenal Tubes/Keofeed (Temporary Placement)	Ensure not lying on cheek or ear when patient in lateral position	Upon placement, every 72 hours and PRN. Use holder unless MD order for nasal bridle. Do not secure with tape or steri-strips.
Endotracheal Holders	Keep surrounding skin as clean and dry as possible. Avoid excessive removal of the adhesive to prevent skin tears and injury	Every 48 hours in collaboration with RT. Remove holder and assess skin.
Endotracheal Tubes/Hi-Low suction Cannulas	Provide oral suction to keep mouth as dry as possible. Patients with a recent history of chemotherapy are more apt to develop injury.	Every 6 hours in collaboration with RT, reposition the ET tube (right, left or middle).
External Drains (JP drains, hemovacs, urinary catheters, etc.)	Place gauze underneath lines when appropriate. Allow tubing slack when securing.	Every 12 hours, reinforce with gauze around insertion site and between tube and patient's skin. Do not reposition tube at the insertion site. Assess and change dressing per MD order.
High Flow Cannulas	RT to apply protecta-gel for patients scoring 18 or less on Braden	Every 2-4 hours per house-wide protocol in collaboration with RT
NG/Nasogastric Tubes	For ICU, bridle NG if in place > 12 hours. For Med-Surg/Tele: Secure so free floating in the nares to the extent possible. Ensure not lying on cheek or ear when patient in lateral position.	Every 2 hours, assess skin and perform nasal care. For MS/Tele, and upon placement, every 72 hours and PRN. Use holder unless MD order for nasal bridle. Do not secure with tape or steri- strips.
O2 Cannulas	Apply cushions and/or gauze behind ears and/or under jawbone as needed	Every 2-4 hours per house-wide protocol in collaboration with RT and change cushions every 72 hours and PRN.
O2 Masks with Straps	Apply cushions and/or gauze behind ears and/or under	Every 2-4 hours per house-wide protocol in collaboration with RT and change cushions every 72 hours and PRN.

Medical Devices	Protective Barrier Available	Minimal Recommended Frequency for Repositioning Medical Devices and/or Application of Protective Barrier (Includes Documentation for performing repositioning in Nursing Notes)
	jawbone as needed	
O2 Sensor Probes	Do not apply over damaged skin. Consider taping sensor to digits, wrap with warm blankets to increase blood flow. For forehead probes, do not apply over damaged skin and ensure headband not too tight.	For finger probes every 12 hours (once per shift) and rotate site in collaboration with RT. For forehead probes every 4 hours and PRN and rotate site in collaboration with Rt.
Rotoprone Beds	Apply preventative silicone dressings on all bony prominences and at risk areas. Ensure face shield is not overly secured	Consult WOC upon initiation to ensure all protective barriers in use. Change preventative mepilex dressings every 72 hours. Customary rotation of the bed offloads pressure points.
AFO Boots	Ensure bootstrap is not applied too tightly	Every 2 hours, alternate boot from left to right foot.
BiPAP and CPAP	RT to apply gel pad upon initiation (or similar product).	Every 2-4 hours per house-wide protocol in collaboration with RT (document as skin to device area padded)
Chest Tubes	Reinforce with gauze between 1) Tube and patient skin and 2) bottom edge of dressing between tube and skin.	Every 12 hours, reinforce with gauze around insertion site and between tube and skin. Do not manipulate chest tube at insertion site. Assess and change dressing per MD order and policy
Compression Wraps	Contact PT wound care regarding questions related to removal.	Every 12 hours and more frequently to relieve pressure and smooth out creases from wraps rolling down from top or bunching at the ankle/foot.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 04/09	**SUBJECT: Specimen Labeling**
REVISION DATE: 06/12	**~~POLICY NUMBER: IV.RR~~**
Department Approval:	**~~10/16~~09/21**
Clinical Policies & Procedures Committee Approval:	**~~11/16~~04/22**
Nursinge Leadership~~Executive Council~~ Approval:	**~~01/17~~05/22**
Department of Pathology Approval:	**~~08/17~~08/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/17~~09/22**
Professional Affairs Committee Approval:	**~~10/17~~ n/a**
Board of Directors Approval:	**10/17**

A. **PURPOSE:**

1. To ensure all specimens collected from patients are properly identified and labeled in the presence of the patient.

B. **DEFINITIONS:**

1. Specimen: Any sample taken from a patient from which diagnostic tests can be performed.
2. Cerner log-on ID: **issued to employee by Information Technology**~~The six-letter code or user name consisting of the first three letters of the last name followed by the first three letters of the first name~~.
3. Specimen Type: The type of specimen that will be analyzed in the laboratory (i.e. blood, urine, stool, sweat, saliva, CSF, synovial, amniotic, serous fluid, swab, products of conception (POC), tissue, etc).
4. Specimen Source: The source of the specimen type collected (i.e. urine source (clean catch, catheter, random, first morning, supra-pubic aspiration), swab source (nasopharyngeal, wound (i.e. right posterior hand), serous fluid source (i.e. peritoneal, pericardial, pleural), solid tissue (i.e. right ovary).

C. **POLICY:**

1. Refer to specific specimen collection procedure prior to obtaining specimen.
2. **Specimens must be labeled with a Cerner generated specimen label**
3. **Downtime:**
   - **a. Chart** ~~All~~ **or manual** labels **should only be used during downtime. The label** must be legible and contain:
     - ~~2.~~**i. Minimum of 2 patient identifiers**~~the following~~:
       - ~~a.~~**1)** Patient's full name
       - **2)** Medical record number
       - **3) Financial number (FIN)**
       - ~~b.~~**4) Date of birth**
     - ~~c.~~**ii.** Time and date of the collection~~[~~
     - ~~d.~~**iii.** Source and type of specimen
     - **iv.** Cerner log-on ID of the collector. **Use full log-in ID, do not use initials**
   - ~~e.~~**b. Complete the appropriate downtime lab request form and place with** ~~the front pock of~~**the specimen bag with the sample.**

~~3. The type of label used may be one of the following:~~
~~a. Cerner generated label (preferred)~~

~~b. Handwritten label~~

D. **PROCEDURE:**

1. Verify the physician/Allied Health Professional's order for specimen type.
~~1.~~**2. Print specimen label and take to the bedside of the patient.**
3. Match the collection label(s) information to the patient identification using two patient identifiers prior to collection (Refer to Patient Care Services [PCS] Policy: Identification, Patient).
~~2.~~**a. Log into the patients EHR and open Specimen Collection, scan the patients ID bracelet and verify correct patient information.**
~~a. If multiple specimens are collected confirm each label with the using two patient identifiers.~~
~~b. Do not collect specimen if there are any discrepancies between labels and patient identity.~~
4. Labeling:
~~3.~~**a. After the specimen has been collected, place the Cerner generated label on the container and scan the label indicating verification of collection.**
i. Patient collected specimen
~~a.~~**1)** Only specimens collected by a patient may be pre-labeled (i.e. voided urine, sputum).
ii. Specimens collected by a healthcare provider
~~b.~~**1) M**~~m~~ust be labeled after the specimen **is** collected~~ion~~ **and** in the presence of the patient.
2) Place label on the side of container~~.~~**, never on the lid of a specimen collection container**
~~c. Never on the lid of a specimen collection container.~~
~~Never cover the patient's name on a preexisting specimen label with a Cerner label.~~
~~d.~~**iii. If needed, modify the date and time of collection before electronically signing for the collection.**
iv. ~~During downtime or~~ **If the scanner is not working** ~~Pperform athe Ffinal Ccheck~~:
~~e.~~**1) Manually mark the specimen collected in the patients EHR specimen collection as collected.**
~~i.~~**2) Perform a final check** ~~Recheck~~ that the specimen collected from the patient matches the label ID before leaving the patient's room.
~~1) "Say Out Loud" the last three digits of the patient's identification number (Refer to PCS Identification, Patient) from each label and compare it to the patient's arm band (White board in the operating room). Confirm they match.~~
~~4.~~**5.** Place the collected specimen in the designated lab pick up receptacle for your specific unit.
~~5.~~**6.** Notify lab for pick-up of the specimen **as needed**.

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

1. PCS Procedure: Specimen Handling
2. PCS Policy: Identification, Patient
3. General Laboratory QA Manual~~-~~: Procedure for Assuring Correct Specimen Labeling

F. **REFERENCE(S):**

1. South Carolina Hospital Association. (2011). The final check, A toolkit for the prevention of mislabeled blood specimens Retrieved from http://www.thefinalcheck.org.toolkit.
2. College of American Pathologists. (**2020**~~2016~~). All common laboratory accreditation checklist requirement COM.06100 – Primary Specimen Container Labeling.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY

ISSUE DATE:	**08/97**	**SUBJECT:**	**Cash Elective Procedures**
REVISION DATE:	**01/99; 05/03; 01/06; 09/10; 06/14 07/17**	**POLICY NUMBER:**	**8610-263**

Department Approval:	**~~04/17~~04/22**
Administrative Policies and Procedures Committee Approval:	**~~06/17~~04/22**
Finance & Operations Committee Approval:	**~~07/17~~05/22**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. To establish payment guidelines for patients with financial means to pay for their elective services.

B. **DEFINITIONS:**

1. Cash Patient: A patient who is not currently eligible for a federal, state, other government program, who is not currently an eligible subscriber/dependent under an insurance plan, or who has insurance but is seeking to obtain services that are not a covered benefit under their insurance plan.

C. **POLICY:**

1. The ~~Manager of~~ Patient Access **staff** ~~or designee~~ has the responsibility for providing estimates for **hospital** surgical services. ~~The Patient Access Department will notify the Manager of Patient Access or designee on the Cash Payment Discount Policy form that an estimate and financial arrangements are needed.~~
2. At the time the Doctor's office/**patient** calls to schedule a procedure, Scheduling will be responsible for notifying the Doctor's office of the hospital's cash policy.
3. **Pre-Admitting will contact the patient to obtain/verify admission information and explain the payment amount and policies prior to the service date.** ~~Physician and/or patients' questions regarding prices and payment arrangements will be referred to the Pre admitters of the Patient Access Department~~.

~~1. Registration will inform the patient and/or physician of the payment requirements~~

~~2.~~4. If ~~after Pre-Admission Services screening~~ the patient cannot pay, the Patient Access Manager or designee, in consultation with the hospital's Chief **Financial** ~~Executive~~ Officer designee will determine whether the elective procedure should be performed prior to the anticipated service date.

~~3.~~5. The patient is required to sign the Voluntary Waiver and Financial Agreement Form and payment in full will be requested prior to the patient preoperative appointment. If the patient is unable to pay in full, a deposit of 50% of the estimate will be collected. The balance of the account must be settled and paid in full no later than **three**~~six~~ months after the final bill is received. Exceptions to usual deposit requirements and payment plans require approval from the Manager of Patient Access or designee.

~~4.~~1. Registration will inform the patient and/or physician of the payment requirements. If after Pre-Admission Services screening the patient cannot pay, the Patient Access Manager or designee, in consultation with the hospital's Chief Executive Officer designee will determine whether the elective procedure should be performed prior to the anticipated service date.

~~5.~~6. If a case is canceled, it will be the responsibility of the Manager of Patient Access or designee in consultation with the Chief **Financial** ~~Executive~~ Officer or Vice President Designee to inform the physician ~~and Patient Access~~.

~~6.~~**7.** Procedures may be scheduled when:
   a. Patient has signed the Voluntary Waiver and Financial Agreement Form.
   b. Deposit requirement has been paid and payment of balance arranged.
   c. Patient has become eligible for a federal, state or other government-funded program, or is now currently enrolled as covered person under an insurance plan.
   d. With the approval of the Chief **Financial** ~~Executive~~ Officer or Vice President designee.

~~7.~~**8.** Patient Access will be responsible for notifying scheduling that a procedure is canceled so it can be removed from the schedule.

D. **FORM(S):**

1. Voluntary Waiver and Financial Agreement Form

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY
DISTRICT OPERATIONS

ISSUE DATE: 07/91 **SUBJECT: Mandatory Reporting Requirements**

REVISION DATE: 12/91, 11/94, 02/95, 03/96, 04/97, 07/99, 06/02, 05/03, 07/09, 06/11, 03/15, 09/17 **POLICY NUMBER:** 8610-236

Department Approval:	~~04/17~~05/21
Administrative Policies & Procedures Committee Approval:	~~04/17~~08/21
Organizational Compliance Committee Approval:	~~08/17~~06/~~22~~10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

A. **PURPOSE:**

1. To objectively and systematically monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, assure patient safety and resolve identified quality/risk issues on an ongoing basis.

~~1.~~**2.** To identify and prevent injury, actual or potential, harm to a patient or visitor of Tri-City Health Care District (TCHD). Incident reporting enhances the quality of patient care and reduces healthcare and medical liability.

~~2.~~**3.** This policy/procedure consists of the following areas for reporting including but not limited to (see the Reporting Grid and the National Quality Forum List of Serious Reportable Events – 2011 for additional reporting areas):

a. Adverse Events
b. Sentinel Events
c. Serious Reportable Events
d. Unusual Occurrences (Title 22)

~~3.~~**4.** For Violence Against Hospital Personnel – see Administrative Policy: Assault and Battery Reporting Process 241.

B. **DEFINITION(S):**

1. Adverse Events: A patient safety event that results in harm to a patient including surgical events, product or device events, patient protection events, care management events, environmental events, and criminal events.
2. Root Cause Analysis - is a process for identifying basic or causal factor(s) underlying variation in performance, including the occurrence or possible occurrence of a sentinel event.
3. Sentinel Events: **Sentinel events are events that signal the need for immediate investigation and response. A sentinel event is**~~A~~ **a** patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.
4. Serious Reportable Events **(SREs): a set or**~~of~~ **compilation of serious, largely preventable, and harmful clinical events, designed to help the healthcare field assess, measure, and report performance in providing safe care. SREs are developed by the National Quality Forum.**~~: as developed by the National Quality Forum see National Quality Forum List of Serious Reportable Events 2011~~.
5. Unusual Occurrences (Title 22): Any occurrence such as epidemic outbreak, poisoning, fire, major accident, disaster, other catastrophe or unusual occurrence with threatens the welfare,

safety or health of patients, personnel or visitors.

6. Violence Against Hospital Personnel: acts of assault or battery against on-duty hospital personnel.

C. **POLICY:**

1. It is the District's policy to investigate any sentinel event, unusual occurrence, adverse event, or serious reportable even from an interdisciplinary perspective and take action to reduce the risk of recurrence.
   a. Each sentinel event, adverse event, and serious reportable event**s** will be **reviewed to determine if a more** intensively assess**ment review is required**~~ed~~ through the use of the Root Cause Analysis (RCA) process.
   b. Every effort will be made to include the physicians and staff involved in the incident in the RCA process.
   c. A report of each RCA shall be communicated to the Quality Assurance/Performance Improvement **(QA/PI) and** /Patient Safety Committee (~~QA/PI~~/PS) of the Medical Staff, for periodic reporting to the Board of Directors ~~through Professional Affairs Committee (PAC) and Board of Directors meeting~~.
   d. RCAs shall not be reported to ~~the Joint Commission, nor to~~ any external agency or organization, except upon specific, written advice of legal counsel. The investigation and reporting process, including development of the RCA, is intended to remain within the bounds of Attorney-Client and Attorney Work Product privileges.

D. **REPORTING TIMEFRAMES:**

1. The first person to identify an incident will notify his/her supervisor as soon as it is safe to do so.
   a. The supervisor must assure that the incident is reported **to** the ~~Director of~~ Risk Management **Department**, Chief Nurse Executive **(CNE)/ Chief of Patient Care Services (CPCS)**, and ~~the Director of~~ Regulatory Compliance. The CNE/**CPCS** will assure that the event is then reported to the Chief Executive Officer **(CEO)**~~, and Chief Operating Officer (COO)~~ prior to reporting to regulatory agencies.
2. The patient's primary and/or involved physician(s) is notified.
3. Based on the incident, a decision will be made to report to the appropriate regulatory agency within the required timeframe.

E. **COMMUNICATION:**

1. Reported incidents are communicated to the appropriate medical staff Quality Review committees and the Board of Directors.
2. Incidents may be reported in an expedited manner by Administration via verbal or electronic methods.

F. **ATTACHMENT(S):**

1. Reporting Grid
~~2. National Quality Forum List of Serious Reportable Events 2011~~

G. **RELATED DOCUMENTS:**

1. Administrative Policy: Assault and Battery Reporting Process 241

H. **REFERENCES:**

1. National Quality Forum. (2020). Serious reportable events. Retrieved from http://www.qualityforum.org/topics/sres/serious_reportable_events.aspx
2. California Health and Safety Codes https://codes.findlaw.com/ca/health-and-safety-code/unu
3. California Title 22; §72541 Unusual Occurrences,
~~1.~~**4.** CA Health & Safety Code §§ 1279.1, 1279.2, 1279.3, and 1280.4
~~2.~~**5.** California Code of Evidence Section 1157

~~3.~~**6.** California Hospital Association Consent Manual ~~2016~~
~~4.~~**7.** **California Title 17 Code of Regulation $2500 - Reporting to the Local Health Authority**~~Title 17~~
~~5.~~**8.** Title 22, Section 70736

Reporting Grid

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Adverse Drug Reaction (ADR)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Investigational Drug Pharmacists/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	All ADRs must be documented in the research participants medical and research record.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Adverse Event (AE)	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial/Clinical Research Coordinator	Clinical Trial Site/Principal Investigator of Clinical Trial, Sub Investigator of Clinical Trial/Clinical Research Coordinator	Aes are to be captured in the case report forms and as part of the medical records. There are no special reporting requirements for AEs at TCMC.	Policy: Clinical Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Animal Bites		Emergency Department, Business Office	Humane Society	Phone Call	Emergency Dept.
Assault & Battery to On-Duty Health Care Personnel	A.B. #508 CA Penal Code # 240,242	Security Department	Local Law Enforcement Professional & Regulatory Services (P&RS), Employee Health, Dept. of Health	Phone Call within 72 hours of occurrence. Employee Injury Report	Admin. Policy #241
Assault Victims Domestic Violence	CA Penal Code 11160/11161 CCR Title 11, Section 920	Emergency Department, Business Office Registrars, Social Service Department, Nursing Staff, Security, Risk Management	Local Law Enforcement	Phone police immediately and written report - 2 working days	Admin. Policy #310
Cancer/Reportable Neoplasms	Title 17, California Code of Regulations, Section 2593	Oncology Data Registrar	California Department of Public Health (CDPH) Cancer Prevention Section	Within six months of diagnosis	Oncology Registry/CNE
Certification of Birth	Health and Safety Code Section 10101	Birth Certificate Clerk Medical Records Department	San Diego County Registrar	Within 10 days of birth	Medical Records Dept.
(Suspected) Child Abuse	Penal Code: 11164-11174.3	Social Service Department Health Practitioner, Child Care Custodian	Child Protective Services or Local Law Enforcement	Immediately by Phone-And Within 36 Hours in Writing	Admin. Policy #308 Social Service Dept. #308

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Chromosomal Defects in Fetus or Infant	Title 17 CCR 6532	Lab performing the analysis or physician making diagnosis	CDPH	Within 30 days of diagnosis using form provided by CDPH	Women's & Children's Services
(Illegal) Drug Use - non employee	CA Penal Code, Section 11-160	Security Dept.	Oceanside Police	Telephone and written report	Admin. Policy #236
(Suspected) Elder and Dependent Adult Abuse	Penal Code: Section 368 Welfare & Institution Code #15600--15637	Social Service Department Health Practitioner, Care Custodian	Occurring in a LTC Facility report to Long Term Care Ombudsman or Local Law Enforcement; All others to County Adult Protective Services	Telephone Report-Immediately Written Report-Within 2 Working Days	Admin. Policy #309 Social Service Dept. #309
Infectious Diseases (Reportable *) (See Reporting Responsibility Table)	Title 17, Chapter 4, CCR 2500 Health & Safety Code 3125	Nursing Staff Emergency Department, Infection Control Practitioner, Laboratory - Microbiology & Chemistry	Infection Control Practitioner Public Health Department	Phone immediately to Public Health depending on disease. Fax information to Public Health using PM 110.	Infection Control #110
Lapses in Consciousness/Seizures	Health & Safety Code 3125 Section 410 Title 17, CCR 2500	Physician	Local Health Officer who reports to DMV	Fax information to Public Health using PM 110.	Physician Protocol
Mental Health holds beyond 24 hours (ED) (Unusual Occurrence)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Manager Emergency Department	CDPH	Phone after 24 hour mark followed by letter to CDPH	Emergency Dept., Mental Health Unit
Missing Patient		Security Department	Local Law Enforcement Agencies	Telephone immediately within reasonable time frame (given situation)	Admin. Policy #305
Multiple bee stings (Unusual occurrence)	Title 22 CCR 70737	Emergency Department Nursing Staff	County of San Diego, CDPH	Phone call immediately to CDPH written report	Admin. Policy #228
Needle stick Injury/BS Exposure	Fed and Cal OSHA Rec. Blood borne Path.	Supervisor	Employee Health or ED	Immediate Supervisor Investigative Report. Employee Health uses separate injury log for needle sticks.	Employee Health Services/ Infection Control
Neural Tube Defects in a Fetus	Title 17, California Code of Regulations, Section 6531	Medical Records Department	CDPH Alpha-Feto Protein Screening Program	Within 30 days of initial diagnosis	Women's & Children's Services

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Newborn Abandonment: Voluntary surrender (abandonment of newborns up to 72 hours old)	SB 1368	Health Care Practitioner	Child Protective Services	As soon as possible; no later than 48 hours	Admin. Policy #380
Newborn Screening Test refusal (PKU)		Women's & Children's Services Representative	CDPH Genetic Disease Branch	Prior to infant discharge Fill out form #NBS-PR	Women's & Services
Occupational Injuries/Illnesses	Labor Code 3209.3 CCR Title 8 S - 14003	Physician	Employer & Employees Insurer	Written Report within 5 working days	Physician Protocol Employee Health Services
Outbreaks or undue prevalence of infectious or parasitic disorder	Title 17, Chapter 4 CCR 2502	Any healthcare provider (physicians, PA, RN, nurse midwife, or Infection Control Practitioner)	Local Health Officer	Phone, fax or mail information to Public Health using the CMR form found in the IC Manual.	Infection Control #IC.12
Patient Death	Title 22 72549 HSC 10250	Health Care Practitioner; Physician	Medical Examiner CDPH at a time and manner as requested, Pt. Reps – TCMC	Phone immediately Complete form 8720-37	PCS Policy IV.Z, PCS Procedure
Patient death due to unusual circumstances, i.e. suicide	Title 22 Section 70737, 71535	Health Care Practitioner Administration	Local law enforcement officer, medical examiner and CDPH. CMS and regional CDPH	Local law enforcement contacted prior to medical examiner. CDPH as soon as practical confirmed in writing. Incident report on file by facility for 1 year.	Admin Policy #228 PCS Policy IV.Z, PCS Procedure
Patient death while patient in seclusion or restraint for behavior management	42 CFR Section 482.13(f)(f) Reporting is required whether or not R/S was the cause of death Title 22, CCR Section 70737(a) Section 71535	Director of Regulatory Compliance	Centers for Medicare and Medicaid Services (CMS) CDPH	As soon as aware. By telephone: (415) 744-3726 or fax (415) 744-2692	Admin Policy #228 PCS Policy IV.Z, PCS Procedure

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Patient death while in medical surgical restraint	Title 22, CCR, Section 70737(a) Section 71535	Director of Regulatory Compliance	CDPH	As soon as reasonably practical, by phone: (800) 824-0613 Followed by letter: 7575 Metropolitan Drive Suite 104 San Diego, CA 92108	PCS Policy IV.Q
Patient Injury/Death due to Device Malfunction	Safe Medical Device Act 21 CFR 803	Health Practitioner Director of Risk Management	–MFR-Serious Injury FDA&MFR-Death or FDA if MFR is unknown	Within 24 hours via form FDA3500A and phone 301-796-6670. E-mail: MDRPOLICY@FDA.HHS.GOV Annual Summary of Medical Device Related Death and Serious Injury Report to FDA on Form FDA 3419 by January 1st of each year as described in 803.33	Admin. Policy #201
Patient Transfer Violation	(COBRA) Health and Safety Code 1317 through 1317.99 Title 42 U.S.C. Section 139 dd	Director of Regulatory Compliance	CDPH HCFA	7 days 72 hours	Admin. Policies 228, 506; PCS Policy VI.D
Pesticide Poisoning	Title 8 CCR 14003	Emergency Department Health Care Practitioner	Emergency Department Mgr. Local Health Officer Co. Dept. of Agric. Deputy Agricultural Commissioner	Phone call within 24 hours	Emergency Dept.
PKU Specimen not obtained		Unit Representative where infant was a patient	California Department of Public Health Genetic Disease Branch	When patient transferred, expires Fill out form # (BS - No - 90)	Women's & Children's Services
Rhesus Hemolytic (RH) Disease – Newborn	Title 17 CCR Section 6510 Title 22 CCR 70737	Health Care Practitioner	CDPH - Women's & Children's Services Office physician who made diagnosis	Use reporting form "A case report of RH Disease of Newborn"	Women's & Children's Services
Reye Syndrome	HSC Section 304.5	Attending Physician	CDPH	Within 7 days of diagnosis using reporting form "CBC Reye Syndrome..."	Physician Protocol

CIRCUMSTANCE	REGULATION STATUTE	BY WHOM	TO WHOM	WHEN/HOW	TCMC REFERENCE POINT OR PROTOCOL
Serious Adverse Event (SAE) as related to Clinical Research	ICH guidance for Clinical Safety Data Management: Definitions and Standards for Expedited Reporting	Attending Physician/Principal Investigator of Clinical Trial/ Sub Investigator of Clinical Trial	Clinical Trial Site/Principal Investigator/Sub Investigator/Clinical Research Coordinator	Report Immediately to Attending Physician and Clinical Trial Site personnel. All SAEs must be documented in the research participants medical and research record.	**Policy: Clinical** Research Subject Safety & AE/SAE/Incident Reporting Policy; Policy number #010
Threat to kill	Tarasoff	Psychotherapist/Health Care Practitioner	Intended victim and local law enforcement	Immediately by telephone	Behavioral Health Unit, Social Service Dept.
Unusual occurrences that threaten the welfare of the patient, staff or visitors (i.e., allegation of staff sexual misconduct)	Title 22 Section 70737, 71535	Health Care Practitioner Administration Director of Regulatory Compliance	CDPH Local law enforcement as appropriate	As soon as reasonably practical - confirmed in writing Occurrence on file by facility for 1 year	Admin. Policy #228
Adverse effect of a vaccine	National Childhood Vaccine Injury Act	Health Care Provider	VAERS Hotline 800-822-7967	After administration by telephone	Infection Control

National Quality Forum
List of Serious Reportable Events - 2011

1. SURGICAL OR INVASIVE PROCEDURE EVENTS

1A. Surgery or other invasive procedure performed on the wrong site (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1B. Surgery or other invasive procedure performed on the wrong patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1C. Wrong surgical or other invasive procedure performed on a patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1D. Unintended retention of a foreign object in a patient after surgery or other invasive procedure (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

1E. Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

2. PRODUCT OR DEVICE EVENTS

2A. Patient death or injury associated with the use of contaminated drugs, devices, or biologics provided by the healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2B. Patient death or injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

2C. Patient death or injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

3. PATIENT PROTECTION EVENTS

3A. Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3B. Patient death or injury associated with patient elopement (disappearance) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

3C. Patient suicide, attempted suicide, or self-harm that results in injury, while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4. CARE MANAGEMENT EVENTS

4A. Patient death or injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration) (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4B. Patient death or injury associated with unsafe administration of blood products (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4C. Maternal death or injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers

4D. Death or injury of a neonate associated with labor or delivery in a low-risk pregnancy (new)
Applicable in: hospitals, outpatient/office-based surgery centers

4E. Patient death or injury associated with a fall while being cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4F. Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, long-term care/skilled nursing facilities

4G. Artificial insemination with the wrong donor sperm or wrong egg (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

4H. Patient death or injury resulting from the irretrievable loss of an irreplaceable biological specimen (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

4I. Patient death or injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5. ENVIRONMENTAL EVENTS

5A. Patient or staff death or injury associated with an electric shock in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5B. Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5C. Patient or staff death or injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

5D. Patient death or injury associated with the use of physical restraints or bedrails while being

cared for in a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

6. RADIOLOGIC EVENTS

6A. Death or injury of a patient or staff associated with the introduction of a metallic object into the MRI area (new)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices

7. POTENTIAL CRIMINAL EVENTS

7A. Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7B. Abduction of a patient/resident of any age (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7C. Sexual abuse/assault on a patient or staff member within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

7D. Death or injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting (updated)
Applicable in: hospitals, outpatient/office-based surgery centers, ambulatory practice settings/office-based practices, long-term care/skilled nursing facilities

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
DISTRICT OPERATIONS

ISSUE DATE:	**1996**	**SUBJECT:**	**Purchase of Budgeted Capital Assets**
REVISION DATE:	**06/00, 05/03, 06/06, 08/06, 05/09, 05/12**	**POLICY NUMBER:**	**8610-252**

Administrative Content Expert~~Department Approval~~:	**~~02/17~~07/22**
Administrative Policies & Procedures Committee Approval:	**~~02/17~~08/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
~~Finance & Operations Committee Approval:~~	**~~05/17~~**
Board of Directors Approval:	**05/17**

A. **PURPOSE:**
1. To establish the capital thresholds and authorization process to purchase capital assets at Tri-City Healthcare District (TCHD).

B. **SCOPE OF THE POLICY:**
1. All TCHD departments.

C. **DEFINITION(S):**
1. Capital Asset – A tangible item, project or software, that is purchased, designed or constructed, for a total cost of $5,000 or greater, or a group of like items with a total cost of $10,000 or greater, and with a useful life of three years or greater.
2. Budgeted Capital Asset - Capital asset that has been approved by the TCHD Board of Directors during the District's annual budgetary cycle or during special presentation to the Board of Directors.

D. **POLICY:**
1. The purchase of a capital asset will be initiated by the requesting department's Director. That Director is responsible for identifying the requirements and specifications needed to purchase a capital asset. Such requirements may include but are not limited to obtaining a quote for the specific asset and completing a capital request form.
2. The requesting Director will communicate with Supply Chain Management to confirm current capital request procedures. All capital requests must be submitted to the Director of Supply Chain who will present the request to the Capital Committee for initial approval. The final approval level will be determined as outlined per TCMC Policy 8610-232, Signature Authority.

E. **FORM(S):**
1. Capital Purchase Requisition Form - Sample

F. **RELATED DOCUMENT(S):**
1. Administrative Policy: Signature Authority 232
2. Board of Directors Policy: Budget for Medical Equipment or Medical Services for Tri-City Healthcare District 14-001

Capital Purchase Requisition Sample

Tri-City Medical Center
4002 VISTA WAY | OCEANSIDE, CA | 92056

CAPITAL PURCHASE REQUISITION

FUNDING SOURCE: ☐CAPITAL BUDGET ☐FOUNDATION ☐ AUXILIARY ☐OTHER

ITEM IS: ☐A REPLACEMENT OF AN EXISTING ASSET* ☐A NEW ASSET

*FORM #8402-1014 – EQUIPMENT DISPOSITION REQUISITION MUST ACCOMPANY THIS REQUISITION IF THIS ITEM IS REPLACING AN EXISTING ASSET

DEPARTMENT NAME	DEPARTMENT NO.	REQUESTED BY	EXT.

DATE OF REQUEST	DATE REQUIRED	VENDOR

ALL CAPITAL PURCHASE REQUISITIONS MUST INCLUDE A COMPLETED CAPITAL EQUIPMENT REQUEST ATTACHMENT A

QUANTITY	CATALOG NUMBER	ITEM DESCRIPTION	UNIT COST	EXTENDED COST

ADDITIONAL COMMENTS:		
	SUB-TOTAL	
	SALES TAX	
	FREIGHT	
	TOTAL	

SOURCE OF ADDITIONAL FUNDS:
TRANSFER FROM BUDGET NUMBERS (S): _____ / _____

☐ LEASE PURCHASE
☐ CASH PURCHASE

SUPPLY CHAIN USE ONLY

DIRECTOR, REQUESTING DEPARTMENT	CHIEF NURSING OFFICER	DIRECTOR, SUPPLY CHAIN MANAGEMENT
DIRECTOR, INFORMATION TECHNOLOGY	CHIEF FINANCIAL OFFICER	BUDGET #
DIRECTOR, FACILITIES	CHIEF OPERATING OFFICER	PURCHASE ORDER NUMBER
CHIEF MARKETING OFFICER	CHIEF EXECUTIVE OFFICER	ORDER DATE

8402-1002 (REV. 02/17)

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: NEW **SUBJECT: Self-Pay & Collections Policy**

REVISION DATE: **POLICY NUMBER:**

Administrative Content Expert Approval:	**11/22**
Administrative Policies & Procedures Committee Approval:	**11/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. To provide an overview of the process in which Tri City Medical Center follows for assigning self-pay and balance after insurance accounts to a third-party collection agency.

B. **DEFINITION(S):**
1. Charity Care – The portion of the hospital stay in which a third-party payer is not responsible and the patient does not have means to pay and for which the hospital does not have payment expectation.
2. Self-Pay Patient – A patient who meets the following criteria:
   a. No Medi-Cal eligibility
   b. No third-party insurance
   c. No compensable injury (i.e.: Workers Compensation, auto insurance)
   d. A patient who **chooses to pay for their treatment** directly rather than using private health insurance
3. Uninsured Patient - Patient who is not currently eligible for a federal, state, other government program or who is not currently an eligible subscriber/dependent under an insurance plan

C. **SELF PAY PROCESS:**
1. Patient balance after insurance:
   a. The encounter is sent to a first party self-pay outsourcing vendor which is an extension of the hospitals business office to pursue the balance due by the patient.
   b. The first party self-pay outsourcing vendor contacts the patient through a series of letters and phone calls spanning 120 days.
      i. Day 2 – Notice 1 mailed to the patient
      ii. Day 35 – Notice 2 mailed to the patient
      iii. Day 92 – Notice 3 Final "Goodbye" Letter and Financial Assistance Application mailed to the patient
   c. After 120 days the balance is then assigned to a collection agency for additional collection measures. Exceptions include:
      i. Patient has a payment arrangement in good standing
      ii. Patient has provided documentation the balance was included in a bankruptcy
      iii. Patient has a charity application under review
      iv. Patient has applied for financial assistance and a determination not yet made
      v. The account balance is below a threshold set by the hospital that balances must reach/exceed to be assigned to collections

vi. Med-Cal Managed Care, Medicare or Medi-Cal is responsible for any portion of the balance outstanding
vii. Statute of Limitations exceeded (based on the guarantor's state of residence)

d. Interest free extended payment plans will be made available to patients that qualify. Payment terms are agreed upon between the hospital and the patient based on the patient's ability to pay the agreed upon amount monthly.

2. Self-Pay (Uninsured) Patients:
   a. Financial counseling services are provided to uninsured and underinsured patients which include but are not limited to:
      i. Applying for state and Federal Health Care Programs
      ii. Identify if coverage is available under the ACA (Affordable Care Act)
      iii. Inform the patient of Financial Assistance Programs available at the facility and assist in completing the application
   b. If the patient remains uninsured/under-insured after this process the encounter is sent to first party self-pay outsourcing vendor which is an extension of the hospitals business office to pursue the balance due by the patient.
   c. The first party self-pay outsourcing vendor contacts the patient through a series of letters and phone calls spanning 120 days.
      i. Day 2 – Notice 1 mailed to the patient
      ii. Day 35 – Notice 2 mailed to the patient
      iii. Day 92 – Notice 3 Final "Goodbye" Letter and Financial Assistance Application mailed to the patient
   d. After 120 days the balance is then assigned to a collection agency for additional collection measures. Exceptions include:
      i. Patient has a payment arrangement in good standing
      ii. Patient has provided documentation the balance was included in a bankruptcy
      iii. Patient has a charity application under review
      iv. Patient has applied for financial assistance and a determination not yet made
      v. The account balance is below a threshold set by the client that balances must reach/exceed to be assigned to collections
      vi. Medi-Cal Managed Care, Medicare or Medicaid is responsible for any portion of the balance outstanding
      vii. Statute of Limitations exceeded (based on the guarantor's state of residence)
   e. Interest free extended payment plans will be made available to patients that qualify. Payment terms are agreed upon between the facility and the patient based on the patient's ability to pay the agreed upon amount monthly.

D. **PROGRAMS AVAILABLE TO UNINSURED, UNDER-INSURED OR THOSE CHOOSING NOT TO USE THEIR INSURANCE:**

1. Tri City Medical Center offers a variety of programs to patients for meeting their financial obligations, included are:
   a. Self-Pay Discount Program (uninsured or those not using their insurance ONLY)
   b. Financial Assistance
   c. Charity to those eligible based on income

E. **COLLECTIONS PROCESS:**

1. Eligibility:
   a. Account has completed the patient billing cycle without resolution
   b. Final "Goodbye" letter was sent to the patient informing them that a payment remains due
   c. Account exceeds the amount set-forth in the facilities policy outlining collection threshold eligibility (=/> $25)
2. Balance after Insurance / Self-pay (Uninsured) Patients:
   a. Accounts are assigned weekly to collections through a systematic process performed by first party self-pay outsourcing vendor

i. This information is transmitted electronically in accordance with both client and regulatory requirements

b. Accounts are split between 2 collection agencies based upon a predefined alpha-split
   i. California Business Bureau, Inc. (CBB)
   ii. CMRE Financial Inc.

c. The collection agency will have access to the supporting documentation to validate the debt owed by the guarantor or the estate thereof should the guarantor be deceased

d. Collections are pursued in a consistent manner based upon hospital procedure and applicable law including Federal Fair Debt Collection Practices Act, Rosenthal Fair Debt Collection Practices Act, and other state and federal financial assistance laws

e. Accounts assigned to collections may be recalled and returned to Tri City Medical Center at the discretion of the hospital and/or state or federal laws and regulations.

f. Accounts that have "Returned Mail" on file are eligible for collections assignment only after reasonable efforts have been made and are exhausted. Reasonable efforts include:
   i. Skip tracing
   ii. Contacting the Guarantor via telephone

F. **REFERENCE(S):**

1. Affordable Care Act (ACA)
2. Federal Fair Debt Collection Practices Act
3. Rosenthal Fair Debt Collection Practices Act

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
COMPLIANCE~~DISTRICT OPERATIONS~~

ISSUE DATE:	**02/99**	**SUBJECT:**	**Advanced Beneficiary Notice**
REVISION DATE:	**11/02; 12/02, 12/03, 10/05, 11/08 02/11; 10/13, 09/17**	**POLICY NUMBER:**	**8610-503**

Administrative Content Expert~~Department~~ Approval:	**~~03/17~~011/21**
Administrative Policies & Procedures Committee Approval:	**~~04/17~~12/21**
Organization Compliance Committee Approval:	**~~08/1706/22~~10/22**
~~Medical Executive Committee Approval:~~	**~~n/a~~**
Audit, Compliance and Ethics Committee Approval:	**09/17**
Board of Directors Approval:	**09/17**

A. **PURPOSE:**

1. To insure an Advance Beneficiary Notice (ABN) is obtained from Medicare beneficiaries when Tri-City Healthcare District (TCHD) wishes to bill for outpatient tests and services that may not be covered by CMS.
2. TCHD will conduct patient care and all other business operations in a legal and ethical manner. Employees are expected to observe federal, state and local laws. TCHD will not tolerate fraud, waste and/or abuse in any manner, and employees are expected to adhere to all guidelines and regulations governing Medicare and other Federal and State funded healthcare programs.

B. **OVERVIEW:**

1. Effective departments include: Admitting Services (Scheduling and Registration), Compliance, Case Management, Medical Staff, Physician Office Staff, Laboratory, Patient Accounts, Ancillary Departments.
2. Advance Beneficiary Notice (ABN): An ABN is a written notice given to a Medicare Beneficiary before Part B services are furnished when TCHD believes that Medicare will not pay for some or all of the services on the basis that they are not reasonable and necessary (i.e., under §1862(a)(1) of the Act) and TCHD wishes to bill the patient for the provided services. The ABN gives the beneficiary an idea of why TCHD is predicting the Medicare denial. The information in the ABN will assist the beneficiary in making an informed decision whether or not to receive the service and be financially responsible for the payment.
3. If TCHD expects payment for the services to be denied by Medicare, TCHD employees will advise the beneficiary before services are furnished that, in our opinion, the beneficiary will be personally and fully responsible for the payment.
4. "Personally and fully responsible for payment": This means that the beneficiary will be liable to make payment "out-of-pocket," through other insurance coverage (e.g., employer group health plan coverage), or through Medicaid or other federal or non-federal payment source. TCHD must issue notices each time, and as soon as, we believe Medicare payment will be denied due to a medical necessity reason. TCHD is not required to give ABN's to beneficiaries for items or tests that are statutorily excluded from Medicare payment, such as oral medications or routine screening tests, which fall under the routine physical exclusion (i.e., under §1862(a)(7) of the act.) If TCHD does not provide a proper ABN in situations where one is required, TCHD will be held liable for the loss of payment if Medicare denies the claim.
   a. Notation: An ABN must be obtained for initial standing orders (for extended course of treatment) that contain tests that may be covered. However, it is not necessary to obtain a new ABN each time the test is performed in accordance with the standing order.

b. Routine use of the ABN is prohibited. There must be a specific reason to believe Medicare will determine that the test ordered may not be considered reasonable and necessary.

5. An ABN must be obtained when one or more of the following circumstances exist when TCHD wishes to bill the patient for the provided services:
   a. The test for a routine exam or screening not covered by Medicare.
   b. The test in for investigative or research use only.
   c. The diagnosis provided may not or does not meet medical necessity requirements.
   d. No diagnosis provided.
   e. The test may only be paid for a limited number of times within a specified time period and this visit may exceed that limit.
   f. The test has not been approved by the Food and Drug Administration.
   g. For those services which Medicare excludes from coverage under Part A or Part B (e.g., tests associated with routine checkups, glasses, hearing aids, routine foot care, personal comfort items, etc.) an ABN may be obtained noting the appropriate reason of non-coverage.
   h. Patients must be notified well enough in advance of receiving a medical service so the patient can make a rational, informed decision.
6. The ABN will clearly identify the following:
   a. Description of service(s) that may be denied, including procedure name, price, and CPT/HCPC code if available
   b. Reason why the service may be denied
   c. Patient's name
   d. Patient's Medicare number
   e. Patient's or guarantor's signature and date
   f. Witness signature and date

C. **DEMAND BILL:**

1. A claim must always be sent for an initial determination on the basis of the likelihood of denial of payment for a service as "not reasonable and necessary" under Medicare standards. Enter an occurrence code 32 on the UB-04 in one of the fields numbered 32 through 35. It is the occurrence code that indicates that an ABN has been issued. A condition code of 20 must be entered in one of the fields numbered 24 through 30 to indicate TCHD felt the services would probably be non-covered or denied by Medicare.

D. **PROCEDURE:**

1. Employees entering the computerized order for outpatient tests and performing registration must review the physician's diagnosis, when processing every outpatient Medicare order.
2. If the patient presents with a completed ABN from the physician's office, proceed with performing the ordered tests. A copy of the ABN must be made and kept with the patient's order
3. If the patient presents with no ABN and the diagnosis provided does not meet Medical Necessity Guidelines for the test(s) being ordered, registration staff must complete an ABN.
4. Instruct the patient on the purpose of the form and ask patient or guardian to sign one of two options: 1) agree to pay for service(s), which may be denied, and therefore obtain the service(s), or (2) deny responsibility and do not obtain the service(s). If the patient or guardian wishes to discuss the situation with their physician or a nurse, the registration employee will either contact the physician or a nurse in a timely manner to discuss the situation so the beneficiary may make an informed decision.
5. In the case in which the Beneficiary demands the service(s) and refuses to pay or sign the ABN form, then a second employee witness should sign the ABN form and a note should be made that the beneficiary refused to sign. In this case the services may be provided and if Medicare payment is denied, the beneficiary will be responsible for payment.
6. If the patient denies payment responsibilities and declines the test(s), then perform only those tests that meet the Medical Necessity Guidelines. It is the patient's responsibility to inform the

ordering physician that services were not performed. If the patient agrees to pay for the service(s) then perform all tests ordered.

7. The signed ABN form should be distributed as follows: give the back copy to the patient, retain the middle copy at physician's office or registration office, and file the original copy with the physician's order.

E. **REFERENCES:**

1. Medicare Carrier's Manual 7300.5, Part III (HCFA Publication 14-3) 3730
2. CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

F. **ATTACHMENT(S):**

1. Advanced Beneficiary Notice English– Sample
2. Advanced Beneficiary Notice Spanish- Sample

TCHD Advanced Beneficiary Notice English- Sample

(A) Notifier:
(B) Patient Name: **(C) Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Form CMS-R-131 (03/11) Form Approved OMB No. 0938-0566

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

9560-1021
(Rev. 12/11)

ADVANCE BENEFICIARY NOTICE
OF NON COVERAGE

Affix Patient Label

TCHD Advanced Beneficiary Notice Spanish - Sample

A. Notificante:
B. Nombre del paciente: **C. Número de identificación:**

Notificación previa de NO-cobertura al beneficiario (ABN)

NOTA: Si Medicare no paga **D.** _____ a continuación, usted deberá pagar.
Medicare no paga todo, incluso ciertos servicios que, según usted o su médico, están justificados.
Prevemos que Medicare no pagará **D.** _____ a continuación.

D.	E. Razón por la que no está cubierto por Medicare:	F. Costo estimado:

Lo que usted necesita hacer ahora:

- Lea la presente notificación, de manera que pueda tomar una decisión fundamentada sobre la atención que recibe.
- Háganos toda pregunta que pueda tener después de que termine de leer.
- Escoja una opción a continuación sobre si desea recibir **D.** _____ mencionado anteriormente.

Nota: Si escoge la opción 1 ó 2, podemos ayudarlo a usar cualquier otro seguro que tal vez tenga, pero Medicare no puede exigirnos que lo hagamos.

G. Opciones: Sírvase marcar un recuadro solamente. No podemos escoger un recuadro por usted.

❑ **OPCIÓN 1.** Quiero **D.** _____ mencionado anteriormente. Puede cobrarme ahora, pero también deseo que se cobre a Medicare a fin de que se expida una decisión oficial sobre el pago, la cual se me enviará en el Resumen de Medicare (MSN). Entiendo que si Medicare no paga, soy responsable por el pago, pero **puedo apelar a Medicare** según las instrucciones en el MSN. Si Medicare paga, se me reembolsarán los pagos que he realizado, menos los copagos o deducibles.
❑ **OPCIÓN 2.** Quiero **D.** _____ mencionado anteriormente, pero que no se cobre a Medicare. Puede solicitar que se le pague ahora dado que soy responsable por el pago.
No tengo derecho a apelar si no se le cobra a Medicare.
❑ **OPCIÓN 3.** No quiero **D.** _____ mencionado anteriormente. Entiendo que con esta opción no soy responsable por el pago y **no puedo apelar para determinar si pagaría Medicare.**

H. Información adicional:

En esta notificación se da a conocer nuestra opinión, no la de Medicare. Si tiene otras preguntas sobre la presente notificación o el cobro a Medicare, llame al **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).
Al firmar abajo usted indica que ha recibido y comprende la presente notificación. También se le entrega una copia.

I. Firma:	J. Fecha:

Formulario CMS-R-131 (03/11) Formulario aprobado OMB № 0938-0566

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

8560-1022
(Rev. 12/11)

ADVANCE BENEFICIARY NOTICE OF NON COVERAGE (SPANISH)

Affix Patient Label

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 05/12 **SUBJECT: Compliance Program Overview**

REVISION DATE~~(S)~~: 12/12, 12/15, 02/19 **POLICY NUMBER:** 8750-532

Administrative Compliance Content Expert Approval:	~~12/18~~11/21
Administrative Policies & Procedures Committee Approval:	~~12/18~~12/21
Organizational Compliance Committee Approval:	~~06/22~~10/22
Medical Executive Committee Approval:	n/a
Audit, Compliance & Ethics Committee Approval:	02/19
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. To provide an overview of Tri-City Healthcare District's (TCHD) Healthcare Compliance Program (Compliance Program) and the scope and objectives of the Compliance Program. ~~As set forth below, the~~**The** Compliance Program is comprised of TCHD's Code of Conduct, General Compliance Policies ("General Policies"), and Specific Compliance Policies (Specific Policies) **and applies to all Workforce Members**. The General and Specific Policies are referred to collectively as the "**Compliance** Policies").
2. **TCHD's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other governmental rules control the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.**
~~1.~~3. **TCHD's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. TCHD's Compliance Policies provide more detailed guidance regarding ethical and appropriate conduct, and are intended to be consistent with the general principles established in the Code of Conduct.**

B. **DEFINITION(S):**

1. Workforce Member: Employees, Medical Staff, ~~and~~ Allied Health Professionals, volunteers, trainees, **Business Visitors, Covered Contractors** and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.

~~C. INTRODUCTION:~~

~~1. As set forth in the Code of Conduct, TCHD's mission is to advance the health and wellness of those TCHD serves. An integral component of this mission is TCHD's unequivocal commitment to operating in compliance with applicable federal and state laws and regulations and to demonstrate good corporate citizenship. Both to reflect and achieve this commitment, TCHD has developed and implemented a formal Compliance Program, as described in this Policy.~~

~~2. TCHD's Compliance Program supplements laws, regulations and other governmental rules. As a general matter, laws, regulations, and other governmental rules control the standards set forth in the Compliance Program unless the Compliance Program imposes stricter requirements than these authorities.~~

~~3. TCHD's Code of Conduct provides ethical and compliance guidance on a broad range of conduct. TCHD's Compliance Policies provide more detailed guidance regarding ethical and appropriate conduct, and are intended to be consistent with the general principles~~

~~established in the Code of Conduct.~~

~~D. SCOPE:~~

~~1. Unless otherwise limited, the Compliance Program applies to all workforce members.~~

~~E.~~**C. OBJECTIVES:**

1. The primary objective of TCHD's Compliance Program is to promote ethical and lawful conduct and to ensure compliance with both the letter and the spirit of applicable healthcare laws and regulations. TCHD's Compliance Program is modeled after the voluntary "Compliance Program Guidance for Hospitals," initially published by the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) in February 1998, and supplemented in the "OIG Supplemental Compliance Program Guidance for Hospitals" published in January 2005.
2. TCHD's Compliance Program includes the following seven elements identified by the OIG as fundamental to an effective compliance program:
   a. Implement written policies and standards of conduct;
   b. Designate a Compliance Officer and establish an Internal Compliance Committee;
   c. Conduct effective training and education regarding policies, procedures and practices;
   d. Develop effective lines of communication regarding compliance concerns;
   e. Enforce policies and standards through well-publicized disciplinary guidelines;
   f. Conduct internal monitoring and audits; and
   g. Respond promptly to detected compliance irregularities and implementing appropriate corrective action.
3. A second, but equally important, objective is to ensure maintenance and enforcement of high standards of individual and organizational ethical and legal business practices throughout TCHD. The Compliance Program facilitates TCHD's ability to carry out its health care mission in a manner consistent with its values, principles and mission.

~~F.~~**D. COMPLIANCE PROGRAM COMPONENTS:**

1. Code of Conduct: TCHD has adopted a written Code of Conduct to govern all of TCHD's interactions including interactions with patients, their families, and providers of care, vendors, federal, state and local regulators, payors and the public in general. The Code of Conduct is a critical part of and is incorporated by reference into the Compliance Program.
2. Policies:
   a. TCHD has General and Specific Compliance Program policies. General policies address the fundamental requirements of an effective Compliance Program. Specific policies provide more detailed guidance on compliance with applicable federal and state laws and regulations.
   b. General policies include the following:
      i. Administrative Compliance Policy: Compliance Program Overview 8750-532;
      ii. Administrative Compliance Policy: Compliance Officer 8750-535;
      iii. Administrative Human Resources Policy: Hiring and Employment -8750-544;
      iv. Administrative Human Resources Policy: Compliance Training Program 8750-547;
      v. Administrative Human Resources Policy: Education and Training; Specific Training Programs 8750-548
      vi. Administrative Compliance Policy: Monitoring Compliance/Auditing and Reporting; Introduction; General Policies 8750-551;
      vii. Administrative Compliance Policy: **Responding to Reports of Suspected**
      ~~vii.~~**viii. Non-Compliance and Misconduct; Investigation; Confidentiality**
      ~~Communicating and Reporting Compliance Concerns 8750-557;~~**8750-561 and**
      ~~viii.~~**ix.** ~~Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality 8750-559; and~~
      i. Administrative Compliance Policy: Development and Revision of Code of

Conduct and Policies 8750-564.

c. Specific policies include, but are not limited to the following:
   i. Administrative Compliance Policy: Physician Recruiting Arrangements 8750-579;
   ii. Administrative Human Resources Policy: Conflicts of Interest and Acceptance of gifts 8610-483; **and**
   iii. Administrative District Operations Policy: Hospital Records -Retention -8610-237~~; and~~.

3. Resolution of Conflicts:
   a. Some of the policies that make up TCHD's Compliance Program summarize various government laws, regulations and guidelines. Such policies should not be read or used as substitutes for the actual laws or regulations to which they relate. In other words, TCHD's policies may supplement, and clarify, applicable laws and regulations.
   b. In the event of an inconsistency between any policy in the Compliance Program and applicable laws or regulations:
      i. Follow the applicable law or regulation unless TCHD's policy imposes stricter requirements and
      ii. Report the inconsistency to the **Chief** Compliance **and Privacy Officer or designee.** ~~Officer.~~
   c. If **W**~~w~~orkforce **M**~~m~~embers are unsure as to the appropriate standard, they should not guess. Ask a supervisor or the Chief Compliance **and Privacy** Officer **or designee**~~.~~

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

1. Code of Conduct
2. Administrative Compliance Policy: Compliance Program Overview 8750-532
3. Administrative Compliance Policy: Compliance Officer 8750-535
4. Administrative Compliance Policy: Hiring and Employment, Duty to Report Suspected Misconduct/Potential Compliance Irregularity 8750-544
5. Administrative Compliance Policy: Education and Training; General Annual Compliance Training Program 8750-547
6. Administrative Compliance Policy: Education and Training; Specific Training Programs 8750-548
7. Administrative Compliance Policy: Monitoring Compliance/Auditing and Reporting; Introduction; General Policies 8750-551
8. Administrative Compliance Policy: **Responding to Reports of Suspected Non-Compliance and Misconduct; Investigation; Confidentiality 8750-561**~~Communicating and Reporting Compliance Concerns (Values Line) 8750-557~~
9. ~~Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality 8750-559~~
10. Administrative Compliance Policy: Physician Recruiting Agreements 8750-579
11. Administrative Human Resources Policy: Conflicts of Interest and Acceptance of Gifts 8610-483
12. Administrative District Operations Policy: Hospital Records Retention 8610-237
13. Administrative Compliance Policy: Development and Revision of Code of Conduct and Policies 8750-564

~~H.~~F. REFERENCES:

1. Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.
2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
COMPLIANCE

ISSUE DATE: 12/02

SUBJECT: Disclosure of Protected Health Information (PHI)

REVISION DATE~~(S)~~: 02/03, 09/05, 12/10, 02/19

POLICY NUMBER: 8610-513

Administrative Compliance Content Expert Approval:	~~10/18~~11/21
Administrative Policies & Procedures Committee Approval:	~~12/18~~12/21
Organizational Compliance Committee Approval:	~~12/1806/22~~10/22
Medical Executive Committee Approval:	01/19
Audit, Compliance & Ethics Committee:	02/19
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. To establish guidelines at Tri-City Healthcare District (TCHD) for the release of protected health information ("PHI") for uses and disclosures that require a patient have an opportunity to agree or to object. This policy addresses the following categories of uses and disclosures of PHI:
    a. Facility Directory
    b. Emergency Circumstances
    c. Disclosure to Family/Others Involved in Care
        i. With patient present
        ii. When patient is not present

B. **POLICY:**

1. Disclosures of PHI should be limited to the minimum necessary as indicated by the patient authorizing release to achieve the purpose of the disclosure. TCHD personnel may exercise professional judgment in determining minimum necessary information to achieve purpose of disclosure when a disclosure may avert a serious threat to health or safety.
2. Categories for the release of PHI are as follows:
    a. Use and disclosure for Facility Directory. Permitted uses and disclosure. Except for patients with behavioral health Issues whose information is never listed in the directory and when an objection is expressed, TCHD may use the following PHI to maintain a directory of patients in its facility:
        i. Patient's name
        ii. Patient's location in TCHD
        iii. Patient's condition (described in general terms that does not communicate specific medical information about the patient)
            1) Undetermined. Patient is awaiting physician assessment.
            2) Good. Vital signs stable, within normal limits. Patient is conscious, comfortable. Indicators are excellent.
            3) Fair. Vital signs stable, within limits. Patient is conscious, may be uncomfortable. Indicators are favorable.
            4) Serious. Vital signs may be unstable, not within normal limits. Patient acutely ill. Indicators questionable.
            5) Critical. Vital signs unstable, not within normal limits. Patient may be unconscious. Indicators are unfavorable.
            6) Deceased. No other information may be released by TCHD.
        iv. Patient's religious affiliation
    b. Directory information can be disclosed to:
        i. Members of the clergy
        ii. Other persons who ask for the patient by name (the patient's religious affiliation

shall not be disclosed to such persons).

c. Patient's opportunity to object: TCHD must inform a patient of the PHI that it may include in a directory and the persons to whom it may disclose such information (including disclosures to clergy of information regarding religious affiliation) and provide the patient with the opportunity to restrict or prohibit some or all of the uses or disclosures.

d. Circumstances not requiring patient consent: If the patient's opportunity to object to uses or disclosures cannot practicably be provided because of the patient's incapacity or an emergency treatment circumstance, TCHD may use or disclose some or all of the PHI permitted under this section for TCHD's directory, if such disclosure is:
   i. Consistent with a prior expressed preference of the patient, if any is known to the covered health care provider
   ii. In the patient's best interest as determined by the treating healthcare professional, in the exercise of their professional judgment.
   iii. TCHD must inform the patient and provide an opportunity for the patient to object to uses or disclosures for directory purposes when it becomes practicable to do so.

e. Use and Disclosure to Family/Others involved in Patient's care: TCHD may disclose to a family member, other relative, or a close personal friend of the patient, or any other person identified by the patient, the PHI directly relevant to such person's involvement with the patient's care.
   i. TCHD may use or disclose PHI to notify, or assist in the notification of (including identifying or locating) a family member, a personal representative of the patient, or another person responsible for the care of the patient. Information may include:
      1) Patient's location at TCHD
      2) General condition
      3) Death
   ii. See Patient Care Services Policy: Privacy Code for additional information.

f. Use and Disclosure with the Patient present: If the patient is present for, or otherwise available prior to, use or disclosure and has the capacity to make health care decisions, TCHD may use or disclose the PHI if it:
   i. Obtains the Patient's ~~agreement; (per Patient Care Services Policy: Privacy Code)~~**consent**
   ii. Provides the patient with the opportunity to object to the disclosure, and the patient does not express an objection; or
   iii. Is in the patient's best interest as determined by the treating healthcare professional, in the exercise of their professional judgment.

g. Use and Disclosure when the Patient is not present: If the patient is not present for, or the opportunity to agree or object to the use and disclosure cannot practicably be provided because of the patient's incapacity or an emergency circumstance, the treating healthcare professional may, in the exercise of their professional judgment, determine whether the disclosure is in the best interests of the patient and, if so, disclose only the PHI that is directly relevant to the person's involvement with the patient's health care. TCHD may use professional judgment and its experience with common practice to make reasonable inferences of the Patient's best interest in allowing a person to act on behalf of the patient to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI.

h. Use and Disclosure for Disaster Relief Purposes: ~~See TCHD Disaster Manual for information regarding disclosure of PHI for disaster relief purposes.~~**Follow state and federal guidelines.**

C. **RESPONSIBILITIES:**

1. All personnel providing services on behalf of TCHD to include but not limited to, employees, volunteers, physicians, Allied Health Professionals, students and affiliated business associates are responsible for awareness of this policy and for protecting patient health information from

unauthorized release. The protection of health information and appropriate release of information is a shared responsibility of all personnel to safeguard the information against loss, tampering, access, or use by unauthorized persons.

D. **INFORMATION/DISCLOSURE:**

1. TCHD may orally inform the patient of and obtain the patient's oral agreement or objection to a use or disclosure.
2. TCHD must obtain permission from the parent or guardian for patients who are minors (under 18 years of age) except in the following circumstances:
   a. Emancipated minors (in addition to other specified categories of minors), as specified by law, may inspect or request copies of part or all of their health record.
   b. Pregnancy
   c. Drug abuse
   d. Mental health
   e. Reportable disease
   f. Rape
   g. Sexual assault
3. Patient's agreement or objection will be noted in the registration system. In the event patient objects to the use and disclosure of PHI the information will not be used or disclosed.

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

1. Administrative Human Resources Policy: Confidentiality 8610-455
2. Administrative Human Resources Policy: Coaching and Counseling for Work Performance Improvement 8610-424
3. Administrative Human Resources Policy: Social Media 8610-479
4. Administrative Compliance Policy: Minimum Necessary Requirements for Use and Disclosure of PHI 8610-594
5. Patient Care Services Policy: Privacy Code

F. **REFERENCE(S):**

1. Guidance and complete information beyond the scope of this policy for release of information will be obtained from the California Hospital Association Consent Manual, Federal Register (79 FR 784) and Code of Federal Regulations (45 CFR 164)

Tri-City Health Care District
Oceanside, California

Administrative Policy Manual
Compliance

ISSUE DATE: 7/00 **SUBJECT: Disposal of Confidential Records**

REVISION DATE: 12/05; 02/09 **POLICY NUMBER:** 8610-510

Department Review:	**06/21**
Administrative Policies & Procedures Committee Approval:	**~~05/15~~08/21**
Organizational Compliance Committee Approval:	**06/22**
Audit and Compliance Committee Approval:	**06/15**
Board of Directors Approval:	**06/15**

A. **PURPOSE:**

1. The purpose of this Policy is to establish guidelines for the destruction and disposal of Confidential Records (including those containing Protected Health Information) in accordance with state laws and HIPAA when, and to the extent that, such Confidential Records are otherwise permitted to be destroyed and disposed of under **Tri-City Healthcare District** (TCHD)'s Records Retention and Destruction Policy.

B. **DEFINITION:**

1. Confidential Records: for purposes of this Policy, patient medical records and other documents and records, regardless of form, containing PHI, and other personal information that could identify a patient (including records, documents, and tangible items that contain names, social security numbers, contact information, insurance policy information, etc.) and employment records.
2. Disclosure: the release, transfer, provision of, access to or divulging of PHI outside TCHD.
3. Electronic Media: the electronic storage media on which date is or may be recorded electronically including devices in computers (hard drives) and any removable or transportable digital memory medium, such as magnetic tape or disk, optical disk, flash drive, portable device, digital memory card and transmission media used to exchange information already in electronic storage media (such as internet, extranet, dial-up lines, etc.)
4. Electronic Protected Health Information or "EPHI": PHI that is transmitted by Electronic Media or Maintained in Electronic Media.
5. Protected Health Information (PHI): individually identifiable health transmitted or maintained in paper or electronic format that is created or received by TCHD AND
   a. Relates to the past, present, or future physical or mental health or condition of an individual; OR
   b. Relates to the provision of health care to an individual; OR
   c. Relates to the past, present, or future payment, AND
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
6. Use: the sharing, application, utilization, examination or analysis of PHI within TCHD.
7. Workforce member: employees, **Medical Staff, Allied Health Professionals (AHP),** volunteers, trainees, **Business Visitors, Covered Contractors** and other persons whose conduct in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

C. **POLICY**

1. TCHD Confidential Records must be destroyed and disposed of in a manner that preserves the confidentiality of the information contained in them. TCHD Workforce members, Medical Staff, and applicable business associates shall ensure that reasonable safeguards are in place to limit incidental, and avoid prohibited, Uses and Disclosures of PHI and other personal information

including in connection with the disposal and destruction of Confidential Records. TCHD Workforce members, Medical Staff, and applicable business associates shall carry out destruction and disposal of Confidential Records in compliance with state laws, HIPAA and this Policy. Confidential Records may only be destroyed and disposed of when, and as, permitted under TCHD's **Board of Directors Policy:** Records Retention and Destruction Policy #~~14~~-008.

D. **PROCEDURE:**

1. Confidential records may include the following:
   a. Medical records including, individual components such as laboratory results, provider notes, and orders, test results, schedules, referral slips, research records, etc.
   b. Patient menus
   c. Patient admission and demographic information documents
   d. Billing information, records, and reports
   e. Receipts
   f. Communications with caregivers
   g. Patient identification bracelets
   h. Department and committee reports such as those related to quality, risk management, peer review etc.
   i. Department patient logs
   j. Reports to regulators
   k. Incident reports
   l. Employment record
2. Duty to Safeguard Confidential Records
   a. TCHD shall take reasonable steps to destroy or arrange for the destruction of Confidential Records as provided by this Policy. Responsibility for proper disposal of Confidential Records resides with Medical Records/Health Information and Information Technology departments.
   b. Confidential Records (including PHI or other personal information) in any form may not be abandoned or disposed of in TCHD dumpsters, garbage cans, or other containers that are accessible to the public or other unauthorized persons.
   c. TCHD may contract with a business associate to perform services related to the proper destruction and disposal of Confidential Records in accordance with the TCHD's Business Associate Policy. Such vendors shall provide TCHD with certifications demonstrating appropriate proof of destruction and/or disposal as applicable to their respective contracted services.
   d. Destruction and disposal of Confidential Records is subject to TCHD's Records Retention and Destruction Policy No. 14-008 which addresses, in part the schedule for retention and destruction of medical records and other TCHD business records.
   e. Confidential Records that are subject to an investigation, audit and/or litigation hold shall not be destroyed or disposed of as provided in Records Retention and Destruction Policy No. 14-008.
   f. TCHD Workforce Members who are responsible for disposing of Confidential Records or for supervising others who dispose of Confidential Records must receive training on disposal obligations.
   g. TCHD shall document the destruction and disposal of Confidential Records pursuant to TCHD's policies.
3. Confidential Records – Paper/Hard Copy and Other (Non-Electronic Media)
   a. Confidential Records in paper/hard copy shall be destroyed in a manner that renders PHI and other personal information unreadable, indecipherable and otherwise not capable of being reconstructed. PHI and other personal information that is contained in paper/hard copy Confidential Records including, but not limited to, the categories identified below, must be shredded prior to disposal. The form of such Confidential Records includes printed e-mails, facsimiles, correspondence, labels and file covers as well as originals and copies.

b. For purposes of the shredding requirements in Section (a) above, TCHD requires that TCHD Workforce members, Medical Staff, and applicable business associates use one of the following processes to destroy PHI in paper/hard copy form:
   i. On-site shredding [in designated Department shredders] to destroy PHI prior to removal and disposal from TCHD premises which shall be done by a certified disposal vendor.
   ii. PHI shall be placed in accessible, secured bins identified as "Shred: bins which are picked up by a certified disposal vendor for on-site recycling/destruction. Shred bins should not be used for non-identifiable/non-confidential information, hazardous waste, sharps, linen, medications, tissue, food products, garbage, glass, aluminum or corrugated cardboard.

4. Confidential Records – Labeled Prescription Bottles
   a. PHI on labeled prescription bottles shall be collected and maintained in Pharmaceutical waste containers which are located in various clinical areas of the hospital for collection and disposal by TCHD's certified disposal vendor.
   b. Pharmaceutical waste containers may also be used for the disposal of prescription bottles reflecting a patient's name/PHI.
5. Confidential Records – Electronic Media
   a. TCHD shall ensure that EPHI stored on computers and facsimile machines is destroyed in accordance with this Policy before disposal, reuse or return to a third party leasing company.
   b. Confidential Records in the form of Electronic Media shall be destroyed before disposal by clearing (using software or hardware products to overwrite media with non-sensitive data), purging (degaussing exposing the media to a strong magnetic field) pulverization or shredding.
6. Confidential Records Used Offsite
   a. Confidential Records used off TCHD's campus or other facilities (if and as permitted by TCHD policies) must be returned to TCHD for destruction and disposal in accordance with the procedures set forth in this Policy.

E. ENFORCEMENT AND COMPLIANCE

1. Non-compliance with this Policy could result in potential penalties to TCHD under state and federal laws. TCHD Workforce member, Medical Staff, and applicable business associates who violate this policy are subject to discipline up to and including terminations in accordance with TCHD sanction policies.

F. RELATED DOCUMENT(S):

1. Board of Directors Policy: Records Retention and Destruction Policy 008

G. REFERENCES:

1. 45 Code of Federal Regulations (CFR) Section 160.103
2. 45 CFR Section 164.31(d)(2)(i)
3. 45 CFR Section 164.530 (c)
4. California Civil Code Sections 56.36 and 56.101
5. California. Civil Code Sections 1798.8-1798.84
6. California Health & Safety Code Section 1280.15
7. TCHD Records Retention Policy No. 14-008
8. TCHD Business Associate Policy No. 8610-511

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: **Duty to Report Suspected Misconduct/Potential Compliance Irregularity**

REVISION DATE~~(S)~~: 12/12, 12/15

POLICY NUMBER: 8750-544

Administrative Compliance Content Expert Approval:	**~~11/18~~11/21**
Administrative Policies & Procedures Committee Approval:	**~~12/18~~12/21**
Organizational Compliance Committee Approval:	**06/22**
Medical Executive Committee Approval:	**n/a**
Audit, Compliance & Ethics Committee Approval:	**02/19**
Board of Directors Approval:	**02/19**

A. **PURPOSE:**

1. To provide a statement of the Tri-City Healthcare District's (TCHD) policy regarding the duty to report suspected misconduct or potential compliance irregularities.

B. **DEFINITIONS:**

1. Workforce Members: Employees, Medical Staff, ~~and~~ Allied Health Professionals, volunteers, trainees, **Business Visitors, Covered Contractors** and other persons whose conduct, in the performance of work for TCHD, is under the direct control of TCHD whether or not they are paid by TCHD.

C. **POLICY:**

1. Workforce members are required to report suspected misconduct, including, but not limited to, any practice that the workforce member believes violates or may violate the TCHD Compliance Program or applicable laws, regulations, or other governmental rules. For workforce members who are employees, reporting of suspected misconduct is a condition of employment.

D. **PROCEDURES:**

1. The procedures for reporting suspected misconduct or potential compliance irregularities are set forth in the following policies:
   a. Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556
   ~~b. Administrative Compliance Policy: Communicating and Reporting Compliance Concerns (Values Line) 8750-557~~
2. The procedures for responding to such reports are set forth in the following policies:
   ~~a. Administrative Compliance Policy: Responding to Compliance Issues - Introduction; Suspected Misconduct; Confidentiality 8750-559~~
   ~~b.~~**a.** Administrative Compliance Policy: Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct 8750-560
   ~~c.~~**b.** Administrative Compliance Policy: Responding to Reports of Suspected Non-Compliance and Misconduct 8750-561
3. The procedures for determining the appropriate corrective action and/or discipline for employees who violate applicable laws, regulations, other governmental rules, or the TCHD Compliance Program or supervisors who fail to detect or report such violations, are set forth in the following policy:

a. Administrative Compliance Policy: Responding to Compliance Issues; Remedial Action 8750-562

4. The documentation requirements for misconduct reports are set forth in the following policy:
   a. Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556.
5. Note that suspected misconduct may be reported any day, any time, through the TCHD Confidential Reporting Line (Values Line) at 1-844-521-7862, or online at https://TCHD.ethicspoint.com ~~Note further that~~ TCHD is committed to ensuring that there will be no retaliation or retribution against any employee for performing his or her duty to report in good faith.

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

1. Administrative Compliance Policy: Communicating and Reporting Compliance Concerns; Reporting of Suspected Misconduct/Potential Irregularities 8750-556
2. ~~Administrative Compliance Policy: Communicating and Reporting Compliance Concerns (Values Line) 8750-557~~
3. ~~Administrative Compliance Policy: Responding to Compliance Issues; Introduction; Suspected Misconduct; Confidentiality 8750-559~~
4. **2.** Administrative Compliance Policy: n Non-Retaliation for Reporting Compliance Issues or Suspected Misconduct 8750-560
5. **3.** Administrative Compliance Policy: Responding to Reports of Suspected Non-Compliance and Misconduct 8750-561
6. **4.** Administrative Compliance Policy: Responding to Compliance Issues; Remedial Action 8750-562

Tri-City Health Care District
Oceanside, California

Administrative Policy
District Operations

ISSUE DATE: 05/12 **SUBJECT: Compliance Education and Training**

REVISION DATE(S): 10/17 **POLICY NUMBER:** 8750-549

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~07/17~~11/20
Administrative Policies and Procedures Committee Approval: ~~07/17~~12/21
Organizational Compliance Committee Approval: ~~08/17~~06/22
Medical Executive Committee Approval: 09/17
Audit, Compliance and Ethics Committee Approval: 10/17
Board of Directors Approval: 10/17

A. **PURPOSE:**

1. ~~Policy 8750-549 provides a~~ **A** statement of the **Tri-City Healthcare** District's **(TCHD)** policies regarding the provision of compliance education and training programs.

B. ~~**PROVISION OF COMPLIANCE EDUCATION & TRAINING**~~**POLICY:**

1. ~~Tri-City Healthcare District (~~TCHD~~)~~ shall provide compliance education and training to TCHD ~~employees~~**Workforce Members**, Covered Contractors, and the Board of Directors (BOD) on an annual basis.
2. If a new ~~employee~~ **Workforce Member** begins working at TCHD at a time when the next scheduled New Hire Orientation Program and/or applicable Specific Training Program will not occur within 30 days of ~~his or her~~ **their** date of hire, an as-needed general compliance training session and any applicable specific training programs may be provided.

C. **DEFINITIONS:**

1. **Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.**
2. **Covered Contractor: A Covered Contractor is an individual or entity that has a contractual relationship with TCHD (other than employment), including but not limited to:**
   a. **Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;**
   ~~2.~~**b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.**

~~C.~~**D.** **DETERMINING NEED FOR AS-NEEDED COMPLIANCE EDUCATION & TRAINING:**

1. The Chief Compliance **and Privacy** Officer **(CCPO)** may determine if there is a need for "as-needed" Compliance Training and Education by any means which may include but are not limited to:
   a. Values Line reports,
   b. RL Solutions,
   c. Direct communication with:
      i. ~~TCHD employees~~**Workforce Members, Covered Contractors**
      ii. District BOD

iii. Members of the Medical Staff, or
iv. Community Members
~~d.~~ ~~Regulatory Agency reports~~

~~D.~~**E. DELIVERY:**

1. Compliance training may be presented in any manner the ~~Chief Compliance Officer~~ **CCPO** determines to be effective. This may include, in-person training, videoconference training, ~~computerized~~ **computer-based** training or telephone conference training.

~~E.~~**F. DOCUMENTATION:**

1. TCHD shall maintain, consistent with its record retention policies:
   a. Any documents reflecting requests for compliance education and training; and
   b. Documents concerning the response to requests for compliance education and training, including the guidance offered.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 08/15 **SUBJECT: HIPAA Mitigation**

REVISION DATE~~(S)~~: 08/15, 02/19 **POLICY NUMBER:** 8610-591

Administrative Compliance Content Expert Approval:	~~11/18~~11/21
Administrative Policies & Procedures Committee Approval:	~~12/18~~12/21
Organizational Compliance Committee Approval:	06/22
Medical Executive Committee Approval:	n/a
Audit, Compliance & Ethics Committee Approval:	02/19
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. ~~The purpose of this Policy is to~~**To** establish guidelines for mitigating ~~–~~any harmful effects to Tri-City Healthcare District (TCHD) arising from the Use or Disclosure of Protected Health Information in violation of TCHD's policies and procedures or applicable state and federal privacy laws.

B. **DEFINITION(S):**

1. Business Associate: A person or organization who, on behalf of the District, ~~,~~receives, maintains or transmits PHI on behalf of ~~the District or where the District Discloses PHI to Business Associates.~~ **TCHD.**
2. Disclosure: The release, transfer or access to PHI outside TCHD.
3. Electronic Protected Health Information (EPHI): PHI that is transmitted by **e**~~E~~lectronic **m**~~M~~edia or **m**~~M~~aintained in **e**~~E~~lectronic **m**~~M~~edia.
4. Protected Health Information ("PHI"): Health data created, received, stored, or transmitted by HIPAA-covered entities and their business associates in relation to the provision of healthcare, healthcare operations, ~~and~~ payment for healthcare services~~.~~ **and** individually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD ~~AND~~ **and**
   a. Relates to the past, present or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present or future payment, ~~AND~~**and**
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
5. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.
6. Workforce Member: Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid by TCHD.

~~C. **POLICY:**~~

~~1. TCHD shall mitigate, to the extent practicable, any harmful effects that are known to TCHD arising from a Use or Disclosure of a patient's PHI, , in violation of TCHD's policies and procedures or applicable state and federal laws.~~

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

1. Investigation and Evaluation

a. The Chief Compliance and Privacy Officer or designee will investigate reports of a potential or suspected violation of privacy rights, whether by a Workforce Member, Medical Staff, or a Business Associate. If the report is substantiated, the Chief Compliance and Privacy Officer will consult with the appropriate ~~TCDH~~ **TCHD** leaders and/or ~~legal~~ **General C**~~c~~ounsel to determine the extent of any harmful effects resulting from the incident.

b. An evaluation will be conducted to determine the nature and extent of any harmful effects. The evaluation will consider the following factors:
   i. Whether any damage occurred;
   ii. The type of damage;
   iii. The nature and extent of PHI (including types of identifiers) that was **u**~~U~~**sed** or **d**~~D~~isclosed;
   iv. The reason for the Use and Disclosure;
   v. The extent of distribution of the improperly **d**~~D~~isclosed PHI, including the identity of recipients;
   vi. The cause of the violation including any TCHD policies and procedures and/or privacy laws that were violated by the Use or Disclosure; and
   vii. Any other information that is relevant to the ~~evaluation.~~**investigation.**

2. Mitigation Steps
   a. Based on the evaluation, the Chief Compliance and Privacy Officer and/or the Security Officer shall determine appropriate actions to mitigate harm caused by the violation and will consult with appropriate TCHD leadership as needed.
   b. Mitigation steps may include any of the following actions or a combination of them:
      i. Amend applicable policies and procedures to assure that the violation does not recur;
      ii. Provide focused training and education to person(s) responsible for the violation and/or to a category of **W**~~w~~orkforce **M**~~m~~embers depending on the scope of the violation and policy changes;
      iii. Impose sanctions and/or disciplinary actions up to and including termination against person(s) responsible for the violation in accordance with TCHD's policies;
      iv. Attempt to recover the improperly **u**~~U~~sed or **d**~~D~~isclosed PHI (or obtain confirmation of its destruction) (e.g. misdirected fax, delivery of PHI to wrong patient);
      v. Deactivate/disable access to **e**~~E~~PHI (e.g. remotely wipe/lock mobile devices where lost or stolen);
      vi. Identify and correct Information Technology (~~"~~IT~~"~~) system or physical space vulnerabilities, if any that contributed to the violation;
      vii. Notify affected Individuals of the violation in accordance with TCHD's security incident/breach response policies and of self-protective actions that may be taken to ameliorate or avoid potential harm (e.g. identity theft); and/or
      viii. Other actions as determined by the Chief Compliance and Privacy Officer and/or Security Officer in consultation with Executive Management and/or ~~legal~~ **General C**~~c~~ounsel, if applicable.

3. Business Associate Violations
   a. In the event that TCHD learns of a potential or actual violation of a Use or Disclosure of PHI by one of its Business Associates, TCHD must, if practicable, mitigate the harmful effects of such violation. The Chief Compliance and Privacy Officer and/or Security Officer, in consultation with ~~legal~~ **General C**~~c~~ounsel, if applicable, will contact the Business Associate to develop a mitigation plan.
   b. TCHD will also review whether further action is required under the terms of the Business Associate Agreement and TCHD's policies and procedures based on the nature and extent of the violation (e.g. termination).

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

1. Administrative Compliance Policy: HIPAA Administrative Requirements 8610-585
2. Administrative Compliance Policy: Protected Health Information (PHI) Breach Response 8610-586
3. Administrative Compliance Policy: Sanctions for Non-Compliance -with Privacy and Security Policies & Procedures 8610-531
4. Administrative Compliance Policy: Business Associate Agreement 8610-511
5. HIPAA Business Associate Agreement

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

1. 45 Code of Federal Register (CFR) Section 160.103
2. 45 CFR Section 164.530(f)
3. California HIPAA Codes and Regulations

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY
COMPLIANCE

ISSUE DATE: 03/12

SUBJECT: **Monitoring Compliance/ Auditing and Reporting; Annual Compliance Work Plan**

REVISION DATE~~(S)~~:03/12, 04/18

POLICY NUMBER: 8750-552

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~11/17~~11/20
Administrative Policies &~~and~~ Procedures Committee Approval: ~~11/17~~12/21
Organizational Compliance Committee Approval ~~02/18~~06/22
Audit, Compliance and Ethics Committee Approval: 04/18
Board of Directors Approval: 04/18

A. **PURPOSE:**

1. To provide (1) a statement of Tri-City Healthcare District's (TCHD) policy with respect to the development of an annual compliance work plan ("Work Plan"), and (2) a statement of TCHD's policy of conducting periodic and *ad hoc* compliance reviews and audits of the compliance program and TCHD's performance under the compliance program.

~~B.~~ ~~**INTRODUCTION:**~~

1. Ongoing monitoring and evaluation is essential to the development and maintenance of an effective compliance program. By developing annual work plans and conducting audits and reviews in response to reported concerns, the compliance program ensures that TCHD meets its commitment to conduct business consistent with fundamental ethical standards and to comply with all applicable laws and regulations.

B. **DEFINITIONS(S):**

1. Workforce Member: Employees, Medical Staff, Allied Health Professionals (AHP), volunteers, trainees, Business Visitors, Covered Contractors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

C. **ANNUAL COMPLIANCE WORK PLAN:**

1. TCHD's Chief Compliance **and Privacy** Officer (CCPO) (with the assistance of the ~~Director of Compliance Audit and Monitoring,~~ Compliance Committee, outside consultants and **General** Counsel, as necessary) will recommend and facilitate, as appropriate, the identification of compliance-related risk areas of relevance to hospitals, health systems, and the health care industry in general. These risk areas will be documented in an annual work plan.
2. Risk areas may be identified through any number of channels including, by way of example:
   a. The Office of Inspector General's (OIG) annual work plan;
   b. Recent OIG and/or Department of Justice ("DOJ") enforcement actions and settlements;
   c. Audit reports published by the OIG;
   d. Health care news reports on recent or ongoing government investigations in the health care space;
   e. Payor denial reports;
   f. Internal District reviews;
   g. Exit surveys/interviews with employees and contractors; and
   h. Confidential Reporting Line (Values Line) reports.

3. The work plan shall be developed by the ~~Director of Compliance Audit and Monitoring~~ **Office of Compliance and Privacy** under the supervision of the CC**P**O, who shall:
   a. Implement processes with the assistance of various TCHD departments ~~(such as the Finance Department, by way of example)~~ for assessing TCHD's compliance with respect to the risk areas identified in the work plan;
   b. Supervise the reviews and assessments related to each risk area;
   c. Based on the reviews and assessments, determine whether to develop or enhance training and/or policies related to the risk areas; and
   d. Where appropriate, identify and implement corrective actions.
4. Approval
   a. The annual work plan will be presented to and be approved by senior management and TCHD Board of Directors (Board).
   b. The CC**P**O will be afforded a budget that will enable ~~him or her~~**them** to implement the work plan.

D. **COMPLIANCE PROGRAM EFFECTIVENESS REVIEWS:**

1. The CC**P**O ~~and Director of Compliance Auditing and Monitoring~~ (with the assistance, as appropriate, of outside independent review consultants and/or **general** counsel, as described below) shall develop a protocol for performing periodic reviews of TCHD's policies and practices to determine the effectiveness of the compliance program. The protocol shall assist in the assessment of the following elements of the compliance program:
   a. Compliance program policies (including any requirements relating to documentation)
   b. Effectiveness of compliance training and education provided to all TCHD ~~employees~~**Workforce Members.**
   c. Appropriateness of the monitoring and auditing conducted by the compliance program
   d. Awareness of the compliance program reporting mechanisms, including use of TCHD's **V**~~v~~alues l**L**ine
   e. Promptness of investigations of reported compliance concerns
   f. Process for the development of corrective actions, **if appropriate,** in response to reported concerns

E. **FOCUSED REVIEWS AND AUDITS:**

1. When suspected noncompliance with laws and/or policies is reported, the ~~CCO and/or the Director of Compliance Auditing and Monitoring~~**Office of Compliance and Privacy** shall initiate a formal review and/or audit of the conduct in question.
   a. Technique:
      i. The protocol developed by the CC**P**O may provide for sampling, full claim review, contract review, pre-billing reviews, email and other correspondence review or other appropriate measures.
   b. Review Assistance:
      i. The compliance program reviews and audits shall be conducted under the supervision of the CC**P**O, ~~Director of Compliance Audit and Monitoring and/or legal~~**general** counsel, as appropriate. In addition to, or in lieu of, internal reviewers, outside independent review consultants and/or **outside legal** counsel may be used to assist, as appropriate.
   c. Reviewer Qualifications and Independence:
      i. The entity or individual(s) conducting the compliance program reviews and audits (whether internal or external to TCHD) shall be independent insofar as they must be able to review TCHD's practices and make objective, independent determinations as to the accuracy or effectiveness of those practices.
      ii. The reviewers/auditors shall have the qualifications and experience necessary to adequately identify potential issues related to the subject they are reviewing.
      iii. The reviewers/auditors shall have access to the resources and information necessary to conduct the compliance program reviews and audits, including full

access to documents and ~~employees~~**Workforce Members**.

F. **DOCUMENTATION:**

1. The final version of work papers, notes and other documentation generated in connection with every review shall be maintained in the compliance program files.
2. After completing each annual work plan, the CCPO shall furnish senior management and the Board with a written report of principal findings, conclusions and recommendations.
3. The review findings, conclusions and recommendations (including the written report) shall be documented in the compliance program files.

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

1. Administrative Policy: Compliance Program Overview 8750-532
2. Administrative Policy: Monitoring Compliance Auditing & Reporting – Exit Interviews 8750-554
3. Tri-City Healthcare District Code of Conduct

H. **REFERENCE(S):**

1. Compliance Program Guidance for Hospitals, published by U.S. Department of Health and Human Services, Office of Inspector General, February 1998.
2. Office of Inspector General Supplemental Compliance Program Guidance for Hospitals, January 2005.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
COMPLIANCE

ISSUE DATE: 05/12

SUBJECT: Pending Debarment, Criminal Charges or Adverse Action Against Current Covered Contractors

REVISION DATE: 02/17

POLICY NUMBER: 8750-540

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~09/16~~11/20
Administrative Policies and Procedures Committee Approval ~~Date(s)~~: ~~09/16~~12/21
Organizational Compliance Committee: ~~11/16~~06/22
Medical Executive Committee Approval Date(s): 01/17
Audit, Compliance and Ethics Committee Approval Date(s): 02/17
Board of Directors Approval Date(s): 02/17

A. **PURPOSE:**

1. To provide guidance regarding action(s) ~~of~~ Tri-City Healthcare Districts (TCHD) ~~will~~ take when a Covered Contractor has a pending suspension, debarment, exclusion action, criminal conviction or Adverse Action.

B. **DEFINITIONS:**

1. Covered Contractor – A ~~Covered Contractor is an~~**n** individual or entity that has a contractual relationship with TCHD (other than employment), including but not limited to:
   a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;
   b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to a federal or state health care program.
2. Adverse Action – ~~Adverse action means with respect to a professional license, registration, or certification, a~~any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication, ~~. It~~ includ**inges**, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.
3. Federal Health Care Program – ~~The phrase "Federal health care program" shall~~**Shall** have the same meaning as set forth at 42 U.S.C. 1320a-7b(f) and includes, by way of example, Medicare and Medicaid~~.~~**/MediCal.**

C. **ACTION PENDING RESOLUTION OF CHARGES:**

1. If TCHD learns that:
   a. A current Covered Contractor has been charged with a criminal offense bearing on trustworthiness, or the ability of the Covered Contractor to perform relevant contractual responsibilities; and/or
   b. A current Covered Contractor has been charged with a criminal offense related to health care fraud,
   c. A federal agency has issued a notice proposing to debar, exclude, or otherwise deem the current Covered Contractor ineligible to participate in any Federal health care program, or;
   d. A state agency or authority has proposed to take an Adverse Action against a professional license, certification or registration of a current Covered Contractor

2. Then, pending resolution of the charges:
   a. The Chief Compliance **and Privacy** Officer (CC**P**O) in consultation with ~~Legal~~ **General** Counsel, ~~-~~as necessary and appropriate, shall review whether the Covered Contractor's contract should be terminated based on the circumstances (and/or Covered Contractor's employee should be removed from his or her position related to services furnished at TCHD).
   b. If the Covered Contractor is a credentialed Medical Staff member, the matter shall be resolved through the coordination of the Medical Staff Office**, Chief Medical Officer,**~~-~~and the ~~Chief Compliance Officer~~**CCPO**.
3. ~~TCHD shall make reports to the CCO and Contracts department regarding compliance with the reporting requirements of this policy~~.
4. At the discretion of TCHD, reports will be made to the appropriate licensing authority.

D. **DOCUMENTATION:**
1. For Covered Contractors, such documentation shall be maintained in the Covered Contractor's file consistent with ~~the~~ TCHD's document retention policies. .

E. **REFERENCES**:
1. 42 U.S. Code § 1320a–7b

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE POLICY MANUAL
COMPLIANCE

ISSUE DATE: 03/03 **SUBJECT:** Rights to Request Privacy Protection for Protected Health Information

REVISION DATE: 03/06; 02/09; ~~3~~04/15 **POLICY NUMBER:** 8610-526

Administrative Policies & Procedures Content Expert~~Department Approval Date(s)~~: ~~3/15~~11/20
Administrative Policies & Procedures Committee Approval: ~~3/15~~12/21
Organizational Compliance Committee Approval: 06/22
Audit and Compliance Committee Approval Date(s): 4/15
Board of Directors Approval: 4/15

A. **PURPOSE:**

1. To establish a policy and procedure to comply with a patient's right to request restrictions on the use and disclosure of their protected health information (PHI) in compliance with applicable laws.

B. **DEFINITIONS:**

1. Disclosure: **T**~~t~~he release, transfer, provision of, access to or divulging of PHI outside Tri-City Healthcare District (TCHD).
2. Protected Health Information (PHI): **I**individually identifiable health transmitted or maintained in electronic/other format that is created or received by TCHD; **and** ~~AND~~
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment;~~,~~ **and**~~AND~~
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
3. Treatment, Payment, and Healthcare Operations (TPO):
   a. Treatment: **P**~~p~~roviding, coordinating or managing a patient's care by one or more providers, including: coordinating or management of health care by a provider and a third party; consultations between providers about a patient; or the referral of a patient from one provider to another.
   b. Payment: **A**~~a~~ctivities related to paying or being paid for services rendered including, without limitation:
      i. Eligibility and coverage determinations
      ii. Billing
      iii. Claims management
      iv. Collection activities
      v. Medical necessity and utilization review.
   c. Health **C**~~c~~are **O**~~o~~perations: **B**~~b~~road range of activities related to covered functions including, without limitation:
      i. Quality assessment and improvement
      ii. Provider credentialing
      iii. Patient education and training
      iv. Health practitioner training
      v. Contracting for health care services
      vi. Medical review
      vii. Legal services
      viii. Auditing functions
      ix. Business planning and development

x. Business management and general administrative activities.

4. Use: ~~T~~the sharing, application, utilization, examination or analysis of PHI within TCHD.

C. **POLICY:**

1. TCHD must permit an individual to request a restriction of PHI to carry out treatment, payment or health care operations and disclosures to family members, other relatives or close personal friends otherwise permitted under 45 C.F.R. Section 164.501(b) and TCHD Policy No. 8610-516~~5~~.
2. TCHD is not required to agree to a requested restriction except as provided in Section C.6.
3. All decisions made on requested restriction shall be documented in writing and returned to the patient.
4. If TCHD agrees to a restriction TCHD may not use or disclose PHI in violation of such restriction.
   a. If the ~~individual~~ **patient** who requested the restriction is in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, TCHD may use the restricted PHI, or disclose such information to a health care provider, in order to provide treatment to the ~~individual~~**patient**.
   b. If restricted PHI is disclosed to a health care provider for emergency treatment, TCHD must request that the health care provider not further use or disclose the information outside the treatment episode.
   c. A restriction agreed to by TCHD, is not effective to prevent uses or disclosures of PHI that are permitted or required by law without ~~individual~~ **patient** authorization.
5. TCHD must agree to the request of a~~n individual~~ **patient** to restrict the disclosure of PHI about the ~~individual~~ **patient** to a health plan if
   a. The disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law; and
   b. The PHI pertains solely to a health care item or service for which the ~~individual~~**patient**, or person other than the health plan on behalf of the ~~individual~~**patient**, has paid TCHD in "full."

D. **PROCESS:**

1. Request for restriction- A~~n individual~~ **patient** may request a restriction as follows:
   a. A patient/patient's representative must submit a written request for restriction of PHI to TCHD's ~~Privacy Officer~~**Director of Healthcare Information Management Systems (HIMS)**.
   b. The written request must include:
      1) What the ~~individual~~ **patient** wants to limit
      ii. Whether use is limited to treatment, payment or health care operations
      1) To whom the ~~individual~~ **patient** wants the use and disclosure limit to apply
2. Termination of restriction - TCHD may terminate its agreement to a restriction under the following conditions:
   a. The ~~individual~~ **patient** may submit a written request for termination of a restriction of PHI to TCHD's ~~Privacy Officer~~**Director of HIMS** in writing.
   b. The ~~individual~~ **patient** orally agrees to termination of the restriction and the oral agreement is documented.
   c. TCHD informs the ~~individual~~ **patient** in writing that it is terminating its agreement to a restriction.
      i. Such termination is only effective with respect to PHI created or received after the patient/patient's representative has been informed.
      ii. Such termination is not effective for PHI restricted under Section C.6 above.
3. Documentation of restriction or termination of restriction:
   a. Patients who request a restriction of their ~~protected health information~~**PHI** will be provided with the Request for Special Restriction form to be completed, signed and submitted to TCHD's ~~Privacy Officer~~**Director of HIMS**.
   b. When wishing to terminate the agreement, the Termination of Special Restriction form must be completed, signed and submitted to TCHD's ~~Privacy Officer~~**Director of HIMS**.
4. TCHD shall maintain documentation of such restrictions/termination of restrictions in accordance

with Policy No. 8610-237 -Record Retention.

E. **~~RELATED DOCUMENTS~~FERENCES**:

1. 45 C.F.R Section 164.501 (b)
2. 45 C.F.R. Section 164.522
3. Board Policy #14-008 Records Retention and Destruction **Policy**
4. Hospital Records Retention Policy #8610-237
5. Use and Disclosure of Protected Health Information Records Policy #8610-51~~65~~

F. **RELATED DOCUMENTS:**

1. **Request for Special Restriction form**
2. **Termination of Special Restriction form**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE POLICY ~~MANUAL~~
COMPLIANCE

ISSUE DATE: 05/12 **SUBJECT:** Required Screening of Covered Contractors

REVISION DATE(S): 02/17 **POLICY NUMBER:** 8750-539

Administrative Policies & Procedures Content Expert~~Department Approval~~: ~~09/16~~12/21
Administrative Policies & Procedures Committee Approval ~~Date(s)~~: ~~09/16~~03/22
Organizational Compliance Committee: ~~09/16~~06/22
Medical Executive Committee Approval ~~Date(s)~~: ~~01/17~~ n/a
Audit, Compliance and Ethics Committee Approval ~~Date(s)~~: 02/17
Board of Directors Approval ~~Date(s)~~: 02/17

A. **PURPOSE:**

1. To provide guidance of the Tri-City Healthcare District's (TCHD'S) policy regarding **required** screening **of** Covered Contractors.

B. **DEFINITIONS:**

1. Covered Contractor – **A**~~a~~n individual or entity that has a contractual relationship with TCHD (other than employment), including, but not limited to:
   a. Any individual or entity directly involved in providing patient care, including, but not limited to, physicians and Allied Health Professionals such as physician assistants and nurse practitioners;
   b. Any individual or entity directly involved in coding and/or billing functions, including the preparation and presentment of reimbursement claims to any federal or state health care program.
2. Adverse Action – ~~Adverse action means with respect to a professional license registration, or certification,~~ any negative finding, unfavorable decision or action, or any decision or action that could have a negative or unfavorable implication. It includes, but is not limited to: revocation, denial, fine, monitoring, probation, suspension, letter of concern, guidance, censure, reprimand, disciplinary action, restriction, required counseling, loss, voluntary or involuntary surrender, and initiation of inquiry, investigation or other proceeding that could lead to any of the actions listed.
3. OIG List of Excluded Individuals/Entities is located at https://.exlusions.OIG.hhs.gov.
4. System for Award Management (SAM) is located at **https://www.sam.gov/SAM/pages/public/index.jsf** ~~https://www.sam.~~
5. Medi-Cal Suspended and Ineligible Provider List at http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

C. **SCREENING COVERED CONTRACTORS:**

1. Periodically, but at least on an annual basis and prior to contracts being considered for approval by the Board of Directors **(BOD)**, TCHD shall screen Covered Contractors against the:
   a. Office of Inspector General's List of Excluded Individuals/Entities (OIG LEIE), and
   b. System for Award Management (SAM), and
   c. Medi-Cal Suspended and Ineligible Provider List.
2. Periodically, but at least on an annual basis, ~~the District~~ **TCHD** shall require each Contractor to certify in writing that the Covered Contractor:
   a. Has not been charged with or convicted of committing any criminal offense;
   b. Does not have any charges pending for violating any criminal law;

c. Has not been debarred, excluded or otherwise deemed ineligible for participation in Federal health care programs;
d. Is not the subject of or otherwise part of any ongoing federal or state investigation; and
e. Possesses a current professional license, registration, or certification, as applicable, and is in good standing with, and has had no Adverse Action taken by, any and all authorities granting such license, registration or certification, as applicable.

3. All Contracts are to be evaluated and assessed on an annual basis per CMS (Center for Medicare and Medicaid Service) regulations and provide a certificate in writing.
4. In the event that the Covered Contractor cannot provide the certification set forth in Section C.1 above, the Covered Contractor shall provide complete and accurate information with respect to the matters at issue.
5. In addition, as specified in **Administrative Policy:**~~8750~~ **Pending Debarment, Criminal Charges or Adverse Action against Covered Contractors** 540, Covered Contractors are required to report any criminal convictions under state or federal law, in writing to the **Office of** Compliance **and Privacy** ~~Department~~ within five (5) working days of such convictions.

D. **RETENTION:**

1. TCHD shall not knowingly retain any Covered Contractor if the ~~/~~Covered Contractor:
   a. Has been convicted of a criminal offense that has a bearing on the (a) trustworthiness of the Covered Contractor, or (b) ability of the Covered Contractor to perform relevant job responsibilities; or
   b. Has been convicted of committing a health care fraud-related criminal offense; or
   c. Is currently debarred, excluded or otherwise ineligible for participation in Federal health care programs; or
   d. Does not have a current professional license, registration or certification as applicable, and/or is not in good standing with, and/or has had an Adverse Action taken by, the relevant state authorities that grant such license, registration or certification, as applicable.
   e. When the Covered Contractor is a member of the TCHD Medical Staff, there shall be coordination between the Medical Staff Office and the Chief Compliance Officer in order to ensure appropriate action and follow-up is conducted.
   f. When a Covered Contractor is identified as being impacted by this policy, or as soon as possible thereafter, TCHD employees, Medical Staff, **Chief Medical Officer**-and Board of Directors shall consult with the Chief Compliance **and Privacy** Officer and/or ~~Legal~~ **General** Counsel to determine the appropriate action to be taken.

E. **DOCUMENTATION:**

1. For Covered Contractors such documentation shall be maintained in the Covered Contractors's file consistent with ~~the~~ TCHD's document retention policies.

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

1. Administrative Policy ~~8750-540~~**:** Pending Debarment, Criminal Charges or Adverse Action Against Current Covered Contractors **540**
2. TCHC Board Policy #14-008 – Board Document Retention Policy

G. **REFERENCE(S):**

1. ~~Medi-Cal law,~~ Welfare and Institutions Code (W&I Code) sections 14043.6 and 14123

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
COMPLIANCE

ISSUE DATE: 03/03

SUBJECT: **Use and Disclosure of Protected Health Information (PHI) for Fundraising**

REVISION DATE~~(S)~~: 02/06, 01/09, 01/16, 02/19

POLICY NUMBER: 8610-525

Administrative Compliance Content Expert Approval:	~~12/18~~11/21
Administrative Policies & Procedures Committee Approval:	~~12/18~~12/21
Organizational Compliance Committee Approval:	06/22
Medical Executive Committee Approval:	n/a
Audit, Compliance & Ethics Committee Approval:	02/19
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. To establish policies and procedures for the Use and Disclosure of specified Tri-City Healthcare District (TCHD) patient information for fundraising activities in accordance with the Health Information Portability and Accountability Act of 1996 (HIPAA).

B. **DEFINITIONS:**

1. Authorization: The written form that complies with HIPAA and state law that is obtained from the Individual or ~~his or her~~**their** personal representative in order for TCHD to **u**~~U~~se and **d**~~D~~isclose PHI.
2. Business Associate: A person or organization who, on behalf of ~~the District~~**TCHD**, performs certain functions or activities involving the Use or Disclosure of PHI or services that require the Business Associate to create, receive, maintain or transmit PHI on behalf of ~~the District~~**TCHD** or where ~~the District~~**TCHD** needs to disclose PHI to Business Associates for the services.
3. Direct Solicitation Fundraising Literature: Any written communications which primary purpose is the direct solicitation of the financial resources necessary to support the mission and purposes of TCHD.
4. Disclosure: The release, transfer, provision of, access to or divulging of PHI outside TCHD.
5. Fundraising: The process of securing the financial resources necessary to support the mission and purposes of the TCHD.
6. Minimum Necessary Standard: The amount of information reasonably necessary to accomplish the purpose of the Use, Disclosure or request.
7. Payment: Reimbursement for health care services provided. Includes activities undertaken by a health care provider to obtain or provide reimbursement for the provision of care including, but not limited to, determinations of eligibility, billing, claims management, collection activities, obtain payment under a contract of reinsurance or stop loss, related health care data processing, review of coverage under health plans, medical necessity reviews, and utilization management.
8. Permissible Patient Information: The limited categories of PHI that TCHD may **u**~~U~~se or **d**~~D~~isclose to a Business Associate or to the Tri-City Hospital Foundation without a patient Authorization, for the purpose of raising funds for TCHD's own benefit and expressly limited to the following:
   a. Demographic information relating to the Individual including name, address, other contact information, age, gender, and date of birth
   b. Dates of health care provided to an Individual
   c. Department of service (general department) information

d. Treating physician
e. Outcome information (to screen out only)
f. Health insurance financial class

9. Protected Health Information (PHI): Individually identifiable health information transmitted, maintained, created or received by TCHD and
   a. Relates to the past, present, or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment, **and**~~AND~~
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
10. Treatment: The provision of coordination, management, consultation or referral of a patient's health care by a provider(s).
11. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.
12. Workforce Member: Employees, Medical Staff and Allied Health Professionals, volunteers, trainees, and other persons whose conduct, in the performance of work for TCHD is under the direct control of TCHD whether or not they are paid for by TCHD.

C. **POLICY:**

1. In order to protect the privacy of a patient's information, Tri-City Hospital Foundation shall act in accordance and compliance with HIPAA and the Privacy Practices of TCHD when conducting fundraising activities for TCHD.
2. TCHD may **u**~~U~~se or **d**~~D~~isclose permissible patient information to its Business Associates or to the Tri-City Hospital Foundation for the benefit of TCHD fundraising.
3. Uses and Disclosures are subject to the minimum necessary requirements.
4. TCHD may not condition treatment or payment on a patient's choice with respect to fundraising communications.

D. **PROCESS:**

1. Notice of Privacy Practices
   a. TCHD's Notice of Privacy Practices shall indicate that TCHD may **u**~~U~~se or **d**~~D~~isclose a patient's PHI to its Foundation or Business Associates for fundraising purposes and that the patient has the right to opt out of receiving such communications.
   b. TCHD may not **u**~~U~~se or **d**~~D~~isclose PHI for fundraising purposes unless the statement required by Section 1.a is included in the Notice of Privacy Practices.
2. Use of Permissible Patient Information
   a. After a patient has been made aware of the TCHD's Notice of Privacy Practices, TCHD may **u**~~U~~se or **d**~~D~~isclose permissible patient information for fundraising purposes.
   b. Except as provided in this Policy, TCHD may disclose permissible patient information to the Tri-City Hospital Foundation or Business Associates for fundraising purposes without first obtaining a patient's authorization.
   c. TCHD and/or the Foundation may use permissible patient information to identify patients for patient testimonials that will be **u**~~U~~sed and/or **d**~~D~~isclosed for fundraising purposes.
   d. Before contacting a patient for fundraising purposes, TCHD and the Foundation shall verify that the individuals they wish to contact have not opted out of fundraising communications.
   e. TCHD and the Foundation shall implement the minimum necessary standard on fundraising Uses and Disclosures. TCHD and the Foundation must adhere to more restrictive federal and state privacy laws for certain highly sensitive health information (including but not limited to mental health, substance abuse, HIV/AIDS, psychotherapy notes and abuse). Due to the sensitive nature of these treatments, additional authorization is needed prior to using for fundraising communication. The Chief Compliance and Privacy Officer should be consulted prior to obtaining the patient's authorization.

f. TCHD and the Foundation may not **u~~U~~se** or **d~~D~~isclose** permissible patient information (or any patient PHI) with a non-affiliated entity for purposes of that entity's fundraising (for example where a Medical Staff member specializes in the treatment of a specific disease and a non-profit association fundraises for research related to that specialty).

3. Patient Testimonials Used for Fundraising Purposes.
   a. When **u~~U~~sing** and/or **d~~D~~isclosing** a patient's testimonial, including the patient's PHI for fundraising purposes, TCHD and/or the Foundation acting as TCHD's Business Associate must obtain from the patient prior to such Use and/or Disclosure:
      i. An authorization; and
      ii. Consents to videotape, photograph and/or publish the patient's testimonial, as appropriate.
   b. The authorization and consent form shall be obtained regardless of the manner in which TCHD/Foundation learned about the patient's testimonial or whether the patient has consented either verbally or in writing (e.g. e-mail) to such Use/Disclosure.
   c. The authorization must be completed in a manner that adequately describes the categories of PHI being **u~~U~~sed/d~~D~~isclosed** and the purpose of the Use/Disclosure.
   d. TCHD and the Foundation shall only **u~~U~~se** or **d~~D~~isclose** the patient's testimonial (and PHI) with a valid patient authorization.
4. Fundraising Notifications
   a. Each fundraising notification shall provide the patient with a clear and conspicuous opportunity to elect not to receive any further fundraising communications.
   b. The method provided to opt out of receiving further fundraising communications shall not result in a patient incurring an undue burden or more than a nominal cost. Tri-City Hospital Foundation permits patients to opt out of future fundraising communications by telephone at (760) 940-3370 or by e-mail at TCHFoundation@tcmc.com.
   c. Any TCHD workforce member or business associate who is advised by a patient of ~~his/her~~**their** request to opt out of receiving future fundraising communications, must contact the Foundation to document the request.
5. Patients Who Opt Out
   a. Fundraising communications will not be made to patients who have opted out of such communications.
   b. Tri-City Hospital Foundation will track opt out notifications to ensure that further fundraising communications are not made to patients who have elected to opt out.
6. Opting Back In
   a. Patients who desire to opt back in to receive fundraising communications can do so by sending an e-mail with such request to TCHFoundation@tcmc.com or by opting in at an event or through the Foundation's website.
7. Direct Solicitation Fundraising Literature
   a. Direct solicitations do not include marketing to donors or prospective donors. (e.g. newsletters) where patient PHI is not used.
8. Business Associates
   a. Before the Tri-City Hospital Foundation shares any permissible patient information with a Business Associate, the Tri-City Hospital Foundation shall have the Business Associate sign the TCHD Business Associate Addendum.
   b. If the Tri-City Hospital Foundation becomes aware of a breach of the Privacy Practices of TCHD by a Business Associate, the Tri-City Hospital Foundation shall immediately notify the Chief Compliance and Privacy Officer.

E. **FORMS):**
1. Authorization for Use or Disclosure 8700-1002 - Sample

F. **RELATED DOCUMENT(S):**
1. Administrative Compliance Policy: Notice of Privacy Practices 8610-518
2. Administrative Compliance Policy: Business Associate Agreement 8610-511

3. HIPAA Business Associate Addendum

G. **REFERENCE(S):**

1. 45 Code of Federal Regulations (CFR) Section 164.502
2. 45 CFR Section 164.514(f)
3. 45 CFR Section 164.508
4. Health Information Portability and Accountability Act of 1996 (HIPAA)

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:
Person/Organization authorized to *release* (use or disclose) the information: Tri-City Medical Center
(TCMC or other Entity)
Person/Organization authorized to *receive* the information (name and address of entity):
Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Fax: _____ Email: _____

I would like the Health Information:
☐ Mailed as: ☐ CD ☐ Paper ☐ Faxed ☐ E-Mail ☐ Secured ☐ Unsecured

This Authorization applies to the following specific information to be disclosed (select from the following).[1]:
☐ All health information pertaining to any medical history, mental or physical condition and treatment received. Dates include: _____
[Optional] Except for these specific limitations: _____

☐ Only include the following records or specific types of health information. Dates include: _____
☐ Discharge Summary ☐ Laboratory Tests ☐ EKG
☐ Consultation Reports ☐ History/Physical Report ☐ X-Ray Report
☐ Emergency Dept Report ☐ Operative/Procedure Report
☐ Other (please specify): _____

I understand that this will include information relating to (check if applicable):
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
☐ Psychiatric Care (patient to initial here _____)
☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: 30 days

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.
I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056. Attn: Medical Records/Health Information.
I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

Affix Patient Label

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

8700-1002
(Rev. 3/21)

AUTHORIZATION FOR USE AND DISCLOSURE

White - Med Records Yellow - Patient

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION[3]

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization (pursuant to HIPAA laws and regulations).
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. Please be aware that once your information leaves Tri-City Medical Center, Tri-City Medical Center will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.
6. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by the federal confidentiality law (HIPAA).
7. I hereby release Tri-City Medical Center and its employees and my attending physicians and their associates from any and all legal liability that may arise from the release of this information to the party named on Page 1 of this Authorization Form.

SIGNATURE

Signature _____ Date/Time _____AM/PM
[Patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient[2]:

_____

Witness: _____

Authorization for Use or Disclosure of Health Information – Footnote references

[1] This form may not be used to release both psychotherapy notes and other types of health information [*(see 45 CFS § 164.508(b)(3)(ii)*]. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

[2] A spouse or financially responsible party may only authorize release of medical information for use in the following:

a. to process an application for the patient
b. as a spouse or dependent for the following:
    a. a health insurance plan or policy
    b. a nonprofit hospital plan
    c. a health care service plan or
    d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ **Date Received:** _____

Date of Birth: _____ **Visits to be Included:** _____

SS#: – – _____ _____ _____

Telephone #: _____

Distribution: ☐ **Mail** ☐ **Pick-up** ☐ **CD** ☐ **Other**

Completed by: _____
Signature Date

SAMPLE

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth** _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:
Person/Organization authorized to *release* (use or disclose) the information:[1] Tri-City Medical Center

Person/Organization authorized t ...tity):

...a code)

This Authorization applies to t ...d (select from the following).[2]:

☐ All health information pertain ...dition and treatment received.
Dates include: _____
[Optional] Except for these sp

DELETE – replace with current version

☐ Only the following records or ...e: _____
- ☐ Discharge Summary
- ☐ Consultation Reports ...ort
- ☐ Emergency Dept Rep
- ☐ Laboratory Tests

☐ Other
(please specify) _____

I understand that this will includ
- ☐ AIDS (Acquired Immu ...deficiency Virus) Infection
- ☐ Psychiatric Care (patie
- ☐ Treatment for alcohol a

EXPIRATION

This Authorization expires [on t _____

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.
I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056, Attn: Medical Records/ Health Information.
I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

AUTHORIZATION FOR USE OR DISCLOSURE

SAMPLE

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION[3]

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization[4].
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. If this box ☐ is checked, I understar…er remuneration directly or indirectly for the use or disclosure o…

SIGNATURE

Signature _____ _____ AM/PM
[Patient/representative/spo…

If signed by someone other than the pa…

_____

Witness: _____
(If you have authorized the a…who is not legally required to keep it confidential, it may…California law prohibits recipients of your health info…ot with your written authorization or as specifica…

Authorization for Use or Disclosure o…

DELETE – replace with current version

---

[1] If the Authorization is being requeste…n such entity shall be referred to as the Requestor througho…

[2] This form may not be used to release …h information [(*see 45 CFS § 164.508(b)(3)(ii)*]. If this form is be…y notes, a separate form must be used to authorize release of any ot…

[3] The Requestor is to complete this sec…

[4] Under HIPAA, the individual must be…it has been requested by a covered entity for its own uses and di…

[5] A spouse or financially responsible pa…ion for use in the following:
- a. to process an application for the…
- b. as a spouse or dependent for the following:
  - a. a health insurance plan or policy
  - b. a nonprofit hospital plan
  - c. a health care service plan or
  - d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ **Date Received:** _____

Date of Birth: _____ **Visits to be Included:** _____

SS#: __ __ __ – __ __ – __ __ __ __

Telephone #: _____

Distribution: ☐ **Mail** ☐ **Pick-up** ☐ **CD** ☐ **Other** _____ **Completed by:** _____
Signature **Date**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE COMPLIANCE

ISSUE DATE: 08/15

SUBJECT: **Verification of Identity and Authority of Persons Requesting Protected Health Information (PHI), including Personal Representatives**

REVISION DATE~~(S)~~:08/15, 02/19

POLICY NUMBER: 8610-593

Administrative Policies & Procedures ~~Compliance~~ Content Expert ~~Approval~~:	**~~09/18~~11/21**
Administrative Policies & Procedures Committee Approval:	**~~12/18~~12/21**
Organizational Compliance Committee Approval:	**06/22**
Medical Executive Committee Approval:	**n/a**
Audit, Compliance & Ethics Committee Approval:	**02/19**
Board of Directors Approval:	**02/19**

A. **PURPOSE:**

1. The purpose of this Policy is to define the steps for verifying the identity and legal authority of a person requesting a patient's PHI, including Personal Representatives, prior to Disclosure.

B. **DEFINITION(S):**

1. Authorization: **T**~~t~~he written form that complies with Health Insurance Portability and Accountability Act (HIPAA) of 1996 and state law that is obtained from the Individual or ~~his or her~~**their** Personal Representative in order for TCHD to **u**~~U~~se and **d**~~D~~isclose PHI.
2. Disclosure: **T**~~t~~he release, transfer, provision of, access to, or divulging of PHI outside of Tri-City Healthcare District (TCHD).
3. Individual: **T**~~t~~he person who is the subject of protected health information.
4. Personal Representative: **T**~~t~~he person who has the authority to act for the Individual in making decisions related to health care under state law (except where an unemancipated minor has the authority to act as an Individual for certain services or circumstances) or, with respect to deceased persons, the person who has the authority to act on behalf of the deceased Individual or the Individual's estate as relevant to such personal representation.
5. Protected Health Information (PHI): **I**~~i~~ndividually identifiable health information transmitted or maintained in paper or electronic form that is created or received by TCHD **and** ~~AND~~
   a. Relates to the past, present or future physical or mental health or condition of an individual; **or**~~OR~~
   b. Relates to the provision of health care to an individual; **or**~~OR~~
   c. Relates to the past, present, or future payment, **and**~~AND~~
   d. Identifies the individual OR with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
6. Use: **T**~~t~~he sharing, application, utilization, examination or analysis of PHI within TCHD.

C. **POLICY:**

1. TCHD shall take reasonable steps to verify the identity of a person requesting Disclosure of a patient's PHI and the authority of such person to have access to the PHI where the authority is not known to TCHD.

2. TCHD shall take reasonable steps to verify the legal authority of a patient's Personal Representative where TCHD is required to treat such person as the patient.
3. If, under applicable laws, a Disclosure is conditioned on particular documentation, statements or representations from the person requesting the PHI, TCHD may rely, if such reliance is reasonable under the circumstances, on documentation, statements or representations that, on their face, meet the applicable requirements.
4. TCHD shall obtain any documentation, statements or representations, whether oral or written, from the person requesting PHI when they are a condition of a Disclosure.

D. **PROCEDURE**:

1. Verification of Identity of a Patient
   a. Telephone: A person representing ~~himself or herself~~**themselves** as a patient can be verified using the following information:
      i. Demographic information that can be confirmed in TCHD's [system], electronic health record or Patient Accounting system.
      ii. The patient is known to TCHD from prior contact.
   b. In Person: A person representing ~~himself or herself~~**themselves** as a patient can be verified by using the following information:
      i. Presentation of identification such as a driver's license or other official photo identification record that would permit TCHD to confirm the identity is that of the patient.
      ii. Verbal statements of demographic information that can be confirmed in TCHD's [system] electronic health record.
      iii. The patient is known to TCHD from prior contact.
   c. Emancipated minor patients: **A**~~a~~n emancipated minor is deemed equivalent to an adult for purposes of determining who may be given access to ~~his or her~~**their** PHI. TCHD shall obtain a copy of the minor's Department of Motor Vehicles identification card showing emancipation or a signed Declaration of Emancipation.
   d. Deceased patients: The PHI of a deceased patient is subject to HIPAA privacy protections for as long as TCHD maintains the PHI.
      i. TCHD should obtain a copy of the death certificate if the patient's death is not otherwise directly known to TCHD.
      ii. TCHD shall follow the procedures for verifying the identity of the patient's Personal Representative when responding to requests for Disclosures of PHI of deceased patients.
2. Verification of Identity and Authority of Third Parties
   a. Personal Representative: ~~an individual who may represent the patient and authorize TCHD's Use and Disclosure of PHI to the extent of the Personal Representative's legal authority.~~
      i. TCHD shall verify the identity of the patient's Personal Representative in the same manner it would a patient as set forth in **this policy**~~Sections 1.a and 1.b above~~.
      ii. The Personal Representative's authority to act for the patient arises from his or her authority under state law to make health care decisions for the patient (or in the case of deceased Individuals it may also be to carry out responsibilities related to the estate). TCHD shall verify the legal authority of the patient's Personal Representative by obtaining and reviewing written documents that support the nature and scope of the Personal Representative's legal authority under state law.
      iii. The Personal Representative shall provide information and/or documents to support his or her authority as follows:
         1) Unless an exception applies, a parent or guardian appointed by the Court or other person acting *in loco parentis* with legal authority to

make health care decisions on behalf of the unemancipated minor: Court issued Letters of Guardianship or other legal documents evidencing parental rights to make health care decisions.

2) Surrogate who is 18 years or older and appointed by the patient to make health care decisions for the patient: The patient must personally inform the supervising provider, orally or in writing, of the appointment and it must be promptly recorded in the record. The surrogate appointment is effective only during the course of treatment or illness or stay or for 60 days whichever is shorter.

3) Agent named under a Power of Attorney for Health Care or Advance Health Care Directive: **V**~~v~~alid, executed Power of Attorney for Health Care Directive form naming the person requesting PHI as the agent for health care decisions **and may:**~~:~~
   a) ~~The Power of Attorney for Health Care document~~**May** ~~may specify~~ **Specify** limitations on an agent's ability to make health care decisions on behalf of the patient. For example, it may only apply for a specific treatment. In such cases, TCHD should not treat the person as the Individual for all purposes such as signing an Authorization for the Disclosure.
   b) ~~The Power of Attorney for Health Care document may~~**May** ~~contain~~ **Contain** conditions precedent to the agent's powers such as only applying when the patient is incapacitated. In such cases, TCHD should not treat the agent as the patient's Personal Representative when the patient is not incapacitated.
   c) ~~The Power of Attorney document may~~**May** ~~only~~ **Only** be a General Power of Attorney to manage finances and other business. In such cases, TCHD should not rely on the Power of Attorney as it does not permit the person to make health care decisions for the patient unless it specifically mentions the right to make health care decisions.

4) Guardian or Conservator: Obtain court-issued Letters of Guardianship or conservatorship.

5) Executor or Administrator: Obtain court-issued Letters Testamentary of Letters of Administration.

6) Beneficiary of a deceased patient as defined in Probate Code Section 24: Obtain excerpts of the will identifying the beneficiary.

7) To release PHI to site and sponsor representatives on study subject, TCMC must have fully executed study-related patient consent on file.

b. Family, relatives, domestic partners, close friends and other persons designated by the patient who are involved in patient's care or payment of the patient's care and for notification purposes: TCHD may disclose limited PHI upon verifying the following circumstances:

   i. If the patient is available for, or otherwise available prior to a Use or Disclosure and has the capacity to make health care decisions, TCHD may **u**~~U~~se or **d**~~D~~isclose PHI if it has the patient's agreement; or it provides the patient with the opportunity to object and the patient does not express an objection; or it can reasonable infer from the circumstance, based on professional judgment, that the patient does not object to the Disclosure. For example, an emergency room nurse may discuss a patient's treatment in front of the patient's friend when the patient asks the friend to come into the treatment room or a patient account representative may discuss the patient's bill with their son who is at TCHD with the patient.

ii. If the patient is not available, or the opportunity to agree or object is not practicable because of incapacity or emergency circumstances, TCHD may use its professional judgment to determine if the Disclosure is in the best interest of the patient and, if so, only disclose the PHI that is directly relevant to the person's involvement with the patient's care or payment related to the patient's health care or needed for notification purposes. For example, TCHD may use professional judgment and experience with common practice to make reasonable inferences of the patient's best interest in allowing a person to pick up filled prescriptions, x-rays or similar forms of PHI or may provide information on a patient's condition to their spouse when the patient is unconscious.

iii. TCHD will not discuss a patient's PHI with family, relatives, domestic partners, and close friends if the patient expressly indicates it may not do so.

iv. When TCHD is permitted to share limited PHI with family, relatives, domestic partner, and close friends as provided above, it should not discuss past medical information that is unrelated to the patient's current condition.

c. Public Officials seeking PHI:

i. Verification of Identity: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify the identity of a person when the Disclosure of PHI is to a public official or a person acting on behalf of a public official:

1) For in person requests, presentation of an agency identification badge, other official credentials, or other proof of government status;

2) For requests made in writing, the request is on the appropriate government letterhead; and

3) If the Disclosure is to a person acting on behalf of a public official, a written statement on appropriate government letterhead that the person is acting under the government's authority or other evidence or documentation of agency such as a contract for services, memorandum of understanding, or purchase order, that establishes that the person is acting on behalf of the public official.

ii. Verification of Authority: TCHD may rely, if such reliance is reasonable under the circumstances on the following to verify authority when the Disclosure of PHI is to a public official or a person acting on behalf of a public official.

1) A written statement of the legal authority under which the information is requested, or, if a written statement would be impracticable, an oral statement of such legal authority; and

2) If a request is made pursuant to legal process, warrant, subpoena, order, or other legal process issued by a grand jury or a judicial or administrative tribunal is presumed to constitute legal authority for purposes of verification of identity and authority.

d. Exceptions to Recognizing Persons as Personal Representatives

i. TCHD may elect not to treat a person as the Personal Representative of a patient (adult or minor) if the following requirements are satisfied and the election is documented in the patient's record:

1) TCHD has a reasonable belief that:

a) The patient has been or may be subject to domestic violence, abuse or neglect by such person;

b) Treating such person as the Personal Representative could endanger the patient; and

2) TCHD, in the exercise of the professional judgment of the health care provider, decides it is not in the best interest of the patient to

treat the person as the patient's Personal Representative.

3) TCHD shall consult with ~~Legal~~ **General** Counsel as necessary and appropriate regarding the election decision.

ii. TCHD shall not treat a parent as the Personal Representative of a minor in the following circumstances:

1) If the minor has the authority to consent to medical treatment under state law, ~~he or she is~~**they are** generally the person authorized to have access to medical records regarding the treatment and to decide whether records get released to other persons. If a minor has the right to inspection, then TCHD shall not grant a Personal Representative access to the minor patient's PHI.

2) A court determines or other law authorizes someone other than the parent to make treatment decisions for a minor.

3) A provider makes a good faith determination that a parent or other legal representative who has authority to consent to treatment would have a detrimental effect on the provider's professional relationship with the minor.

4) If the minor has been removed from the physical custody of a parent or guardian in a dependency proceeding, the parent or guardian may not access the minor's mental health information without a court order.

e. Legal Review

i. TCHD **Office of** Compliance ~~Department~~ **and Privacy** shall consult with ~~Legal~~ **General** Counsel as necessary and appropriate regarding the authority of a Personal Representative, issues involving unemancipated minor rights to access medical records or any other information relevant to this policy.

f. Documentation

i. TCHD shall retain copies of all documentation obtained for purposes of these verification procedures.

E. FORM(S):

1. Authorization for Use or Disclosure 8700-1002 - Sample

F. REFERENCE(S):

1. 45 Code of Federal Regulations (CFR Section 160.103)
2. 45 CFR Section 164.502(g)
3. 45 CFR Section 164.510
4. 45 CFR Section 164.514(h)
5. Cal. Health & Safety Code Section 123110(g)
6. Probate Code Section 24

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:
Person/Organization authorized to *release* (use or disclose) the information: Tri-City Medical Center
(TCMC or other Entity)
Person/Organization authorized to *receive* the information (name and address of entity):
Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
Fax: _____ Email: _____

I would like the Health Information:
☐ Mailed as: ☐ CD ☐ Paper ☐ Faxed ☐ E-Mail ☐ Secured ☐ Unsecured

This Authorization applies to the following specific information to be disclosed (select from the following).[1]:
☐ All health information pertaining to any medical history, mental or physical condition and treatment received. Dates include: _____
[Optional] Except for these specific limitations:

☐ Only include the following records or specific types of health information. Dates include: _____
- ☐ Discharge Summary
- ☐ Laboratory Tests
- ☐ EKG
- ☐ Consultation Reports
- ☐ History/Physical Report
- ☐ X-Ray Report
- ☐ Emergency Dept Report
- ☐ Operative/Procedure Report
- ☐ Other (please specify): _____

I understand that this will include information relating to (check if applicable):
- ☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
- ☐ Psychiatric Care (patient to initial here _____)
- ☐ Treatment for alcohol and/or drug abuse.

EXPIRATION

This Authorization expires [on the following specific date]: 30 days

RESTRICTIONS

I understand that California law prohibits the recipient of my health information pursuant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.
I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056. Attn: Medical Records/Health Information.
I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

Affix Patient Label

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

8700-1002
(Rev. 3/21)

AUTHORIZATION FOR USE AND DISCLOSURE

White - Med Records Yellow - Patient

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION[3]

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization (pursuant to HIPAA laws and regulations).
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. Please be aware that once your information leaves Tri-City Medical Center, Tri-City Medical Center will no longer be able to protect that information, and the recipients of your information may not be legally required to protect your information.
6. Information disclosed pursuant to this Authorization could be re-disclosed by the recipient and might no longer be protected by the federal confidentiality law (HIPAA).
7. I hereby release Tri-City Medical Center and its employees and my attending physicians and their associates from any and all legal liability that may arise from the release of this information to the party named on Page 1 of this Authorization Form.

SIGNATURE

Signature _____ Date/Time _____AM/PM
[Patient/representative/spouse/financially responsible party]

If signed by someone other than the patient, state your legal relationship to the patient[2]:

_____

Witness: _____

Authorization for Use or Disclosure of Health Information – Footnote references

[1] This form may not be used to release both psychotherapy notes and other types of health information [*(see 45 CFS § 164.508(b)(3)(ii)*]. If this form is being used to authorize the release of psychotherapy notes, a separate form must be used to authorize release of any other health information.

[2] A spouse or financially responsible party may only authorize release of medical information for use in the following:

a. to process an application for the patient
b. as a spouse or dependent for the following:
    a. a health insurance plan or policy
    b. a nonprofit hospital plan
    c. a health care service plan or
    d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ **Date Received:** _____

Date of Birth: _____ **Visits to be Included:** _____

SS#: – – _____ _____ _____

Telephone #: _____

Distribution: ☐ **Mail** ☐ **Pick-up** ☐ **CD** ☐ **Other**

Completed by: _____
Signature Date

SAMPLE

Completion of this document authorizes the use or disclosure of individually identifiable health information, as set forth below, consistent with California and Federal law concerning the privacy of such information.
Failure to provide all information requested may invalidate this Authorization.

USE OR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth** _____
(Please print)

I hereby authorize the use or disclosure of my health information as follows:
Person/Organization authorized to *release* (use or disclose) the information:[1] Tri-City Medical Center
(TCMC or other Entity)

Person/Organization authorized to *re*[illegible]):

_____

_____

_____

[illegible]de)

This Authorization applies to the [illegible]lect from the following).[2]:

☐ All health information pertaining [illegible]on and treatment received.
Dates include: _____
[Optional] Except for these speci[illegible]

☐ Only the following records or spe[illegible]
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Emergency Dept Report
- ☐ Laboratory Tests

☐ Other
(please specify) _____

I understand that this will include in[illegible]
- ☐ AIDS (Acquired Immunod[illegible]ciency Virus) Infection
- ☐ Psychiatric Care (patient [illegible]
- ☐ Treatment for alcohol and/[illegible]

DELETE – replace with current version

EXPIRATION

This Authorization expires [on the f[illegible]

RESTRICTIONS

I understand that California law pro[illegible]ant to this authorization from making further disclosure of my health information unless the Recipient obtains another authorization from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS

I understand that I may refuse to sign this Authorization.
I understand that I may revoke this authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the following address: 4002 Vista Way Oceanside, CA 92056, Attn: Medical Records/ Health Information.
I understand that my revocation will be effective upon receipt, but will not affect any use or disclosures completed prior to receipt of the revocation.

AUTHORIZATION FOR USE OR DISCLOSURE

8700-1002
(Rev 5/15)

Tri-City Medical Center
4002 Vista Way, Oceanside, California 92056

White-Med Records Yellow-Patient

SAMPLE

ADDITIONAL RIGHTS AND REQUIREMENTS IF REQUESTOR SEEKS THIS AUTHORIZATION[3]

I understand that if Requestor seeks this authorization:

1. My health information will be used for the following purpose(s): ☐ Continuing Medical Care ☐ Insurance ☐ Legal ☐ Other (Please specify) _____
2. I may inspect or obtain a copy of the health information that I am being asked to use or disclose.
3. I must receive a copy of this Authorization[4].
4. Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on my providing or refusing to provide this authorization. However, this does not apply if the Requestor is seeking to use the information as follows: (i) to conduct research-related treatment; (ii) to obtain information in connection with my eligibility or enrollment in a health plan of which I am not already a member; (iii) to enable the Requestor to determine its obligation to pay a claim; or (iv) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the disclosure of psychotherapy notes.
5. If this box ☐ is checked, I understand the Requestor may receive compensation or other remuneration directly or indirectly for the use or disclosure of m

SIGNATURE

Signature _____ _____ AM/PM
[Patient/representative/spouse

If signed by someone other than the patien

_____

Witness: _____ _____

(If you have authorized the disc *is not legally required*
to keep it confidential, it may be *fornia law prohibits*
recipients of your health inform *th your written*
authorization or as specifically

DELETE – replace with current version

Authorization for Use or Disclosure of H

_____

[1] If the Authorization is being requested by ch entity shall be referred to as the Requestor throughout t

[2] This form may not be used to release bot formation [*(see 45 CFS § 164.508(b)(3)(ii)*]. If this form is being tes, a separate form must be used to authorize release of any other

[3] The Requestor is to complete this sectio

[4] Under HIPAA, the individual must be pr s been requested by a covered entity for its own uses and disclo

[5] A spouse or financially responsible party for use in the following:

a. to process an application for the pa
b. as a spouse or dependent for the fo
   a. a health insurance plan or po
   b. a nonprofit hospital plan
   c. a health care service plan or
   d. an employee benefit plan

For TCMC Medical Records/Health Information use Only

MRUN: _____ **Date Received:** _____

Date of Birth: _____ **Visits to be Included:** _____

SS#: _ _ _ – _ _ – _ _ _ _

Telephone #: _____

Distribution: ☐ Mail ☐ Pick-up ☐ CD ☐ Other _____ **Completed by:** _____
Signature Date

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT POLICY MANUAL

ISSUE DATE: 11/14

SUBJECT: Culture Follow Up Emergency Department

REVISION DATE:

Department Approval:	~~07/14~~**06/20**
Department of Emergency Medicine Approval:	~~07/14~~**04/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	~~08/14~~**09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	~~10/14~~ **n/a**
Board of Directors Approval:	**11/14**

A. **PURPOSE:**

1. To define the procedure by which Emergency Department (ED) Nurses track, review, and follow up positive cultures in the Emergency Department on discharged patients.

B. **DEFINITIONS:**

~~2.~~**1.** Culture: Any urine, wound, cerebral spinal fluid (CSF), respiratory or other bodily fluid culture that is obtained in the Emergency Department. ~~on a discharged patient~~.

2. Positive Culture **is defined as bacteria in the lungs, urine, gastrointestinal tract, blood, or CSF.**

3. **Positive cultures are identified by the laboratory, based on specific criteria and filtered to the Emergency Department via the electronic medical record to "Positive Culture Results."**~~is defined as:~~

~~a. Urine: Any final positive report that indicates greater than100,000 cfu/ml in patients greater than36 months, or greater than10,000 cfu/ml in patientsless than36 months old.~~

~~b. Wound/Stool: Any final positive report~~

~~c. Respiratory (including flu, RSV, pharyngeal): any preliminary or final positive report.~~

~~d. Other Cultures: Any final positive report~~

~~4. Negative Culture: Any culture that does not meet the above criteria.~~

~~5. Tracking Board: Emergency Department electronic tracking system.~~

~~6. "Positive Culture Results" Tab: The subset of the Tracking Board that filters for positive culture results.~~

~~7.~~**4.** ~~Ad Hoc Charting: The section in Cerner utilized by Providers to document in "Forms."~~

a. **"ED Nurse Culture Results Review Form" in AdHoc**: The particular form that should be utilized by nurses to document culture follow up actions.

~~8.~~**5.** Antibiotic Sensitivities~~: These~~ are listed on the **form and** ~~2~~2nd ~~page of a positive culture report and~~ help to guide treatment.

a. "S"=Susceptible. The bacteria will be killed by the listed antibiotic
b. "R"=Resistant. The bacteria will NOT be killed by the listed antibiotic.
c. "I"=Intermediate. The bacteria might or might not be killed by the listed antibiotic

~~9.~~**6.** Common "equivalent" names for antibiotics

a. Septra or Bactrim = Trimethoprim/Sulfamethoxazole
b. Keflex = Cephelexin=Cefazolin (per Dr. Smith 2-27-14 for UTIs)
c. Cipro = Ciprofloxacin
d. Levaquin = Levofloxacin
e. Macrobid or Macrodantin = Nitrofurantoin

~~B.~~C. POLICY

1. The designated ED Nurse will review the Positive Culture Results Tab once per day
2. The designated ED Nurse will follow the procedure outlined below to eliminate all positive cultures that do NOT require MD/PA follow up action.
3. The designated ED nurse will document in the EHR any and all actions taken on each patient.

~~C.~~D. FUNCTION OF THE "POSITIVE CULTURE RESULTS" TAB:

1. Displays all Preliminary and Final culture results from the Microbiology lab at TCMC.
2. Completely negative cultures will not show up.
3. Positive cultures will automatically drop off list after 14 days.
   a. All follow up must be completed within 14 days
4. The "Follow Up" column has a drop-down menu attached to it
   a. If this "Follow Up" column is EMPTY, no work has been done on this patient
   b. If this "Follow Up" column shows START, that indicates that an RN or MD/PA has begun to work on this patient.
   c. If one clicks COMPLETE in the- "Follow Up" column, the patient will be permanently deleted from the tracking screen
      i. COMPLETE should only be clicked when the patient requires no further action or follow up by ANY provider.
      ii. Do not click COMPLETE until all necessary follow up has been completed.

~~D.~~E. PROCEDURE

1. Print Screen of "Positive Culture Results" tab on Tracking Screen
   a. A printout MUST be made of the Culture Results Tracking screen BEFORE any action is taken for the day
   b. This printout must be done on a daily basis and placed in the Culture Results binder located in the Emergency Department.
   c. To print list click on the "print" button on right side of screen.
2. Positive Blood or CSF Culture
   a. All positive Blood and CSF cultures (preliminary or final) will be addressed by the **designated** MD/PA. ~~on duty in Fast Track or Station D.~~
3. Positive **Ascitic, Penile, Pharyngeal, Pleural, Stool, Urine, Vaginal, or Wound Culture:** ~~Urine Culture~~
   a. Open patient's chart and review the positive culture report
      i. If it is a PRELIMINARY report, take no action
      ii. If the FINAL REPORT **is negative, as per laboratory guidelines, document in the "ED Nursing Culture Results Review Form", "Culture reviewed. Not clinically significant. No further action warranted."** ~~shows less than100,000 cfu/ml (or less than10,000 cfu/ml for patients less than36 months), Click~~ **click,** "COMPLETE" in the Follow Up Column on the Tracking Screen to permanently remove the patient.
         ~~1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not clinically significant. No further action warranted."~~
      iii. If the FINAL REPORT **is positive, as per laboratory guidelines follow the following steps:** ~~shows greater than100,000 cfu/ml (or greater than10,000 cfu/ml for patients less than36 months),~~
         1) Review Clinical Notes and/or Medication List
   b. If an antibiotic was not prescribed →Click START in the Follow Up Column on the Tracking Screen.
      i. Document all actions taken ~~in Ad Hoc Charting under~~ "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. No antibiotic was prescribed. Referred for follow up by MD/PA."

c. If an antibiotic was prescribed
   i. Compare the prescribed antibiotic to the list of "susceptible" antibiotics on the positive culture report
   ii. If the prescribed antibiotic matches one of those listed as "susceptible," Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient
   iii. Document all actions taken in ~~Ad Hoc Charting under~~ "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Correct antibiotic already prescribed. No further action warranted."

d. If the prescribed antibiotic does NOT match one of those listed as "susceptible," click START in the Follow Up Column on the Tracking Screen to refer it to the MD/PA.
   i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not sensitive to prescribed antibiotic. Referred for follow up by MD/PA."

~~4. Positive Pharyngeal, Stool, Vaginal, Penile, Pleural Fluid, Ascitic Fluid, or Wound Culture~~
~~a. Review patient's chart (Clin Notes and/or Medication List)~~
~~b. If an antibiotic was not prescribed,~~
~~i. Click START in the Follow Up Column on the Tracking Screen.~~
~~1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. No antibiotic prescribed. Referred for follow up by MD/PA."~~
~~c. If an antibiotic was prescribed~~
~~i. Compare the prescribed antibiotic to the list of "susceptible" antibiotics on the positive culture report~~
~~ii. If the prescribed antibiotic matches one of those listed as "susceptible," Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient~~
~~1) Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Correct antibiotic already prescribed. No further action warranted."~~
~~d. If the prescribed antibiotic does NOT match one of those listed as "susceptible," click START in the Follow Up Column on the Tracking Screen to refer it to the MD/PA.~~
~~i.4. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not sensitive to prescribed antibiotic. Referred for follow up by MD/PA.~~

5. Positive Influenza or RSV
   a. Click COMPLETE in the Follow Up Column on the Tracking Screen to remove the patient
      i. Document all actions taken in Ad Hoc Charting under "ED Nursing Culture Results Review" Form. In this case, chart "Culture Reviewed. Not clinically significant. No further action warranted."

~~TRI-CITY MEDICAL CENTER~~ ~~Emergency Preparedness Management~~	~~Section: Emergency Preparedness Management~~ ~~Subject: Influx of Infectious Patient: *Epidemic Influenza or other Respiratory Transmitted Disease*~~ ~~Policy Number: 4006 IC 15.0~~Page ~~1 of 4~~
~~Department: Hospital Wide~~	~~EF~~ DELETE – follow Infection Control Policy: Influx of Infectious Patient: Epidemic Influenza or other Respiratory Transmitted Disease ~~mittee~~

Department Approval:	09/22
Environmental Health and Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administrative Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~1) Purpose:~~

~~Provide a plan to manage patients requiring Droplet or Airborne Precautions when the availability of rooms, staff, supplies or other recourses are limited~~

~~a) Supportive Data:~~

~~Influenza epidemic or pandemic are different from many threats for which public health and the health-care system are currently planning [1,2]:~~

~~1) A pandemic will last much longer than most other emergency events and may include "waves" of influenza activity separated by months (in 20th century pandemics, a second wave of influenza activity occurred 3 to 12 months after the first wave).~~

~~2) The numbers of health-care workers and first responders available to work can be expected to be reduced; they will be at high risk of illness through exposure in the community and in health-care settings, and some may have to miss work to care for ill family members.~~

~~3) Because of how widespread an influenza pandemic, resources in many locations could be limited.~~

~~2) Policy:~~

~~a) Most like scenarios that would result in an influx of infectious patients~~

~~(i) Epidemic influenza~~

~~(ii) Epidemic gastroenteritis~~

~~(iii) Epidemic exposure to suspected biological agent~~

~~(iv) Epidemic biological agent (such as smallpox)~~

~~3) Procedure:~~

~~a) Level 1- 15 or more patients waiting for bed placement~~

~~(i) Notify Administration- ED Charge RN~~

~~(ii) Assess all current inpatients for discharge or transfer potential- Administrative Coordinator~~

~~(iii) Contact local skilled nursing facilities for bed availability- Case manager~~

~~(iv) Contact Public Health Department for coordination of patient placement- Infection Control~~

~~(v) Notify all Directors-Administrative Coordinator~~

~~(vi) Exceed the state mandated nurse-patient ratio, if needed- Chief Nurse Executive~~

~~(vii) Post security at ED entrances- Senior Director Support Services~~

~~b) Level 2- 25 or more patients waiting for bed placement~~

~~(i) Activate Code Orange- Chief Executive Office~~

~~c) Need for Airborne Precautions~~

~~(i) Use negative pressure rooms: 143, 243, 443, 287, 387, 487 and 200~~

TRI-CITY MEDICAL CENTER Emergency Preparedness Management	Section: Emergency Preparedness Management Subject: Influx of Infectious Patient: *Epidemic Influenza or other Respiratory Transmitted Disease* Policy Number: 4006 IC 15.0 Page 1 of 4
Department: Hospital Wide	EFFECTIVE: 12/05 Infection Control Committee

(ii) Use private room with portable HEPA filter (call Pulmonary Services)
(iii) Consider moving patients out of Behavioral Health and use this building for patients who require Airborne Precautions

[1] Preparing for an Influx of Infectious Patients, Joint Commission: The Source, August 2004 [2] Influenza Pandemic Response Plan. California Department of Health Services, September 2001 Page 1 of 4

d) Need for Droplet Precautions
(i) Use negative pressure room, if available. See 3.3.1 and 3.3.2 (Influenza H5N1 only)
(ii) Private rooms
(iii) Cohort with like illness
(iv) Semi private room, maintain 3 feet separation
(v) Create patient care areas in the Assembly Rooms 1-3 (Child Care to Annex D)
(vi) Create patient care areas in the parking lot (Activate Surge Capacity Tents)

e) Need for Contact Precautions
(i) Private rooms
(ii) Cohort with like condition
(iii) Semi private room, with low risk roommate
(iv) Create patient care areas in the Assembly Rooms 1-3 (Child Care to Annex D)

f) Create patient care areas in the parking lot (Activate Surge Capacity Tents)
(i) San Diego County Health Officer declares a Public Health Emergency
(ii) Contact point- Station M 858-565-5255 (24/7 availability)
(iii) Activate Code Orange (if not already activated)
Refer to County of San Diego, Health and Human Services, Pandemic Influenza and Other Highly Infectious Respiratory Transmitted Disease Response Plan- Version 2.00 October 2005

g) Tri City Medical Center would most likely be a Type C Quarantine facility. Type C facilities care for actual and suspect cases. This would include individuals with:
(i) Compatible symptoms and laboratory confirmation of the specific pandemic strain of influenza (confirmed case)
(ii) Compatible symptoms following suspected/known exposure with pending laboratory confirmation (probable case)
(iii) Atypical clinical symptoms following suspected or known exposure (suspect case)
(iv) Contacts under surveillance that become febrile with oral temperatures > 101° F (38°C) on two successive readings.
(v) Individuals with other associated symptoms such as coughing or sneezing
(vi) Ill persons requiring specialized health care may be isolated in a hospital, but, depending on their medical needs, persons may also be isolated at home or in a designated health care facility or community based facility.
(vii) For non-hospital isolation, home/personal residence isolation is preferred and will be utilized first unless a contraindication exists such as homelessness, non-compliance with isolation or at-risk persons in the home with inability to maintain separation.
(viii) Transportation to an isolation facility will be coordinated with the EMS DOC.

h) If there is no hospital bed available, contact Station M.

i) *Prophylaxis requirements:*
(i) Required for entry to facility if vaccine is available. NOTE: Prophylaxis may not be available.
(ii) If no prophylaxis is available, individuals working with confirmed and suspect cases must use Standard and Droplet Precautions.

TRI-CITY MEDICAL CENTER Emergency Preparedness Management	Section: Emergency Preparedness Management Subject: Influx of Infectious Patient: *Epidemic Influenza or other Respiratory Transmitted Disease* Policy Number: 4006 IC 15.0Page 1 of 4
Department: Hospital Wide	EFFECTIVE: 12/05 Infection Control Committee

(iii) Strict respiratory hygiene to include frequent hand hygiene and masks must also be enforced.

j) *Staffing*:

(i) Maintain pre-epidemic staffing levels, if possible

(ii) If the number and types of staff are insufficient to meet the needs of the number of people being contained, additional staff may be requested through the County Emergency Operations Center (EOC) k) After activation of Code Orange, the Incident Commander will:

(iii) Designate the Planning Chief to compile a list of individuals who can enter the facility.

(iv) This should be established in collaboration with the Public Health Officer and/or the authorized designee.

(v) The list will include the smallest possible number of people required for patient care, disease investigation, and facility maintenance (physicians, nurses or aides, laboratory personnel, housekeeping, dietary, and maintenance personnel, etc.)

(vi) This list will be kept by the **Personnel Pool Unit Leader** or designee.

(vii) The **Safety and Security Officer** or designee will ensure that all personnel who enter the facility have been recently prophylaxed with vaccine or antivirals if available and are on the list of individuals who may enter the facility

(viii) The **Human Resources Director** or designee will:

(1) Ensure that employees monitor and report their temperature and any symptoms every 12 hours until

(a) 14 days after they are vaccinated or

(b) 14 days after they completed their antiviral prophylaxis or

(c) 5 days after the date of last patient contact

(2) Those personnel on the list to enter the facility that are not vaccinated or on prophylaxis drugs will also monitor and report their temperature and any symptoms every 12 hours and use personal protective equipment (PPE) while in the facility until 14 days after they have been vaccinated, placed on antiviral therapy when it becomes available or 5 days from date of last contact.

(3) This access monitoring system will include a confidential log of all persons who enter and leave, including staff, and will include each person's vaccination, antiviral treatment status, temperature and any symptoms reported.

(4) Until 14 days after immunization, once vaccine is available, or completion of antiviral therapy, all personnel will check their temperature every 12 hours. At the beginning of each shift, they are to report their temperatures or any illness to the person assigned to monitor employees' health. On off days, they are required to be in telephone contact each morning to report their temperatures. Once the waiting period is over, personnel are not required to routinely check their temperatures. They are still required to report any illness.

(5) Staff with febrile oral temperatures >38°C on two successive readings will not be able to work.

(6) Patients with oral temperatures >38°C on two successive readings will require *Standard and Droplet Precautions*. If the suspect pathogen is found to be transmitted via airborne route, than *Standard and Airborne Precautions* will be initiated, if available. If the suspect pathogen is found to be transmitted via direct/indirect (fomite) routes, then *Contact Precautions* will be added.

(ix) Extended Epidemic- PRIORITIES

(1) Sustained staffing

(2) Vaccine acquisition and distribution

(3) Antiviral medication acquisition and distribution

TRI-CITY MEDICAL CENTER Emergency Preparedness Management	Section: Emergency Preparedness Management Subject: Influx of Infectious Patient: *Epidemic Influenza or other Respiratory Transmitted Disease* Policy Number: 4006 IC 15.0Page 1 of 4
Department: Hospital Wide	EFFECTIVE: 12/05 Infection Control Committee

(4) Mask supply and reuse
(5) Bed availability
(6) Security

Staffing and possible quarantine	Consider housing staff at hospital	Request staff from outside affected areas	Train additional staff to perform non-critical functions
Medication supply	Request additional vaccine and antiviral medications	Reprioritize vaccination and antiviral distribution strategies	
Bed availability	Use available private rooms; cohort with like illness	Consider transfer to another facility	

Appendix A

World Health Organization (WHO) Stages of Alert Phases of a Pandemic Pandemic Stage Definition

Novel (new) Virus Alert
novel virus detected in one or more humans
little or no immunity in the general population
potential, but not inevitable precursor to a pandemic

Pandemic Alert
- novel virus demonstrates sustained person-to-person transmission and causes multiple cases in the same geographic area

Pandemic Imminent
- novel virus causing unusually high rates of morbidity and mortality in widespread geographic areas Pandemic
- further spread with involvement of multiple continents

Second Wave
- after the number of cases falls and the pandemic appears to be ending, typically a second wave of cases occurs within several months

Pandemic Over
- cessation of successive pandemic "waves", accompanied by the return (in the U.S.) of the more typical wintertime "epidemic" cycle

1.

Standard Precautions for all patients and all aspects of patient care.

- Prevent direct contact with all body fluids (including blood), secretions, excretions, non-intact skin (including rashes) and mucous membranes.
- Handwashing, gloves when contact with above.
- Mask/eye protection/face shield while performing procedures that cause splash/spray.
- Gowns to protect skin and clothing during procedures.

DELETE – follow Infection Control Policy: Influx of Infectious Patient: Epidemic Influenza or other Respiratory Transmitted Disease

	BACTERIA								VIRUS				TOXINS			
	ANTHRAX	[illegible]	CHOLERA	GLANDERS	[illegible]NIC PLAGUE	[illegible]NIC PLAGUE	TULAREMIA	Q FEVER	SMALLPOX	[illegible]NE ENCEPHA	ICEPHAULTIS	[illegible]GIC FEVERS	BOTULISM	RICIN	[illegible]/COTOXINS	[illegible]EROTOXIN B
Transmission-based Precautions																
Contact Precautions		X							X							
Airborne Precautions				X					X							
Use of **N95** mask by **all** individuals entering the room									X							
Droplet Precautions						X				X						
Wash hands with antimicrobial soap		X	X						X			X				
Patient Placement																
No restrictions	X						X						X	X	X	X
Cohort 'like' patients when private room unavailable			X		X	X		X			X					
Private Room		X	X	X	X	X			X	X		X				
Negative Pressure									X							
Door closed at all times				X					X							
Patient Transport																
No restrictions	X						X	X			X		X	X	X	X
Limit movement to essential medical purposes only		X	X	X	X	X			X	X		X				
Place mask on patient to minimize dispersal of droplets				X		X			X	X						
Cleaning, Disinfection of Equipment																
After DC routine terminal cleaning with hospital-approved disinfectant			X	X			X	X	X	X	X		X	X	X	X
Disinfect surfaces with bleach/water sol. 1:9 (10% sol.)	X	X			X	X						X				
Dedicated equipment disinfected prior to leaving room		X							X			X				
Linen management as with all other patients	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Routine medical waste handled per internal policy	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Discharge Management																
No special discharge instruction necessary	X		X	X			X	X		X	X		X	X	X	X
Home care providers should be taught Standard Precautions	X	X			X	X						X				
Patient discharged from hospital when no longer infectious						X			X			X				
Patient discharged 72 hours after antibiotics completed						X										
Post-mortem Care																
Droplet Precautions						X										
Airborne Precautions									X							
Use of **N95** mask by **all** individuals entering the room									X							
Negative Pressure									X							
Contact Precautions									X			X				
Routine terminal cleaning with hospital-approved disinfectant		X	X	X			X	X	X	X	X		X	X	X	X
Disinfect surfaces with bleach/water sol. 1:9 (10% sol.)	X				X	X						X				

Continued on next page

Diagnosis and Treatment Table

Syndrome	Differential Diagnosis	Bioterrorism Threat Disease Description	Initial laboratory & other diagnostic test results	Immediate public health & infection control actions
Acute Respiratory Distress with Fever	Dissecting aortic aneurysm, Inhalational anthrax, pulmonary embolism	**Inhalational Anthrax:** Abrupt onset of fever; chest pain; respiratory distress without radiographic findings of pneumonia; no history of trauma or chronic disease; in 24-36 hrs. progress-ion to shock & death.	Chest x-ray with widened mediastinum; gram-positive bacilli in blood; definitive testing available through public health laboratory network.	Notify Department Manager to initiate BT Plan. Alert laboratory to possibility of anthrax. Standard Precautions.
Acute Respiratory Distress with Fever	Community acquired pneumonia, Hantavirus Pulmonary Syndrome, meningococc emia, pneumonic plague, rickettsiosis	**Pneumonic Plague:** Apparent severe community-acquired pneumonia but with hemoptysis, cyanosis, gastrointestinal symptoms, shock	Gram-negative bacilli or coccobacilli in sputa, blood or lymph node; safety-pin appearance with Wright or Giemsa stain; definitive testing available through public health laboratory network.	Droplet Precautions (surgical mask for all). Notify Department Manager to initiate BT Plan. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview & possible chemoprophylaxis; get detailed address & phone number information. Alert laboratory to possibility of plague.
Acute Respiratory Distress with Fever	Plague, Q fever, Staphylococc-al enterotoxin B, phosgene, tularemia	**Ricin (aerosolized):** Acute onset of fever, chest pain and cough, progressing to respiratory distress & hypoxemia; not better after antibiotics; death in 36-72 hrs.	Chest x-ray with pulmonary edema. Consult with Local Health Department regarding specimen collection and diagnostic testing procedures.	Notify Department Manager to initiate BT Plan. Standard Precautions.
Acute Respiratory Distress with Fever	Influenza, adenovirus, mycoplasma	**Staphylococcal enterotoxin B:** Acute onset of fever, chills, headache, non-productive cough & myalgia (influenza-like) with a NORMAL chest x-ray.	Primarily clinical diagnosis. Consult with Local Health Department regarding specimen collection and diagnostic testing procedures.	Notify Department Manager to initiate BT Plan. Standard Precautions.
Acute Rash with Fever	Varicella, disseminated herpes zoster, vaccinia, monkeypox, cowpox	**Smallpox:** Papular rash with fever that begins on the face and extremities and uniformly progresses to vesicles and pustules; headache, vomiting, back pain, and delirium common	Clinical with laboratory confirmation; vaccinated, gowned and gloved person obtains specimens (scabs or swabs of vesicular or pustular fluid). Call public health immediately before obtaining specimen; definitive testing available through public health laboratory network.	Call Infection Control and Department Manager to initiate BT Plan. Contact and Airborne Precautions required. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview and vaccination; get detailed address and phone number information. Call Local Health Department immediately.

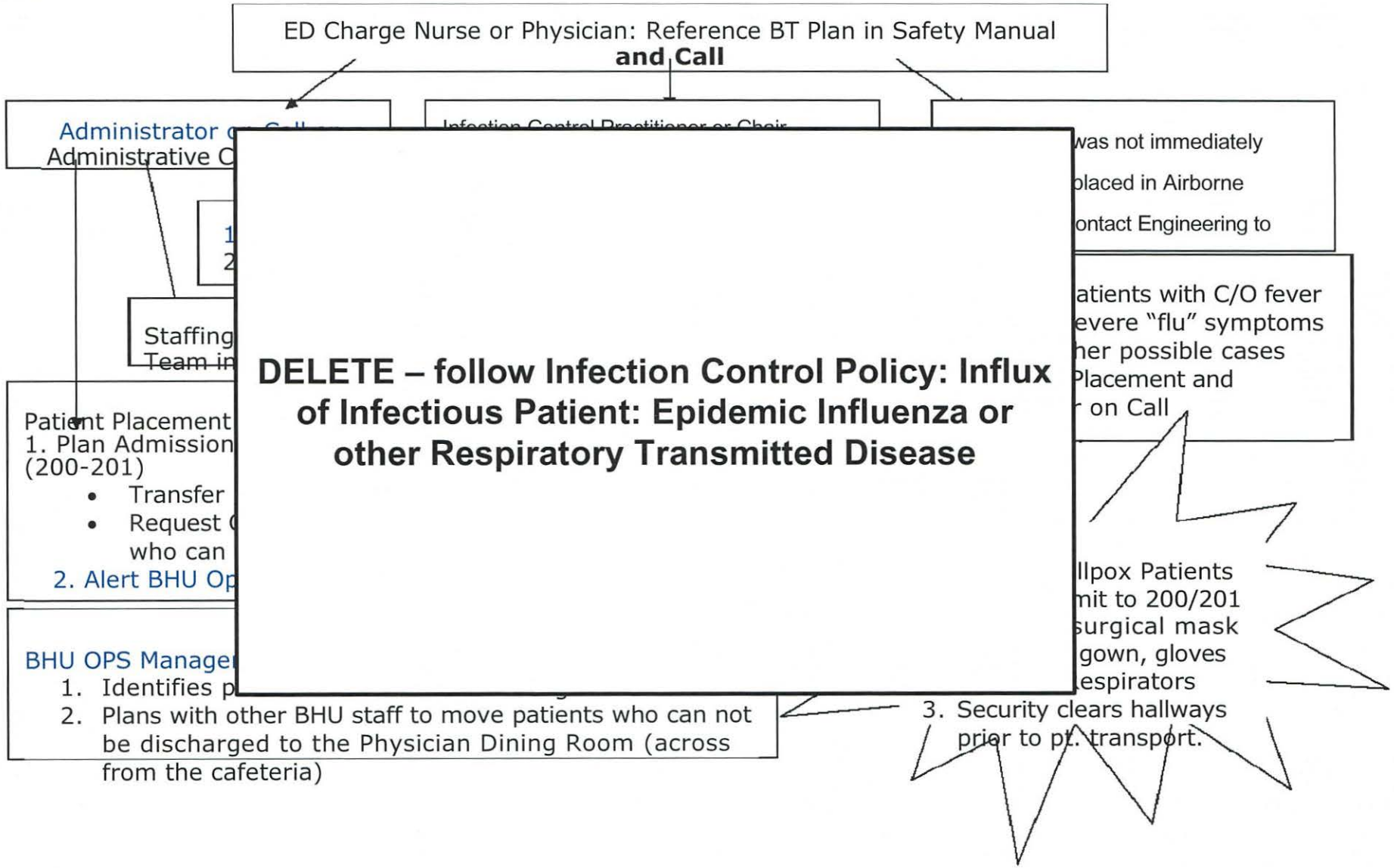
End page

Syndrome	Differential Diagnosis	Bioterrorism Threat Disease Description	Initial laboratory & other diagnostic test results	Immediate public health & infection control actions
Acute Rash with Fever	Meningococcemia, malaria, typhus, leptospirosis, borreliosis, thrombotic thrombocytopenic purpura (TTP), Hemolytic Uremic Syndrome (HUS)	**Viral Hemorrhagic Fever (e.g., Ebola):** Fever with mucous membrane bleeding, petechiae, thrombocytopenia and hypotension in a patient without underlying malignancy	Definitive testing available through public health laboratory network--call public health immediately.	Call Infection Control and Department Manager to initiate BT Plan. Contact Precautions. Ask family members/close contacts of patient to stay at the hospital (if already present) for public health interview and follow-up; get detailed address and phone number information.
Neurologic Syndromes	Guillain-Barre Syndrome; myasthenia gravis; mid-brain stroke; tick paralysis; Mg++ intoxication; organophosphate, CO_2, paralytic shellfish, or belladonna-like alkaloid poisoning; polio; Eaton-Lambert myasthenic syndrome	**Botulism:** Acute bilateral descending flaccid paralysis beginning with cranial nerve palsies	CSF protein normal; EMG with repetitive nerve stimulation shows augmentation of muscle action potential; toxin assays of serum, feces, or gastric aspirate available through public health laboratory network.	Call Infection Control and Department Manager to initiate BT Plan. Request botulinum antitoxin from local/state health department. Standard Precautions.
Neurologic Syndromes	Herpes simplex, post-infectious	**Encephalitis** (Venezuelan, Eastern, Western): Encephalopathy with fever and seizures and/or focal neurologic deficits.	Serologic testing available through public health laboratory network.	Call Infection Control and Department Manager to initiate BT Plan. Standard Precautions.
Influenza-like Illness	Numerous diseases, including Q Fever	**Brucellosis:** Irregular fever, chills, malaise, headache, weight loss, profound weakness and fatigue. Arthralgias, sacroiliitis, paravertebral abscesses. Anorexia, nausea, vomiting, diarrhea, hepatosplenomegaly. May have cough and pleuritic chest pain.	Tiny, slow-growing, faintly-staining, gram-negative coccobacilli in blood or bone marrow culture. Leukocyte count normal or low. Anemia, thrombocytopenia possible. CXR nonspecific: nml, bronchopneumonia, abscesses, single or miliary nodules, enlarged hilar nodes, effusions. Serologic testing and culture available through public	Notify laboratory if brucellosis suspected--microbiological testing should be done in a biological safety cabinet to prevent lab-acquired infection. Call Infection Control and Department Manager to initiate BT Plan. Standard Precautions.

End page

Syndrome	Differential Diagnosis	Bioterrorism Threat Disease Description	Initial laboratory & other diagnostic test results	Immediate public health & infection control actions
Influenza-like Illness	Numerous diseases, including Q Fever	Tularemia (Typhoidal, Pneumonic): Fever, chills, rigors, headache, myalgias, coryza, sore throat initially; followed by weakness, anorexia, weight loss. Substernal discomfort, dry cough if pneumonic disease.	Small, faintly staining, slow-growing, gram-negative coccobacillus in smears or cultures of sputum, blood. CXR may show infiltrate, hilar adenopathy, effusion. Definitive testing available through public health laboratory	Notify laboratory if tularemia suspected--microbiological testing should be done in a prevent lab-acquired infection. Call Infection Control and Department Manager to BT Plan. Standard Precautions.
Blistering Syndromes	Mustard agents, Staphylococcal enterotoxin B	T2 Mycotoxin: Abrupt onset of mucocutaneous & airway irritation including skin (pain &blistering), eye (pain &tearing), GI (bleeding, vomiting, and diarrhea), & airway (dyspnea & cough)	Consult with Local Health Department regarding specimen collection and diagnostic testing procedures.	Unlike other biological agents or biotoxins, trichothecene mycotoxins are dermally and patients exposed to them should be decontaminated as soon as possible with soap and copious amounts of water. Notify Department Manager to initiate BT Plan.

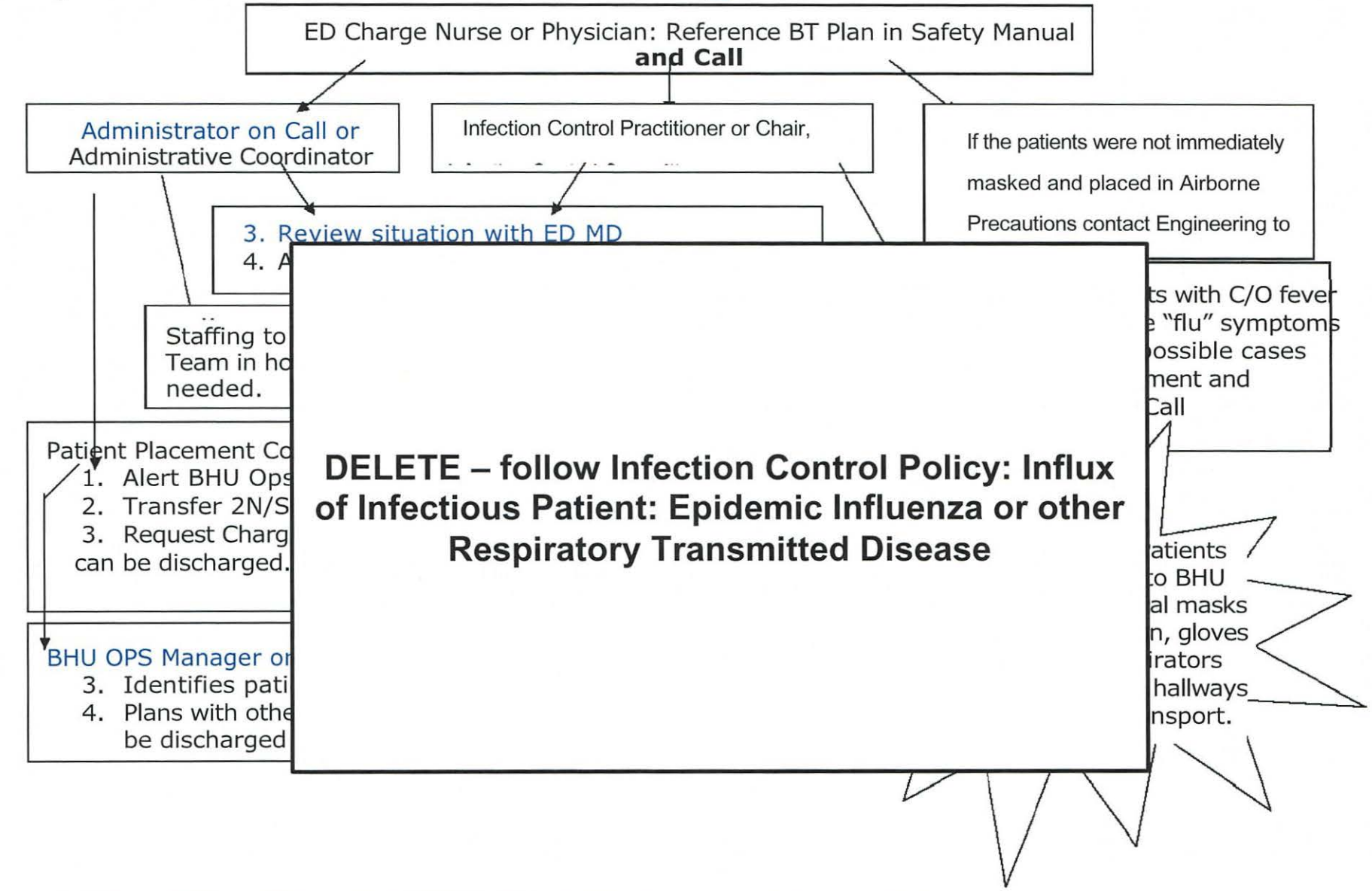
~~Emergency Department Presentation Suspected Smallpox: 1 to 4 Patients~~



DELETE – follow Infection Control Policy: Influx of Infectious Patient: Epidemic Influenza or other Respiratory Transmitted Disease

Emergency Department Presentation
Suspected Smallpox: More than 4 Patients

~~**Public Health approves the discharge/dismissal of all persons in**~~



Tri-City Medical Center

~~Oceanside, California~~

~~Emergency Preparedness Management~~

DELETE: Follow Security Policy: Traffic Control in Event of a Disaster

EFFECTIVE DATE: 11/88

SUBJECT: Traffic Control In The Event Of A Disaster: Security Department Specific

REVISION DATE:07/90, 04/94, 04/91, 03/97, 05/00, 6/03, 12/05, POLICY NUMBER: 4009 ~~Page 1 of 2~~

Department Approval:	09/22
Environmental Health and Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	
	~~CROSS REFERENCE APPROVAL:~~

~~1.0 PURPOSE:~~

~~To provide orderly flow of traffic to and from the medical center in the event of a disaster.~~

~~2.0 PERSONNEL:~~

~~2.1 Security Supervisor~~

~~2.2 Security Officers.~~

~~2.3 Other assigned personnel from the labor pool.~~

~~3.0 POLICY:~~

~~The Security Supervisor or his designee is responsible for establishing and maintaining traffic flow during a disaster. He may supplement their staff from the labor pool as needed.~~

~~4.0 PROCEDURE:~~

~~4.1 In the event of activation of the disaster plan, the following procedure will be instituted:~~

~~4.1.1 In the event of a major disaster, traffic to and from the hospital will be strictly controlled.~~

~~4.1.1.1 Security personnel will be posted at both the Vista Way and Thunder Drive entrances to the Medical Center grounds.~~

~~4.1.1.2 The Vista Way entrance will admit emergency vehicles, private vehicles (only if casualties are being transported), physicians and local agencies (police, fire departments), etc.~~

~~4.1.1.3 The entrance shall be secured with barricades and appropriate signs, tape, and traffic cones.~~

~~4.1.1.4 Hospital personnel must have proper identification to gain entrance and shall be directed to the east, or Thunder Drive entrance.~~

4.1.1.5 Security will assure adequate personnel by requesting additional personnel from the Labor Pool. The additional designated personnel shall be properly identified with vests and flashlights.

4.1.1.6 Visitors and concerned family members of casualty victims will be directed to the Child Care/Family Information (CC/FIC) at the Education Annex.

Tri-City Medical Center

Oceanside, California

Emergency Preparedness Management

EFFECTIVE DATE: 11/88 **SUBJECT: Traffic Control In The Event Of A Disaster: Security Department Specific**

REVISION DATE: 4/91, 3/97, 5/00, 6/03, 12/05 **POLICY NUMBER: 4009**

CROSS REFERENCE:

REVIEW DATE: 7/90, 4/94 **APPROVAL:**

4.1.1.7 Security personnel will also be posted at the hospital triage area to assist in orderly flow of traffic. Traffic cones and tape will be used to cordon off this area.

4.1.1.8 Physicians will be directed to the physicians parking lot upon arrival.

4.2 In the event of a disaster situation, sufficient security personnel shall be posted at parking lot entrances, triage area and emergency entrances to maintain the orderly flow of traffic and emergency vehicles.

5.0 AUTOMATIC REVIEW:

This policy/procedure will be reviewed annually and updated as needed. It is the responsibility of the Security Supervisor to:

5.1 Orient and educate the security staff to the disaster plan.

5.2 Maintain an updated version of the Security Disaster plan and Call back roster.

TRI-CITY MEDICAL CENTER Emergency Preparedness Management	Section: Emergency Preparedness Management Subject: Disaster Procedure for Earthquake Policy Number: 4010 Page 1 of 2
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/88~~ ~~REVISED: 5/01, 3/07, 5/00, 6/03, 12/05~~ ~~REVI~~ DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

Department Approval:	09/22
Environmental Health and Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administrative Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~1.0 **INTRODUCTION:**~~

~~Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of the Hospital Emergency Incident Command System (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedures.~~

~~2.0 **PURPOSE:**~~

~~To provide guidelines for staff to follow during and after an Earthquake.~~

~~3.0 **PROCEDURE:**~~

~~Everyone's safety depends on each employee remaining calm.~~

~~3.1 Remain calm. Do not panic or run through or outside the building. The greatest point of danger is just outside doorways and close outer walls because of falling debris.~~

~~3.2 If you are in the building, remain where you are. If possible, take cover under a desk, table, bench, or in doorways, hallways, or against inside walls. These areas are the most sound structurally during an earthquake.~~

~~3.3 Keep visitors, patients, and other employees out of stairwells and elevators. (The elevator system is equipped to shut down during an earthquake and open at the nearest floor.)~~

~~3.4 If you are outside, stay away from the building. Stay clear of walls, utility poles, and downed wires and trees.~~

~~3.5 The most important thing to remember is to remain calm. Reassure and assist patients and visitors. DO NOT ABANDON YOUR PATIENTS.~~

~~3.6 If possible, turn off utilities. Use good judgment.~~

~~3.7 In the event of a major earthquake, be aware that the phone system will probably be out at least initially. Use runners to communicate between departments.~~

~~3.8 The person designated in charge will need to assign someone to assess damages, supplies, and casualties. The information will then need to be delivered via a runner to the Incident Command Center located in French Rooms 1 and 2.~~

~~3.9 If a fire occurs, follow the FIRE PROCEDURE.~~

~~3.10 If evacuation is necessary, follow EVACUATION PROCEDURE.~~

~~4.0 IN CASE OF DAMAGE TO GAS:~~

~~4.1 Inspect for leaky pipes (by smell only).~~

~~4.2 If you smell gas:~~

~~4.2.1 Contact Incident Command Center for immediate assistance. 4.2.2 Open all windows and doors so gas can escape.~~

~~4,2,3 Engineering will shut off the main valve and notify the gas company. 4.2.4 Notify PBX, who will in turn notify the gas company.~~

~~4.3 WATER~~

~~4.3.1 If pipes are broken, Engineering will shut off the main valves which brings water into the hospital.~~

~~4.4 ELECTRICITY~~

~~4.4.1 If you suspect a short circuit, call Command Center for immediate assistance.~~

~~NOTE:~~ ~~Each department should evaluate its area and set up specific procedures to follow in the event of damage to utilities. This is particularly important for areas where gas of any kind is used.~~

~~5.0 REMEMBER IF AN EARTHQUAKE OCCURS:~~

~~5.1 Remain calm.~~

~~5.2 Assure patient's safety. DO NOT ABANDON PATIENTS.~~

~~5.3 Do not try to leave or enter the building.~~

~~5.4 Stay away from outer walls, windows, trees, utility poles, and downed wires.~~

~~5.5 Check utilities.~~

~~5.6 Use telephones only for an emergency.~~

~~5.7 Above all, USE GOOD JUDGEMENT.~~

Tri-City Medical Center
Oceanside, California

EMERGENCY PREPAREDNESS MANAGEMENT

ISSUE~~EFFECTIVE~~ DATE: 04/88	**SUBJECT: Employee Disaster Call Back Procedure: Hospital Wide**
REVISION DATE: 10/91, 02/97, 06/00, 06/03, 12/05	**POLICY NUMBER: 4012 ~~Page 1 of 1~~**

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~CROSS REFERENCE:~~ **~~REVIEW DATE:~~** **~~APPROVAL~~**

A. **PURPOSE:**
1. To outline the call back procedure to summon appropriate personnel to the facility if a disaster occurs.

B. **POLICY:**
1. When the department call-back procedure is implemented, each individual will call a portion of the department staff as indicated by the attached Call Back Tree.

C. **PROCEDURE:**
1. When the Incident Commander has determined that the disaster call back procedure for department is to be initiated, the Director or his/her designee will be notified by the Incident Commander and advised of the circumstances. The Director/designee will initiate the department call-back tree.
2. Each individual will call the personnel from the department telephone list shown directly below their name. Advise the staff of the disaster.
3. If any staff member is unable to reach the individual below or beside their name, they will continue down the list and contact the next staff member, etc.
4. The caller will pass the message as it was delivered to them.
5. Each staff member will report to duty at the facility or remain on standby to return if the need arises.
6. Proper identification will be necessary to gain entry onto the campus and into the hospital. Every staff member must keep their TCMC ID badge with them at all times.

~~TRI-CITY MEDICAL CENTER~~ ~~Emergency Preparedness Management~~	~~Section: Emergency Preparedness Management~~ ~~Subject: Bomb Threat~~ ~~Policy Number: 4013~~ Page 1 of 3
~~Department: Security Department Specific~~	~~EFFECTIVE: 11/88~~ ~~REVISED: 9/93, 3/97, 6/00, 6/03, 12/05~~ ~~REVIEWED: 11/91~~

ISSUE DATE: 11/88 **SUBJECT:** Bomb Threat

REVIEW DATE: 11/99 **POLICY NUMBER:** 4013

REVISION DATE: 09/93, 03/97, 11/99, 06/00, 06/03, 12/05

Environment of Care Content Expert Approval:	09/22
Environmental Health & Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **INTRODUCTION:**

1. It is the policy of Tri-City Medical Center to protect patients, visitors, employees, and others persons and property in the event a bomb threat.

B. **PURPOSE**

1. The intent of this policy is to prevent death or injury to patients, visitors and staff or the destruction of Medical Center property due to a bomb explosion. It is the purpose of these procedures to establish guidelines to be followed in the event of a bomb threat, explosion, or discovery of an explosive or incendiary device.

C. **PROCEDURE:**

1. Each department and its employees must be informed of these procedures and report immediately any unusual person, activity, or object. A chain of command must be established within each department of the Medical Center to ensure prompt and intelligent action in the event of such an emergency.
2. The Oceanside Police and Fire Departments will respond upon request, conduct a preliminary investigation, and take action as dictated by the circumstances. These outside departments will not assume authority for the order of evacuation. This responsibility shall rest with Administration or his designee.

D. **EXPLOSIVE DEVICES**

1. The homemade bomb is usually one of two basic types.
   a. Open bomb and the concealed or disguised bomb:
      i. No effort is made to conceal the nature of the open type bomb. It is usually composed of one or more sticks of dynamite tied together and fitted with a safety fuse and blasting cap.

ii. It may consist of a short length of pipe, filled with an explosive, and capped at both ends with a piece of safety fuse protruding from a hole drilled in one of the caps.

b. Fuses appearing to be burned can still be active and capable of exploding and causing severe injury. Sometimes a plastic substance having the appearance and consistency of putty is used. This material may be used in an open type bomb and is detonated by an explosive cap attached to electrical or safety fuse.

E. **ACTION RESPONSE – EMPLOYEE**

1. Employee receives a bomb threat call:
   a. Remain Calm
   b. Try to gain maximum information possible from the caller.
   c. Do not assume call is a hoax.
   d. Have a co-worker notify Security Department via PBX Emergency Line # 66.

F. **ACTION RESPONSE – PBX**

1. PBX Operator receives telephone bomb threat.
   a. Log all information regarding the threat Bomb Threat Checklist (Attachment A:)
      i. Exact time call is received
      ii. Time of notification of key personnel
      iii. Any information obtained from the caller (refer to the PBX "Bomb Threat Checklist")
      iv. Time situation is cleared and all departments are back to normal.
   b. The following questions should be asked:
      i. What building or office is the bomb in?
      ii. Where in the building or office (inside, outside, roof, basement, etc.).
      iii. What does it look like? (box, suitcase, pipe, shoe box, etc.).
      iv. What type o explosive is used?
      v. When is it set to go off? (exact time and date)
   c. Other suggestions which might be of help:
      i. Pay particular attention to any strange or peculiar background noises.
      ii. Listen closely to the voice - male or female; age; voice quality - accent or speech impediment. Record every word and impression immediately and notify the Administrator/ designee and the Security Supervisor.
2. If the threat is received on a weekday between 8:00 a.m. and 5:00 p.m.:
   a. Contact the Security Department and advise them of the situation.
   b. Contact the Administrator/designee and advise them of the situation and stand by for instructions.
   c. At the direction of the Administrator/designee, PBX will notify the Oceanside Police and Fire Departments via 911.
   d. Notify the Sr. Director of Support Services.
   e. Notify the EOC/Safety Officer
   f. Notify the Public Information Officer
3. If the threat is received on weekends and/or after 5:00 p.m.:
   a. Contact the Security Department and advise them of the situation.
   b. Contact the Administrator or the Administrator on-call at his residence, advise him of the situation and stand by for instructions.
   c. Notify the Oceanside Police and Fire Departments via 911.
   d. Notify the Sr. Director Support Services
   e. Notify the Hospital Safety Officer
   f. Notify the Public Information Officer

G. **ACTION RESPONSE OF:**

1. The Sr. Director of Support Services/or designee will direct the assessment of the threat to

determine if the hospital is going to initiate the hospital wide Code Orange response procedures.

a. Upon notification that a bomb threat has been received, the Incident Commander will open the Command Center and will initiate the following:
   i. All decisions regarding searches, key personnel notification, evacuations.
      1) The Command Center will be located in French Rooms 1 & 2.
      2) All communications will be via the Medical Center telephone system.
      3) In case of a bomb threat PBX will overhead page 7575.
      4) If the threat is directed at a specific department required to contact PBX, PBX will page "PBX 7575", for example: "7575 – Pulmonary".
      5) The use of any type of portable radio is prohibited. All searches will be according to the attached Checklist.

b. Should a general recall of Medical Center personnel be ordered by the Incident Commander, the Disaster Call-back Procedure will be used.

c. If a bomb is found, the following shall apply:
   i. Order evacuation of all personnel from the area shall be determined by the Incident Commander. Ensure all personnel remain at a safe distance. It should be noted that a distance of 300 feet away from the concerned area is considered a safe minimum distance.
   ii. Inspect the area to assure that the area has been completely evacuated.
   iii. Make sure that no person touches a suspect object/device or anything attached to it. **DO NOT ATTEMPT TO MOVE, COVER, OR JAR IT. LEAVE IT ALONE!**
   iv. Have personnel standing by in the nearest lobby or entrance to guide and assist the Sheriff's Department Bomb Disposal Detail.
   v. Have pre-selected personnel at strategic locations to prevent unauthorized persons from entering the area.

2. In the case a bomb explosion:
   a. A "Code Orange" will be activated. Each department will perform its duties as outlined in these procedures.
   b. Triage teams along with available physicians and nurses shall be directed to an area not affected by the bomb blast.
   c. Guard the explosion scene from unauthorized persons pending an investigation by the law enforcement and safety personnel.
   d. Have pre-selected personnel assigned to strategic locations to prevent unauthorized persons from entering the affected area.
   e. Conduct a secondary bomb search for the possibility of multiple bombs.
   f. Give the ALL CLEAR and notify concerned departments to return to normal operation.

H. **ACTION RESPONSE OF NURSING DEPARTMENT:**

1. In the event a bomb is located on a patient floor:
   a. The Department Director or designee will be responsible to conduct a unit search according to the attached Departmental Search Checklist.
   b. The Department Director or designee must get patients away from all windows and attempt to cover those windows with blankets in order to prevent flying glass.
   c. Open all doors within the suspected area to allow the force of an explosion to dissipate.
   d. DO NOT pull a fire alarm or otherwise alarm the patients. Act as casual as possible and attempt to have a reasonable explanation for the functions being performed.
   e. If evacuation is advised by the police or fire department, the Incident Commander will advise all concerned departments regarding the evacuation.

I. **ACTION RESPONSE OF SECURITY:**

1. Security Supervisor
2. Security Officers
3. Director of Engineering

~~–Emergency Prepare Mgmt\4013 bomb12/05~~

4. Services EOC/Safety
~~3.~~**5.** Officer
~~4.~~**6.** As soon as the Security Department has been advised of a bomb threat, the following procedures are to be implemented:
   a. All doors providing ingress and egress to the Medical Center will be secured.
   b. A systematic search of the Medical Center will begin immediately, according to the Departmental Search Checklist (see attached) and will be coordinated by the Security Supervisor and Director of Engineering, and EOC/Safety Officer.
   c. The Command Center will be established in French Rooms 1 & 2 and it will be the responsibility of the Department Director or designee to call that extension when their department search is completed.
   d. If a suspect area is known, the search pattern will begin in that area. If it is determined that no area is specified, then the pattern will follow these priorities:
      i. Patient areas (ground floor, up).
      ii. General areas (public places).
      iii. Unsecured general areas (no public access).
      iv. Secured general areas.
   e. Each area will be searched with the use of a departmental volunteer. Upon completion of the search, the Department Director or designee will contact the Command Center.
   f. If a bomb or suspect device is located within the Medical Center or on its surrounding property, notification will immediately be sent to the Command Center.
   g. When a bomb or suspect device is located by the searchers, the area will be evacuated at the direction of the Incident Commander. The finding of a bomb or suspect device **will not** terminate a search. All areas will be thoroughly searched in the event that multiple devices have been planted.

Tri-City Medical Center

~~Oceanside, California~~

~~Emergency Preparedness Management~~

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EFFECTIVE DATE: 11/88

SUBJECT: Emergency Preparedness Management Disaster Plan: Administration

REVISION DATE: 7/91; 3/97; 6/00; 5/03, 2/06 ~~**POLICY NUMBER:** 4015 Page 1 of 2~~

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**- n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	
	~~**CROSS REFERENCE:**~~
~~**REVIEW DATE:**~~	~~**APPROVAL:**~~

~~A. POLICY~~

~~1. The Incident Commander has the ultimate authority to determine the status of the Medical Center during any type of disaster or after discussion with the Emergency Department and/or other relative department managers.~~

~~2. It is the Incident Commander's responsibility to coordinate and govern the disaster from the Incident Command Center (ICC) located in French Rooms 1 and 2.~~

~~B. NOTIFICATION~~

~~1. The chain of command for disaster is as follows:~~

~~a. Chief Executive Officer~~

~~b. Vice President, Chief Operating Officer/Chief Nurse Executive~~

~~c. Chief Financial Officer~~

~~d. Other area Vice Presidents~~

~~e. Senior Directors~~

~~f. Administrative Coordinator~~

~~2. Code Orange:~~

~~a. On duty - Chief Executive Officer alerts all administrative staff and assumes responsibility of Incident Commander or appoints designee.~~

~~b. Off duty - Chief Executive Officer determines whether or not administrative staff reports to ICC and informs PBX to call administrative staff with instructions to return to the Medical Center or remain at home.~~

~~c. If administrative secretarial support is required, the Chief Executive Officer will inform PBX to alert the Executive Assistant who will contact other administrative secretarial staff.~~

~~d. All administrators to report to ICC. Executive Assistant, Administrative Assistant to Chief Operating Officer/Chief Nurse Executive to report to ICC. All other administrative secretaries to report to Labor Pool in French Room 3.~~

~~C. PROCEDURE~~

~~1. Incident Commander or appropriate administrator directs disaster activities from ICC following HEICS guidelines:~~

~~a. Evaluates requests for additional personnel, supplies and equipment and provides appropriate approval.~~

~~b. Using HEICS check-off list, ensures all departmental procedures are underway.~~

~~c. Provides for relay of reports to the press and media via Public Information Officer.~~

~~d.~~**a.** ~~Should discontinuance or disruption of hospital services occur, notify the Department of Health Services.~~

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policies & Procedures~~	~~Section: Emergency Preparedness Management~~ ~~Subject: Communications Department Specific~~ ~~Policy Number: 4023~~ Page 1 of 3
~~Department: Hospital Wide~~	~~EFFECTIVE: 11/88~~ ~~REVISED: 9/93, 3/97, 6/00, 1/06~~ ~~REVIEWED:~~

ISSUE DATE: 11/88

SUBJECT: Communications Department Specific

REVISION DATE: 09/93, 03/97, 06/00, 01/06

POLICY NUMBER: 4023

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. PURPOSE:

1. To establish efficient Emergency Communications, and provide clear guidelines for the PBX staff to Following during a disaster.

B. ~~2.0~~ PROCEDURE:

1.~~2.1~~ The staff in the Communications Department will immediately **assess**~~make an assessment of~~ resources available and will report to the **immediate S**~~s~~upervisor/Shift Lead Operator**/designee** ~~or, in his/her absence, the Information Technology Technical Manager~~ upon notification of **a** ~~any~~ disaster.

2.~~2.2~~ The Supervisor/Lead Operator will review the nature of the alert and make necessary arrangements to cover the situation. Upon review of personnel and resources, the Supervisor/Lead Operator will report his/her findings and recommendations to the Information Technology Technical Manager.

3.~~2.3~~ The Supervisor will then report to the Incident Command Center, located in French Rooms 1 & 2, regarding the state of the department. At the direction of the Incident Commander, a universal page will be sent to the Emergency Call list.

4.~~2.4~~ The Supervisor/Lead Operator will provide the Supervisor with an hourly update regarding the status of the area. (Such as manpower, supplies, equipment, etc.) If additional manpower is needed, the call-back procedure will be activated.

5. ~~2.5~~ **In the event the disaster is located within the Communication Department, the implement the following:**~~IN THE EVENT THAT THE DISASTER IS LOCATED WITHIN THE COMMUNICATION DEPARTMENT, THE PROCEDURE IS AS FOLLOWS:~~

a. ~~2.5.1~~ The Supervisor/Lead Operator will notify the Information Technology

Technical Manager.

~~a.~~**b.** ~~2.5.2~~ All personnel will report to the Information Technology department and be accounted for.

~~b.~~**c.** The appropriate departments will be contacted, such as Facilities, Emergency Room, Employee Health Office, and Administration

d. At the direction of the Information Technology Technical Manager, the Supervisor/Lead Operator will begin the call backlist in the order of the employees listed. Refer to Communication call-back list.

C. ~~3.0~~ **EVACUATION PLAN:**

1. In the event that personnel must be evacuated from any communication space due to fire, earthquake, or any other disaster, the following procedure should be observed:

2.~~3.1~~ Remain calm and do not panic.

3.~~3.2~~ Assist the injured, if possible.

4. ~~3.3~~ Personnel will evacuate according to the evacuation routes. The staff will meet by the annex building to account for all.

5. ~~3.4~~ Returning to the scene of the disaster is prohibited unless instructed and deemed safe by proper authorities.

~~2.~~**6.** ~~3.6~~ The Information Technology Technical Manager will be in charge and interface with proper authorities in dealing with all aspects of the disaster that occurred or related to the Communication Department.

D. ~~4.0~~ **COMMUNICATION DEPARTMENT RESPONSE TO CODES:**

1. ~~**4.1**~~ **CODE YELLOW**

a. Announce Code Yellow three times on announcement speaker.

b. **Call the following:**

i. Radiation Officer~~: beeper (0588)~~

ii. Administration~~: 3348~~, when closed **contact the** ~~beep~~ Administrative **Supervisor- (AS)**~~Coordinator: 0375, Between 4:00 p.m and 7:00 p.m., page Administrator on-call, Monday through Friday.~~

iii. Chief of Staff: (Physician)

iv. Office Emergency Service~~: County - 285-6429~~

v. Base Station Coordinator~~: beeper 0388~~

vi. Admitting~~: 3151~~

vii. Security: use security phone

viii. Environmental Services:

2. ~~**4.2**~~ **CODE ORANGE**

a. Announce Code Orange and Area three times on announcement speaker.

b. **Call the following:**

i. ~~———~~Base Station Coordinator~~: beeper 0388~~

ii. Administration~~: 3348~~, when closed **contact the**~~beep~~ **AS**~~dministrative Coordinator: 0375. Between 4:00 p.m. and 7:00 p.m., page Administrator on-call, Monday through Friday~~. Security: use security phone

iii. Facilities Management: (Engineering)

iv. Send out code orange page to all Executive and Director personnel.

3. ~~**4.3**~~ **DOCTOR STRONG**

a. Information to get from caller:

b. Location - room, station, etc.

c. Callers name~~.~~

d. Note time call came in~~.~~

e. Overhead page three times and announce over security radio "Doctor Strong" and the location.

4. ~~4.4~~ **BOMB THREAT**
   a. Speed Dial: **9911** - Oceanside Police & Fire Department
   b. FBI: **923-1122**
   c. Have security call operator, do not give information out over the air.
   d. **Call** Base Station Coordinator~~: beeper 0388~~
      i. Administration~~: **3348**,~~ when closed **contact the** ~~beep~~ **AS** ~~Administrative Coordinator: **0375**. Between 4:00 p.m. and 7:00 p.m., page Administrator on-call, Monday through Friday~~.
      ii. Facilities Services: (Engineering)
      iii. Keep person on phone as long as possible. Note sounds, accents, etc.
      iv. Ask where bomb will explode.
      v. Note if they have knowledge of hospital.
5. ~~4.5~~ **CODE GREEN**
   a. Announce Code Green and Area three times on the announcement speaker. Beep pulmonary supervisor and lead therapist - follow notification of emergency.
   b. Notification must come from Facilities Services, Pulmonary, Nursing, or other authorized personnel.
   c. Code Green will always be beeped to **2222****
   d. When notified get name of person calling.
6. ~~4.6~~ **CODE MI**
   a. Page **3100** to **8888**
   b. This will activate the following beepers:
   c. **1454** - Imaging
   d. **3152** - Laboratory
   ~~a.~~**e.** **0354** - Cardiopulmonary
   ~~b.~~**f.** **6524** - Cardiopulmonary
   g. The "**8888**" will represent a Code MI and signifies that a cardiac patient needs a stat procedure in the Emergency Department. These patients have TOP PRIORITY.
7. ~~4.7~~ **CODE BLUE**
   ~~c.~~**a.** Announce Code Blue and Area three times on the announcement speaker.
   ~~d.~~**b.** Beeper **0066** to Room Number plus *1
   c. Speed dial **965-0066** – Beeper Code Blue (Be sure to enter room number)
   d. Announce Code Blue and Area three more times on the announcement speaker. Call Unit or floor to make sure everyone responded.
8. ~~4.8~~ **CODE PINK**
   a. Announce Code Pink and Area three times on announcement speaker. Wait one minute then repeat above.
9. ~~4.9~~ **CODE RED**
   a. When alarm rings, immediately check alarm number.
   b. Announce Code Red and Area three times on announcement speaker.
   c. Page security and give location of fire
   d. Beep stationary engineer: **0720**
   e. Repeat again in one minute.
   f. Call Administration~~: **3348**,~~ when close **contact** ~~beep~~ A**S**dministrative Coordinator: **0375**. Between 4:00 p.m. and 7:00 p.m., page Administrator on-call, Monday through Friday.
   g. **W**~~W~~ait for instructions from Facilities Services or Administration.

Tri-City Medical Center
Oceanside, California

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EMERGENCY OPERATIONS PROCEDUR

~~EFFECTIVE~~**ISSUE DATE:11/88** **SUBJECT: Code Orange Disaster Plan: Emergency Department Specific**

REVIEW DATE: 03/93; 03/97; 03/99; 04/03; 06/05 **POLICY NUMBER: 4026**

REVISION DATE: 11/91, 11/94 ~~**CROSS REFERENCE:**~~

Emergency Operations Procedure Expert Approval: 03/22
Environmental Health and Safety Committee Approval:09/22
Medical Executive Committee Approval: n/a
Administration Approval: 11/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

~~A. PURPOSE:~~

~~1. To ensure efficiency in Emergency Department responsiveness in the event of a disaster. To maintain adequate availability of physicians, staff, equipment, supplies and shelter; to establish a rapid triage site and decontamination services as needed.~~

~~B. INTRODUCTION:~~

~~1. Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of the Hospital Emergency Incident Command System (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located in the TCMC Fire Safety and Disaster Plan Manual located in the Staff Lounge.~~

~~C. NOTIFICATION:~~

~~1. In the event of a disaster or critical situation, Emergency Medical system (EMS) will radio the TCMC Mobile Intensive Care Nurse (MICN) and communicate the supposed or actual event. The MICN will alert the ED Charge RN; ED Charge RN to notify EDMD Station B, Administrative Coordinator (AC), & ED Nursing Leadership; ED Nursing Leadership to contact ED Medical Director (if not working). AC to notify Safety Officer and Administrative Delegate.~~

~~2. 3.1When a Code Orange is initiated the Charge Nurse will:~~

~~a. Ensure disaster supplies are in place~~
~~b. 3.1 .1 Triage table(s)~~
~~c. 3.1.2 Portable communication radios (from Security)~~
~~d. 3.1.3 Disaster cart~~
~~e. 3.1.4 Radiation care (separate cart)~~
~~f. 3.1.5 Assign a Field Triage Emergency Department RN and MD if requested by scene.~~
~~g. 3.1.6 Assign a Triage Unit Leader~~

~~3. 3.2 Emergency Department Medical Director Responsibilities:~~

~~a. 3.2.1 Coordinates with ED Charge Nurse~~
~~b. 3.2.2 Emergency Department Physician Responsibilities:~~
~~c. 3.2.3 Assumes medical command in the Emergency Department~~
~~d. 3.2.4 Delegates the Emergency Department physician call-back list~~
~~e. 3.2.5 Advises Treatment Area Supervisor when additional physicians are needed~~

f. 3.2.6 Ensures that the field triage team is ready for dispatch to the disaster scene, if needed 3.2.7 Assists Triage Unit Leader in setting up triage area

g. 3.2.8 Assigns incoming Emergency Department physicians to triage area and assigns available physicians to treatment areas of specific patients.

4. 3.3 Emergency Department Administrative Assistant Responsibilities:
   a. 3.3.1 Assist with the following functions as assigned by the Emergency Department Director/Service Line Leader, notifying:
      i. Medical Director of Emergency Department
      ii. Additional clerical staff
      iii. Emergency Department physicians
   b. 3.3.2 Screen calls which interfere with disaster communications
   c. 3.3.3 Communicates needs and reports to the Emergency Department Director
5. 3.4SLL/Operation Manager's Responsibilities:
   a. 3.4.1 Orientation of department personnel to the overall disaster plan and training and specific departmental responsibilities.
   b. 3.4.2 Orientation of staff to evacuation routes.
   c. 3.4.3 Regular review of the disaster plan with all personnel.
   d. 3.4.4 Determine a plan for calling in staff from home, depending on the disaster situation and the needs of the individual department as necessary.
   e. 3.4.5 Maintain telephone lists of all key employees both in the department and at home. Lists to be reviewed quarterly and revised, if necessary.
6. 3.5Following the activation of the plan for a disaster or a drill the SII/Operation Manager will:
   a. 3.5.1 Evaluate staffing levels and send one person to the labor pool if possible.
   b. 3.5.2 Stay in the department and maintain routine patient services throughout the disaster situation unless otherwise directed.
   c. 3.5.3 Develop specific plans and instructions for department operations within the guidelines of the overall Disaster Plan.
   d. 3.5.4 Reevaluate staffing schedules as needed.
   e. 3.5.5 Participate in a critique immediately following a drill if appropriate.
   f. 3.5.6 Plan for long-range staffing, changing the time schedule as necessary.
7. 3.6 Employee's Responsibilities:
   a. 3.6.1 Be familiar with the Disaster Plan and review it regularly.
   b. 3.6.2 Know and be prepared to perform specific responsibilities. Participate in regular training sessions and exercises.
8. 3.7 Clinical Manager Responsibilities:
   a. 3.7.1 Decontamination Situation 5 or less Victims: Assign Clinicians to 1.0 decontamination area shower in ambulance bay:
   b. 3.7.2 Initiate ED Call Back (if additional staff are needed).
   c. 3.7.3 Evaluate which patients are to stay in the ED, be admitted or discharged. Fill out census log and forward to IC.
   d. 3.7.4 Contact IC for staff needed, Lab, Radiology, RN's Unit Secretaries, Lift Team.
   e. 3.7.5 Assign EMT to screen ambulances for known exposure patient transport vs. regular run (if unable to divert).
   f. 3.7.6 Assign Staff to Decontamination Area. Assign an Emergency Department Unit Secretary assigned to:
      i. 3.7.6.1 Triage
   g. 3.7.7 Emergency Department Station's A, B, and C
   h. 3.7.8 Communicate with IC or Area Supervisor for needed supplies and equipment.
   i. 3.7.9 Reassure patients and family members.
9. 3.8 Decontamination Situation 6 or more Victims:
   a. 3.8.1 Consider the initiation of Code Orange
   b. 3.8.2 Initiate ED Call Back

c. 3.8.3 Evaluate which patients are to stay, be admitted or discharged. Fill out census log and forward to IC.
d. 3.8.4 Assign EMT to screen ambulances for exposure vs. regular run (if unable to divert).
e. 3.8.5 Assign Clinicians and Support staff from the ED to the Decontamination Tent.
f. 3.8.6 Assign an Emergency Department Unit Secretary to:
    1) Triage
    2) Emergency Department Station's A, B, and C
g. 3.8.7 Assign Staff and Physician to ED Canopied Emergency Entrance for Medical Triage.
h. 3.8.8 Contact IC for staff needed, Lab, Radiology, RN's Unit Secretaries, Lift Team.
i. 3.8.9 Assign Nurses from Nursing Units to ED to implement the plan of care, perform timely and accurate assessments, provide appropriate intervention, identify outcomes and conduct timely evaluations.
j. 3.8.10 Ensure that the patient is identified by at least a wristband and a patient number and that the disaster tag and category of urgency is assigned.
k. 3.8.11 Records vital signs and treatments in the appropriate area in the disaster packet.
l. 3.8.12 See that the disaster medical record is recorded into inpatient charts for those who are admitted.
m. 3.8.13 Communicate with IC or Area Supervisor for needed supplies and equipment and staff relief.
n. 3.8.14 Reassure patients and family members.

10. 3.9 Disaster Event w/o Decontamination<50 Victims
    a. 3.9.1 Consider the initiation of a Code Orange
    b. 3.9.2 Initiate ED Call Back
    c. 3.9.3 Evaluate which patients are to stay, be admitted or discharged. Fill out census log and forward to IC.
    d. 3.9.4 Assign EMT to screen ambulances for exposure vs. regular run (if unable to divert). 3.9.5 Assign an Emergency Department Unit Secretary to:
        i. Triage
        ii. Emergency Department Station's A, B, and C
    e. 3.9.6 Contact IC for staff needed, Lab, Radiology, RN's , Unit Secretaries, Lift Team.
    f. 3.9.7 Assign Nurses from Nursing Units to ED to implement the plan of care, perform timely and accurate assessments, provide appropriate intervention, identify outcomes and conduct timely evaluations.
    g. 3.9.8 Ensure that the patient is identified by at least a wristband and a patient number and that the disaster tag and category of urgency is assigned.
    h. 3.9.9 Record vital signs and treatments in the appropriate area in the disaster packet.
    i. 3.9.10 See that the disaster medical is recorded into inpatient charts for those who are admitted. 3.9.11 Communicate with IC or Area Supervisor for needed supplies and equipment and staff relief.
    j. 3.9.12 Reassure patients and family members.
11. 3.10 Decontamination > 50 Victims
    a. 3.10.1 Consider the initiation of a Code Orange
    b. 3.10.2 Initiate ED Call Back
    c. 3.10.3 Evaluate which patients are to stay, be admitted or discharged. Fill out census log and forward to IC.
    d. 3.10.4 Assign EMT to screen ambulances for exposure vs. regular run (if unable to divert).
    e. 3.10.5 Assign staff and Physician to ED Canopied Emergency Entrance for Medical Triage.
    f. 3.10.6 Assign an Emergency Department Unit Secretary to:

~~i. Triage~~
~~ii. Emergency Department Station's A, B, and C~~

~~g. 3.10.7 Contact IC for staff needed, Lab, Radiology, RN's, Unit Secretaries, Lift Team.~~
~~3.10.8 Assign Nurses from Nursing Units to ED to implement the plan of care, perform timely and accurate assessments, provide appropriate intervention, identify outcomes and conduct timely evaluations.~~

~~h. 3.10.9 Ensure that the patient is identified by at least a wristband and a patient number and that the disaster tag and category of urgency is assigned.~~

~~i. 3.10.10 Record vital signs and treatments in the appropriate area in the disaster packet.~~

~~j. 3.10.11 See that the disaster medical is recorded into inpatient charts for those who are admitted. 3.10.12 Communicate with IC or Area Supervisor for needed supplies and equipment and staff relief.~~

~~k.~~a. ~~3.10.13 Reassure patients and family members.~~

Tri-City Medical Center
~~Oceanside, California~~
~~Emergency Preparedness Manager~~

DELETE – FOLLOW FOOD AND NUTRITION PLAN

~~**ISSUE DATE; 05/88**~~ ~~**SUBJECT: Emergency Preparedness Management Disaster Plan: Food and Nutrition**~~

REVISION DATE: 07/91, 03/97, 07/02, 04/03, 08/05, 11/05

~~**POLICY NUMBER: 4036 Page 1 of 9**~~

~~**CROSS REFERENCE:**~~

REVIEW DATE: 05/94 ~~**APPROVAL:**~~

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**PURPOSE:**~~

~~To ensure efficient Food & Nutrition services and to maintain adequate availability of personnel in the event of disaster; to establish, supervise, and maintain proper management of food, supplies, and personnel in the event of an emergency/disaster.~~

~~**INTRODUCTION:**~~

~~Due to the varying types and magnitudes of emergency events, Tri City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes this standard operating procedure. The complete plan is located in the TCMC Disaster Plan Manual located in the Patient Food Services Supervisors' office and the main Food & Nutrition Services office.~~

~~**NOTIFICATION:**~~

~~Food & Nutrition Services will be notified of the disaster plan activation from the PBX operator announcing "CODE ORANGE" or "CODE YELLOW" using the overhead page.~~

1. ~~Charge Responsibilities (food service supervisor)~~
   a. ~~Read the Unit Leader Responsibilities found in the Department Disaster packet (usually kept in the Disaster Manual). Charge duty will transfer to the manager/director after one arrives.~~
   b. ~~Complete and send one employee with the personnel inventory form or emergency incident message form to the Incident Command Center. These are found in the Disaster manual located in the patient food service supervisors' office and in the main Food & Nutrition Services office.~~
      ~~The Incident Command Center is located in the French rooms. If the Incident Command Center is not set up, contact the Emergency Department.~~
      ~~Recall staff from breaks for standby to report to disaster priority areas.~~
      ~~(Staff should return immediately if they hear the overhead page activating the disaster plan.~~
   c. ~~Contact manager/director and begin call in procedure. Relay as much information as you can to the Incident Command Center.~~

~~**Food & Nutrition Responsibilities:**~~

~~2.1 The Director of Pharmacy, EVS, Engineering, Food & Nutrition and Security will be contacted by the Command Center and will alert the operations manager of Food & Nutrition as appropriate.~~

EFFECTIVE DATE: 5/88 SUBJECT: Emergency Preparedness Management Disaster Plan: Food and Nutrition Department

REVISION DATE: 7/91, 3/97, 7/02, 4/03, 8/05, 11/05 POLICY NUMBER: 4036 Page 2 of 9

CROSS REFERENCE:

REVIEW DATE: 5/94 APPROVAL:

2.2 The manager will initiate the departmental call tree, if necessary (Appendix A). In the event of a major disaster, all off duty personnel are to report to the labor pool for further direction.

2.3 All on-duty employees are to report immediately to the department for instructions.

2.4 Information regarding staffing levels and available staff resources is completed on the incident emergency message form and taken to the incident command center in the French rooms.

2.5. Food and disposable supplies will be inventoried.

2.6 Meals will be served in the cafeteria when possible. If necessary, other serving areas will be designated by the manager or designee.

2.7 In the event the disaster affects the normal operation of patient food service, the Director or designee will be responsible for any changes necessary to serve food to the patients and will notify the units.

2.8 In the event the disaster interrupts the normal operations of food service such as power failure; disposable ware may be used.

2.9 A list of current vendors who can provide emergency refrigeration, water, and food supplies is kept on file (Appendix B). Emergency phone numbers for contacting vendors at night or on weekends for all of the vendors is on file.

2.10 A disaster menu is kept on file and will be initiated, if necessary. Food and supplies for the menu will last for at least 72 hours. A "Confidential Disaster Information Form" is on file with the primary vendor, details of which would be initiated in the event of a natural disaster. MRE's are available for use by staff and visitors, and as back up supplies for patients.

2.11 As changes occur, an hourly update report will be sent to the Command Center, via department status form.

2.12 A beverage station will be set up, upon request, for the Command Center.

2.13 The departmental procedures on disaster control will be updated and reviewed annually.

2.14 Water may be accessed from the City of Oceanside. In the event that this water is inaccessible, water from the City of Vista would be accessed. Water may also be accessed from two 10,000-gallon drums located on the roof of the medical center. Details of how this water would be accessed are found in the Disaster Manual Engineering specific policy (Failure of H20 Distribution). Additional provisions of bottled water (2000 twelve ounce bottles) and 80 five-gallon jugs of water are stored with disaster supplies in the basement under the operating room suites. Alternative sources for water include commercial water suppliers, i.e. Rayne and Arrowhead.

2.15 Disaster supplies and food designated for disaster use may be stored separately from Food and Nutrition Services, in a room in the basement under the Operating Room Suites.

2.16 In the event that the kitchen cannot be utilized for meal preparation, alternative sites are available, i.e. the Occupational Therapy kitchen, the Pavilion kitchen. A tent may be set up and utilized as needed in the parking lot.

EFFECTIVE DATE: 5/88 SUBJECT: Emergency Preparedness Management Disaster Plan: Food and Nutrition Department

Tri-City Medical Center
Oceanside, California
Emergency Preparedness Management

REVISION DATE: 7/91, 3/97, 7/02, 4/03, 8/05, 11/05 POLICY NUMBER: 4036 Page 3 of 9

CROSS-REFERENCE:

REVIEW DATE: 5/94 APPROVAL:

APPENDIX A

Food & Nutrition Services Disaster Call Tree

STANDING ORDER 9.1 CALL LIST (DISASTER AND MASS CASUALTIES)*

AREA	POSITION	NAME	PHONE
OFFICE	Operations Manager**	Marty Acevedo	941-5841
	Clinical Dietitian	Linda Gastelum	758-4904
	Clinical Dietitian(Alt)*	Erin Goulette	231-1132
FOOD PRODUCTION			
	Cook	Maurilia Parra	945-2250
	Buyer	Gloria Breault	480-9380
	Receiving Clerk	Andres Carachure	726-3798
	Supervisor (Alt)*	Vernon Hampton	231-6425
DISHROOM	Food Service Supervisor	Ward Cave	721-5157
	Food Service Worker	Jesus Tello	216-6130
	Food Service Worker	Rolando Guiterrez	643-9142
	Food Service Worker (Alt)*	Michael Adams	277-7002
DIET OFFICE			
	Diet Clerk	Paul Riecke	224-1008
	Diet Clerk	Mary Lou Grose	757-4330
	Diet Technician	Terry Odfina	758-2825
PATIENT FOOD SERVICE			
	Food Service Supervisor	Eric Clemens	433-2805
	Food Service Worker	Alejandra Hernandez	598-8393
	Food Service Worker	Marily Carachure	724-0846
	Food Service Worker (Alt) *	Josefina Blancas	724-1901
CAFETERIA			
	Cafeteria Supervisor	Jeff Pigza	721-1078
	Food Service Worker	Maria Elena McKeag	758-8104
	Food Service Worker (Alt) *	Michael McGee	696-7343

* Indicates the person to be called only when more than 25 casualties are expected.
** These employees are to be called first and they will then call others, as needed

EFFECTIVE DATE: 5/88 — SUBJECT: Emergency Preparedness Management Disaster Plan: Food and Nutrition Department

REVISION DATE: 7/91, 3/97, 7/02, 4/03, 8/05, 11/05 — POLICY NUMBER: 4036 Page 4 of 9

CROSS REFERENCE:

REVIEW DATE: 5/94 — APPROVAL:

APPENDIX B

Disaster Call List for Vendors

A. Emergency Refrigeration and Freezers
Hollandia Dairy maintains standby refrigerator and freezer trucks. Contact Ken May

B. Procedure for obtaining food and related supplies - refer to the following vendors' list:

ITEM	VENDOR
Water	*Arrowhead Bottling Company (Contact Facilities Department first at Ext. 7148) Hollandia Dairy maintains standby stainless steel water bins which are available for emergency situations.
Dairy Products	Hollandia Dairy - contact: Ken May 744-3222 (office) or 728-2108
Food & Supplies	US Foodservice/Joseph Webb Foods (closest supplier) - contact Kim Jones 745-4200 (office), Ext. 351 US Foodservice/Alliant Toni Wiseman 800.888.3147 ext 8576 714.615.9550 (cell) 949.955.1605 (home)

Primary – US Foodservice Emergency Contact List – Corona Division

Paul Andrzejczyk	800-888-3147	x8983	408-230-8996	
Terry Kostka	800-888-3147	x8981	949-872-5722	714-403-3410 (h)
Emily Hess	800-888-3147	x8740	714-747-7452	951-734-3396 (h)
Toni Wiseman	800-888-3147	x8576	714-615-9550	949-955-1605 (h)

Secondary – US Foodservice Emergency Contact List – Corona Division

Les Wong	800-888-3147	x8908	714-943-0445	
Jim Lewis	800-888-3147	x8942	714-943-6513	951-246-7667 (h)
Jim Humphrey	800-888-3147	x8990	714-904-2353	

Brian Pye 800-888-3147 x8990 714-904-9652 (c)
Russ Sislofsky 800-888-3147 x8969 714-904-2373 (c)
Derrick Britton 800-888-3147 x8992 714-904-5634 (c)
Produce JC Produce
1-800-826-1547
Meat Tip Top Meats - contact
John/Diane Haedrich 438-2620 (office) 729-5753 (home)

Procedure for Disaster Control

A. Procedure for Hand-washing Dishes
1. Use two (2) lanterns
2. Strip and stack dirty trays, etc.
3. Hand wash dirty trays, etc., in portable sinks as follows:
a. Sink #1 (WASH) - add 4 pumps disinfectant to hot water (at least 110 degrees F)
b. Sink #2 (RINSE) - plain hot water (at least 110 degrees F)
c. Sink #3 (SANITIZE) - add 3 pumps sanitizer to hot water (at least 110 degrees F)
d. Dry on rack

B. Waste Disposal
Garbage will be placed in closed containers and removed since garbage disposals could not be used. If garbage and trash could not be removed, they would need to be buried in a pit on the property.

C. Emergency Power
On emergency power, most equipment is still functioning. If pilot gas is available, gas grills, gas ovens, convection ovens (without blowers), gas stoves, deep fat fryers and boilers can be used. Food items that can be prepared include any type of frozen entree, grill items, frozen items that are fried, soups, frozen vegetables and gravies that could be cooked on the stove.
If boiler gas only is available, steamers and steam kettles could be used. Food items that can be prepared include frozen entree, frozen vegetables, fish potatoes, dehydrated potatoes, soups and gravies, and freeze-dried coffee. Flashlights are kept in the supervisors' office. Battery-operated lanterns are kept in the storeroom.

C. Reserve Water

Using the reserve water supply, all china, glassware and utensils would be replaced by disposable paper goods, and we would hand wash only the essential items such as serving utensils and pots and pans.

E. Food Service would rely on telephones in-house to keep updated on the discharge and admissions of patients to the nursing floors and would modify the diets according to the foods available under the circumstances.

F. Security

Only Supervisors have the keys to the refrigerators and freezers. All would be locked except for those in use. The doors to the kitchen would be locked to prevent outsiders from coming into the kitchen. The walk-in freezer and the walk-in refrigerator would be locked until a freezer truck and a refrigeration truck could be obtained from Hollandia, if necessary. However, most freezers and refrigerators are on emergency power. Supervisors would only allow authorized personnel into the walk-ins and the storeroom.

G. Employees

The manager will initiate the departmental call tree if necessary (Appendix A).
Method of call in: If telephone service is available, they would be called. If phone service is out, an employee would be sent to the homes of those living nearest the hospital.
If not access in or out: Shifts would be arranged for people to work and rest out in the cafeteria, take naps and sleeps when needed. Moderate amounts of water and towels would be provided for washing.

H. Concerns

The most immediate concern is proper sanitation and handling and storage of perishable food items, disposal of refuse and the comfort and well being of the patients and employees.

I. Disaster Menu - the following food supplies will last 72 hours and are located in the OR basement or in the Disaster Storage Container. The menu is planned for a census of 200 for each meal.

If food within the department is not available, will provide Boost Plus 1 can/meal and one snack with bottled water – to provide 1420 kcal, 56 gm protein.
"Heater meals" (MRE's) are available as a supplement to foods within the department; 3000 meals are kept on site in the OR basement or in the Disaster Storage Container. These meals may be utilized as needed for patients, staff, and the community.

J. Procedure for Food Preparation and Service for Disaster Where No Power Available:

1. Dietitians' Office - Use one (1) lantern
2. Diet Clerks' Office - Use one (1) lantern
3. Patient Food Service
   a. Pour HOT water into 5 - 2 1/2 gallon Containers, using individual tea bags and freeze-dried coffee for beverages.
   b. Trayline - push trays manually.
   c. Use disposable ware for patient tray service with regular tray.
   d. Supervisors: Check temperature of hot water.
4. Cooks
   a. Boil water for coffee and tea for patient food service and cafeteria.
   b. Keep foods warm in ovens.
   c. Dish up small amounts of food to be served on tray line and in cafeteria.
   d. Replenish foods frequently.
5. Dishroom - Using 2 lanterns, hand wash dirty trays, etc., in portable sinks:

SINK #1 (WASH) Add 4 pumps Solitaire to hot water (at least 110 degrees F)
SINK #2 (RINSE) Plain hot water (at least 110 degrees F)
SINK #3 (SANITIZE) Add 4 pumps Ster-bac to hot water (at least 110 degrees F)

K. Procedure for Specific Disaster, Mass Casualties and for Disruption of Service
L. Procedures for Internal Disaster, Mass Casualties and for Disruption of Services
   a. There shall be controlled traffic through flooded area.
      1. Outside of the department, Environmental Services personnel will reroute traffic away from flooded areas.
      2. Within the department, all employees will be required to leave and relocate to an uncontaminated area as designated by the supervisor.
      3. If it is impossible to relocate traffic, area will be sanitized with a sanitizing agent to prevent contamination.
   b. There shall be communication to all departments regarding contaminated area.
      1. The switchboard shall notify all departments to discourage employees from going to the cafeteria, and/or to notify them of alternate routes.
      2. The department will call the nursing units if patient tray service will be interrupted. Patients who require food before trays can be sent from the kitchen will be served food from the supply available on the nursing units.
   c. All food processing preparation and delivery shall be halted in contaminated areas.
      1. All food carts and related equipment should be relocated to an uncontaminated area, if possible.
      2. Coffee service may be provided to employees.

d. There shall be an orderly and organized plan of clean-up and enough personnel so that the most vital areas are cleaned first.
   1. Environmental Services and Facilities Management personnel will help designated Food & Nutrition Services personnel to clean the kitchen areas, hallways to elevators, hallways to stairwells, cafeteria area, restrooms and offices, respectively.
   2. Within the kitchen and cafeteria, the areas shall be cleaned in the following order: Patient food service area, food production, receiving area, diet office, dishroom, cafeteria serving area, cafeteria, storerooms and dietary offices.

e. All contaminated equipment and floors shall be cleaned and sanitized using appropriate disinfectant. All personnel should be extra conscious of hand washing techniques.

f. When clean up in the kitchen is complete, food preparation and processing may resume. Food carts may be delivered to the floors when hallways are free of contamination. Staff will call nursing floors to notify them of delivery of patient trays.

g. The switchboard will notify all departments when contaminated hallways have been
cleaned and sanitized.

Tri-City Medical Cent
~~Oceanside, California~~
~~Emergency Preparedness Man~~

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EFFECTIVE DATE: 10/05 — ~~**SUBJECT: Emergency Preparedness Management Disaster Plan: Staffing Resource Department Specific**~~

REVISION DATE: 2/06 — ~~**POLICY NUMBER: 4061**~~
~~**CROSS REFERENCE:**~~

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**REVIEW DATE:**~~ — ~~**APPROVAL:**~~

A. **PURPOSE:** To insure efficient Staffing Resource Center services, including patient placement, resource network and registry staffing, and to maintain adequate availability of personnel in the event of disaster, to establish, supervise, and maintain staffing resources and ensure smooth patient placement.

B. **INTRODUCTION:** Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of Hospital Emergency Incident Command Systems (HEICS). Once the decision has been made to activate the disaster plan, the HEICS becomes the standard operating procedure. The complete plan is located in the TCMC Safety and Disaster Plan Manual located in the Staffing Resource Center.

C. **NOTIFICATION:**

1. The Staffing Resource Center will be notified of the Disaster Plan Activation from the PBX Operator announcing "CODE ORANGE" OR "CODE YELLOW" using the overhead page.
2. **Clinical and Operations Manager and/or Staffing Coordinator Responsibilities include:**
   a. Review the Departmental Disaster Plan, Policy #4061, found in the Safety and Disaster Manual.
   b. Report to the Incident Command Center, located in the French Rooms, with a copy of the current staffing sheets. If the Incident Command Center is not set up, contact the Emergency Department.
   c. Inventory equipment
   d. Obtain the Disaster Call-Back Book, located in the Staffing Resource Center, which contains the nursing phone lists.
   e. Delegate calling in staff as required by the Incident Commander.

3. **Administrative Coordinator Responsibilities:**

a. Review the Departmental Disaster Plan, Policy #4061, found in the Safety and Disaster Manual.
b. Notify the Administrator on Call. Assume the role of Incident Command until the Administrator on Call arrives.
c. Report to the Incident Command Center, located in the French Rooms, with a copy of the
    i. current staffing sheets. If the Incident Command Center is not set up, contact the

ii. Emergency Department.

d. Inventory equipment

e. Obtain the Disaster Call-Back Book, located in the Staffing Resource Center, which contains the nursing phone lists. Delegate calling in staff as required by the Incident Commander.

f. Communicate updated nursing unit census to Incident Command Center, including

i. Changing status on admits,

ii. Emergency Department volume.

g. Continue to monitor by making rounds throughout the Hospital to identify any issues and report back at regular intervals to the Incident Command Center once Command has been handed over to an Administrator

4. **Staffing Clerk Responsibilities:**

a. Review the Departmental Disaster Plan, Policy #4061, found in the Safety and Disaster Manual.

b. Copy Daily Staffing Sheet to provide to Director/Staffing Coordinator/Administrative Coordinator for the Incident Command Center.

c. Inventory equipment

d. Obtain list and phone numbers of all available staff not currently working. Provide to Director/Staffing Coordinator/Administrative Coordinator.

e. Call in staff as needed and have them report to the designated labor pool located in French Room 3.

f. Notification of Staffing Clerks as needed.

g. Implement Call-Back List for nursing personnel.

h. Relay child care arrangements/information to nursing units.

i. Continue to monitor staffing and assignments. Reassign as necessary, in coordination with the Incident Command Center.

j. Operate labor pool area if assigned by Incident Command Center.

D. **AUTOMATIC REVIEW:** This policy/procedure will be reviewed annually and updated as needed. It is the responsibility of the Staffing Coordinator to:

1. Orient and educate the staff to the Disaster Plan.

2.1. Maintain an updated version of the Disaster Plan and Call-Back Roster.

Radiation Accidents
The Emergency Care of the Contaminated Patient

1. Triage
   - Treat Life Threate
   - Report {Medical
     {Radiolo

Move to Related Document to Emergency Operation Procedure Manual Policy: Code Yellow – Radiation Disaster Treatment of the Contaminated Patient

2. Clean-Up
   - Remove Patient's
   - Staff - Remove Outer garments, Change Gloves

3. Medical Treatment

4. Radiological Assessment
   - Survey - Document
   - Sample

Nose	Skin
Mouth	Urine
Ears	Blood

→ Label

5. Decontamination

Wound
- Remove Dressing – Save
- Sample And Survey

Drape
Irrigate
Dry
Resurvey
→ Repeat as Necessary

- Dress Wound - Waterproof Dressing

Intact Skin

Wash
Dry
Resurvey
→ Repeat as Necessary

6. Final Survey
   - Document

7. Patient Transfer
   - Clean Path, Clean Gurney Clean Attendants
   - Survey At Control Line

8. Staff Exit
   - Remove Boots, Gloves Last
   - Survey At Control Line

Tri-City Medical Center
Oceanside, Calif

Emergency Preparedness

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EFFECTIVE DATE: 04/03 — **SUBJECT: Mitigation, Preparation, Response and Recovery Plan: Emergency Department Specific**

REVIEW DATE: 12/05

Department Approval:	09/22
Environmental Health and Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

REVISION DATE: — **POLICY NUMBER: 4068 Page 1 of 2**

1.0 PURPOSE

The Tri-City Medical Center (TCMC) must be prepared for a variety of disasters or emergency situations both natural and man-made. In order to react to these disasters or emergencies the Tri-City Medical Center shall prepare and plan for the responses and reactions required in these situations.

2.0 POLICY

2.1 This policy provides a general description of the Tri-City Medical Center approach to the development and implementation of an Emergency Management Program. This program ensures an effective response to either natural or man-made or emergencies that disrupt patient care and treatment.

2.2 The Safety Officer is responsible for the administrative oversight of the Emergency Management Program. The Safety Officer will develop appropriate specific emergency response plans based on priorities established as part of the Hazard Vulnerability Analysis.

2.3 The Safety Officer shall annually perform a Hazard Vulnerability Analysis (HVA) in order to determine and identify the specific procedures required in response to a variety of disasters or emergency situations. The HVA is used to identify probable emergency events, the consequences of the events, and the approach that has the highest likelihood of success for dealing with the consequences of the event.

3.0 PROCEDURE

3.1 The Tri-City Medical Center emergency management committee and the emergency response personnel of the community will annually perform a HVA to determine the types of disasters or emergency situations that have a high probability of occurring within the response areas of the medical center.

3.2 These committees will reconvene for additional hazard analysis anytime throughout the year when new hazards of situation have been discovered with the Hospitals response areas or as new information or experience identifies new contingencies.

3.3 This analysis will be documented on the Hazard Vulnerability Analysis Worksheet. The probability and impact of each of the disasters or emergency situations will be evaluated using

the Hazard Vulnerability Worksheet. A risk scoring will be used to identify the relative threat score ranging from 0—100% will be assigned to each factor. Any factor scoring a 43% or greater will be further evaluated to identify specific actions that have been taken to address the 4 Phases of Emergency Management (mitigation, preparedness, response, and recovery.)

3.4 Each Emergency Management Plan will address the four phrases of emergency management activities: Tri-City Medical Center

EFFECTIVE DATE: 4/03 **SUBJECT: Mitigation, Preparation, Response and Recovery Plan: Emergency Department Specific**

REVISION DATE: **POLICY NUMBER: 4068 Page 2 of 2**

CROSS REFERENCE:

REVIEW DATE: 12/05 **APPROVAL:**

3.4.1 **MITIGATION**: Activities the hospital undertakes to prevent the occurrence of an emergency or minimize the potential adverse effect one may have on its operations. (i.e., installation of stand by or redundant equipment, training, etc.)

3.4.2 **PREPAREDNESS:** activities the hospital undertakes to support and enhance response to a disaster/emergency. (i.e., plan-writing, employee education, preparation with outside agencies, acquiring and maintaining critical supplies)

3.4.3 **RESPONSE:** activities the hospital undertakes to respond to disruptive events. The actions are designed to help reduce casualties, the impact on operations, damage, and to speed recovery. (i.e.: control, warnings, evacuations, etc.)

3.4.4 **RECCOVERY:** activities hospital Center undertakes to return the facility to complete business operations. Short term actions assess damage and return vital life support operations to minimum operating standards. Long term focuses on returning all hospital operations back to normal or an improved state of affairs.

Tri-City Medical Center

Oceanside, California

Emergency Preparedness M

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EFFECTIVE DATE: 6/03 — SUBJECT: Disaster Plan Activation Hospital Wide

REVISION DATE: 12/05 — POLICY NUMBER: 4071 Page 1 of 7

CROSS REFERENCE:

Department Approval:	09/22
Environmental Health and Safety Committee Approval:	09/22
Medical Executive Committee Approval:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

REVIEW DATE: 3/06 — APPROVAL:

1.0 POLICY

To provide guidelines for line of authority and process to be initiated by the Tri-City Medical Center during an internal or external disaster.

2.0 AUTHORITY AND CONTROL

2.1 The Chief Executive Officer/designee, Emergency Room Physician on duty, or the Emergency Department Director has the authority to activate the Disaster Plan. The Chief Executive Officer, or the Administrative Coordinator (between the hours of 7p-7a Mondays thru Fridays, and 24 hours on weekends and holidays) will be notified immediately and apprised of the nature and extent of the disaster. The Chief Executive Officer or designee, assumes the role of Incident Commander and activation of "Code Orange". Once the "Code Orange" code has been called, the Hospital Emergency Incident Command System (HEICS) becomes the Standard Operating procedures, until the Code Orange has been cleared.

2.2 Radio Communication from the 800 MHz console will be received in the Emergency Department and information transferred by two-way radio to the Incident Command Center (ICC). The ICC will be managed by the Incident Commander and located in the French Classrooms.

2.3 The emergency Department Physician on duty will assume responsibility for directing all medical activities until the arrival of the Medical Staff Chief or his/her designated relief. The Medical Staff Chief will be notified as soon as possible for consult, and to assume medical authority.

2.4 At the direction of the Incident Commander, the PBX operator shall page the termination of the disaster code as follows: **"CODE ORANGE SECURED. ALL PERSONNEL RETURN TO DUTY"**, three (3) times in succession.

3.0 NOTIFICATION OF CODE ORANGE ACTIVATION TEAM (KEY OFF-DUTY PERSONNEL, PHYSICIANS, AND SUPPORTIVE AGENCIES)

3.1 The PBX operator, at the direction of the Incident Commander, will notify the following Code Orange Activation Team members of the disaster and its extent.

3.1.1 Chief Executive Officer/Administrative Coordinator after hours and weekends

3.1.2 Emergency Department Director/Emergency Charge Nurse

3.1.3 All Area Vice Presidents

3.1.4 Sr. Directors

3.1.5 Nursing Directors

3.1.6 Director, Media Relations

3.1.7 Dir. Engineering/Duty Engineer

3.1.8 Safety Officer
3.1.9 Security Supervisor/Lead Security Officer
3.1.10 Base Hospital Nurse Coordinator

3.2 The Incident Commander at his/her discretion, will request assistance from the following supportive agencies to obtain supplies, equipment or personnel:
3.2.1 Police Department (911)
3.2.2 Fire Department (911)
3.2.3 Red Cross (291-2620)
3.2.4 County Office of Defense & Disaster Preparedness (565-3490)
3.2.5 Marine Corps Recruit Depot (524-1011)
3.2.6 San Diego County Medical Society (565-8888)
3.2.7 San Diego City Office of Emergency Management (Answering Service 236-6878)
3.2.8 San Diego Blood Bank (296-6393)
3.2.9 KSDO or KFMB Radio may be notified to inform hospital staff to report to the hospital or to deliver other information.

4.0 NOTIFICATION OF OFF-DUTY PERSONNEL

4.1 Each Department Manager or their designated relief shall be responsible for notifying needed off-duty personnel to report immediately to the hospital, as needed.
4.2 Updated home phone numbers of department personnel shall be maintained in each department.
4.3 In case of a major disaster, i.e., earthquake, with many casualties, all off-duty employees should report to the Labor Pool located in Assembly Room 3. Physicians arriving for duty should report to the Medical Labor Pool (Physician Dining Room) Unit Leader for assignments.

5.0 DETERMINATION OF AVAILABLE BEDS AND EXPANSION POTENTIAL

5.1 The Staffing Office shall immediately determine the number of available beds and transmit this information to the Command Post.
5.2 Discharge Planning, or the Administrative Coordinator after hours or on weekends, shall evaluate the patients presently in the hospital to determine if any may be discharged home and report bed expansion potential to the Incident Command Center.
5.3 At the discretion of Administration, and dependant upon the assigned level of the disaster and its impact on the hospital, all elective admissions, treatments, and procedures will be postponed or canceled until the Code Orange is secured.

6.0 COMMUNICATIONS

6.1 The 800 MHz console is located in the Emergency Department and will be utilized to communicate with area hospitals.
6.2 The 800 MHz console has a twenty-four hour capability covering most county, public service, and emergency radio frequencies and "hot line". It is the primary county-wide radio control station for

coordinating emergency medical system utilization of the emergency administrative (secondary) and paramedic networks.
6.3 Communications from the scene will rely on the networks found in the county EMS plan.

6.4 Hospital Communications will be carried out utilizing messengers drawn from the Command Post and two-way radios. Radios will be dispersed to:

6.4.1 Command Post (ICC)
6.4.2 Triage Area
6.4.3 Remote care sites on the campus (ie tents)
6.4.4 Logistics Command Center
6.4.5 Planning Command Center
6.4.6 Finance Command Center
6.4.7 Operations Command Center
6.4.8 PBX (keeps one in office always)

6.5 There are 29 RED Disaster Emergency Phones located on selected nursing units and other areas of the hospital to assist with Hospital communications during a phone system failure.

6.5.1 Administration
6.5.2 Behavioral Health Unit
6.5.3 Emergency Department
6.5.4 Incident Command Center
6.5.5 Lab
6.5.6 Lift Team
6.5.7 Materials Mgmt.
6.5.8 Nursing Units
6.5.9 PBX
6.5.10 Plant
Operations 6.5.11
Radiology
6.5.12 Staffing Office
6.5.13 Surgery

6.6 Note: Off-site areas are communicated with via two-way radios and/or cellular phones.

7.0 PERSONNEL ASSIGNMENTS

7.1 All personnel will remain in, or report to, their assigned departments until further instructions are given. Nursing should prepare for the arrival of direct admits from the Triage Area.

7.2 Managers, after evaluating their department's staffing needs, will send at least one staff member to the Labor Pool (located in the French Room 3).

7.3 As personnel are requested from specific areas, the Labor Pool will assign employees as appropriate.

8.0 RECORDS AND IDENTIFICATION OF CASUALTIES

8.1 Identification:

8.1.1 Pre-numbered disaster packets are stored in the Emergency Department.

8.1.2 One person from the Admitting Department will report to the Triage Area to register patients. Additional Admitting Department personnel will report to the Finance Command Center.

8.1.3 Any available personnel from Medical Records will respond to the Labor Pool.

8.1.4 Pre-assigned disaster patient numbers correlate with the Ident-A-Band number and will be used as the patient's identification. Patients pronounced dead will also receive an identification number.

8.1.5 Ident-A-Bands will be securely attached to the patient, either on the wrist or the ankle, while the patient is in the Triage Area.

8.1.6 The removable portion (triage section) of the nurse's flow sheet will be forwarded to the Patient Status Assistant to document patient information. Upon completion, this information will be sent to the Command Post personnel, who will be responsible for casualty reports.

9.0 HANDLING OF CASUALTIES

9.1 Receiving and sorting of casualties will be accomplished at the triage site. For treatment of contaminated patients, refer to the Radiation or Hazard Materials Policies.

9.2 In the event the Emergency Department is nonfunctional, an alternative triage site will be utilized.

9.3 All casualties will be triaged according to: immediate, delayed, minor/walking wounded, deceased. The triage nurse will supervise this function.

9.4 Skin marking pencils shall be used to write the treatment area designation on the patient. Casualties will be marked on the forehead or on the back of the right hand.

9.5 Consider using helicopter teams for treatment and transport:

9.5.1 Mercy Air (1-800-222-3456)

9.5.2 Astrea (619-448-2068)

9.6 A "Patient's Personal Property Envelope" is contained in the Disaster Box. Patient's valuables, such as jewelry, money, etc., shall be placed in this envelope and locked in the hospital safe in the Admitting Department.

9.7 A "Personal Belongings Bag" marked with the patient's name and disaster number will be kept with the patient.

10.0 MORGUE

10.1 Refrigerated trucks should be considered for mass casualty.

10.2 A security officer shall be assigned to this area to insure that the remains are released only to authorize persons.

10.3 Records of remains released will be kept.

11.0 SUPPLIES, EQUIPMENT, DRUGS, LINEN, ETC.

11.1 Basic supplies, drugs and equipment needed in a disaster situation are maintained by Materials Distribution, Pharmacy, and Environmental Services.

11.2 Upon notification of the disaster, this equipment will be available upon request to the Material/supplies Unit Leader.

11.3 Supplies and drugs will be issued only to authorized and recognized personnel or authorities. Written records of items dispensed will be maintained by the Material/Supplies Unit Leader for supplies and Pharmacy Unit Leader for drugs.

11.4 Materials Distribution, Environmental Services and Pharmacy will maintain lists of outside sources where supplies, equipment and drugs can be obtained on a 24-hour basis.

11.5 Supplies and equipment obtained from outside sources will be brought to Material/Supplies Unit Leader.

11.6 Flashlights are located on each unit.

12.0 BLOOD, PLASMA, PLASMA EXPANDERS

12.1 Immediately upon notification of the disaster situation, the person in charge of the Laboratory will determine the blood supply by type and transmit this information to the EOC.

12.2 Additional blood and plasma determined to be necessary for the disaster may be secured from the San Diego Blood Bank.

12.3 Immediately upon notification of the disaster situation, the person in charge of the Pharmacy will determine the supply of plasma volume expanders by type and transmit this information to the EOC.

13.0 FOOD/WATER

13.1 Guest Services is responsible for the procurement, preparation, serving and control of the food products.

13.2 The cafeteria is designated as the Disaster Feeding Area.

13.3 Alternate methods of preparing and serving food in case of power failure will be predetermined by the Director of Guest Services.

13.4 The Guest Services Department shall maintain a list of outside sources of food suppliers which are available on a 24 hour basis.

13.5 Water supply/distribution (See Water Supply Shortage Plan).

14.0 UTILITIES/ENGINEERING

14.1 The maintenance and continuation of needed utilities (electrical power, gas, water, and sewage) will be the responsibility of the Director of Facilities or designee.

14.2 Predetermined alternate methods of supplying the hospital with essential utilities have been established in the Disaster Utilities Plan.

14.3 The local Police Department maintains direct communication lines with the city's major utility companies for assistance in reestablishing the hospital's utility requirements in the event of a failure.

15.0 ELEVATORS

15.1 If so instructed by the Incident Commander, the Facilities Department shall assure that all elevators are brought to the first floor and that the controls are placed in the "Independent Service" ON position. This will hold the elevators for use.

16.0 HELICOPTERS

16.1 Facilities for landing helicopters are available at Tri-City Medical Center.

17.0 SECURITY

17.1 The Security Leader will assign personnel to act as guards in the following areas: 17.1.1 All hospital entrances
17.1.2 Store rooms
17.1.3 Pharmacy
17.1.4 Morgue

17.2 Security will maintain traffic control.

18.0 NEWS MEDIA

18.1 The Public Information Officer will be responsible for any statements made to the press.

18.2 All members of the press must identify themselves to the Public Information Officer before any information concerning the disaster is released.

18.3 Casualty lists will be transmitted to the Public Information Officer Representative from the Command Post when available.

18.4 At the discretion of the Public Information Officer, the Press Photographers may take general situation photos only; direct facial photographs are not allowed.

19.0 SOCIAL SERVICES

19.1 Social Services will assist relatives and friends of casualties and direct them to the determined location for all information concerning casualties.

19.2 Social Services will obtain information from the Patient Status Assistant and keep family and friends advised.

19.3 Social Services will provide crisis intervention counseling when appropriate to patients, families, and friends.

19.4 Outside telephone inquires concerning the disaster will be directed to the Public Information Officer.

20.0 CLERGY

20.1 Members of the clergy, after presenting identification, will be allowed in the hospital to render assistance to patients and relatives as needed.

Tri-City Medical Center

Oceanside, California
Emergency Preparedness Management
EFFECTIVE DATE: 6/03 — **SUBJECT: Disaster Plan Activation Hospital Wide**
REVISION DATE: 12/05 — **POLICY NUMBER: 4071 Page 7 of 7**
CROSS REFERENCE:
REVIEW DATE: 3/06 — **APPROVAL:**

21.0 AUXILIARY

21.1 The president of the Auxiliary will be responsible for notifying Auxiliary members to report to the hospital.

21.2 Members of the Auxiliary will report to the Labor Pool for assignment.

22.0 HANDLING OF CONTAMINATED PATIENTS

22.1 See "Emergency Procedure for Radiation and Hazard Material Accident".

22.2 Code Yellow – Radiation Disaster, Treatment of the Contaminated Patient, Policy 4065

23.0 EVACUATION

23.1 The Incident Commander or designee shall be authorized to order evacuation of patients and personnel from the hospital. If possible, this decision should be in consult with Medical Staff Chief and Administration. Refer to the Evacuation Plan.

Tri-City Medical Center

~~Oceanside, Californ~~

~~Emergency Preparedness Man~~

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

~~**EFFECTIVE DATE: 6/03**~~ ~~**SUBJECT: HEICS Command Structure: Hospital Wide**~~

~~**REVISION DATE:**~~ ~~**POLICY NUMBER: 4072 Page 1 of 6**~~

~~**CROSS REFERENCE:**~~

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**REVIEW DATE: 12/05**~~ ~~**APPROVAL:**~~

~~**1.0 PURPOSE**~~

~~Outlines job titles and structure of the Hospital Emergency Incident Command System (HEICS) that may be implemented by Tri-City Medical Center during an internal or external disaster.~~

~~**2.0 Hospital Emergency Incident Command System (HEICS)**~~

~~**Definitions of Command Structure and Titles**~~

~~2.1 These job titles and descriptions are intended to be used with a healthcare based incident command system, and are based on the HEICS and NFPA® (Emergency Services) ICS model.~~

~~2.2 Job titles marked with a [.] are critical job titles, which match those used by the federal government, most state and governments, and defined in NFPA 99, Chapter 4, and will probably be consistent with the EOC Organization Chart of your local emergency authority. The lower level titles match Job Action Sheets and the Organization Chart for the HEICS system. These should be adjusted to meet the departments and services provided by the organization.~~

~~2.3 Job titles not filled during an implementation of the plan are the responsibility of the position(s) above them, in actual practice. For example, the functions of the Planning and Finance Chief's might be fulfilled by the Incident Commander in shorter term implementations, that would not require action in those areas.~~

~~**3.0 DEFINITIONS**~~

~~3.1 **Incident Command System (ICS)**~~

~~3.1.1 The Incident Command System is an "all hazards" management system well proven for management of various types of disaster and emergency incidents. It is designed to be scalable, (useable for small and large incidents) and consistent across all kinds of emergencies and all kinds of emergency operations and organizations responding to emergencies.~~

~~3.1.2 It features consistent job titles for key positions so communications from agency to agency and agency to hospital can be made because everyone knows the job titles and~~

functions. It also features Job Action Sheets (JAS) that provide guidance and training for persons who have a responsibility. It is intended to be implemented with the staff at hand, and jobs handed off when more senior or appropriate staff become available, and to provide a structure for documentation of both the current status during the emergency, and documentation of activity after the event.

3.2 Incident Command Center (ICC):

3.2.1 The ICC is the disaster command center, where information is collected and used by the Incident Commander and staff, and the center of communications of

requests and directions for emergency response staff. (The ICC is located in the French Rooms 1&2), the ICC is generally not in, or near the emergency areas, such as Emergency Departments, but located where all information is available and adequate space is available for all related activities.

3.3 HEICS (Hospital Emergency Incident Command System):

3.3.1 The HEICS is a group of ICS tools developed in California, and freely available online for examples. It is the most common model used in healthcare. The HEICS document, as downloaded, is not a complete system, but is a model taken from a number of Southern California hospitals in and around Orange County CA. HEICS is the basic model, with NFPA 99, for the plans described herein.

3.4 **Organization Chart:**

3.4.1 The HEICS Organization Chart, which is attached to this list, is a typical organization for the Incident Command System. It should be modified to reflect the actual departments and services in your organization. It is used to define reporting relationships during an emergency event, and to assist the Incident Commander and staff in assuring that the best person available staffs critical jobs, and to assist the personnel pool in managing staff available during the emergency.

4.0 INCIDENT COMMAND STAFF

[.] Incident Commander:

Organize and direct the Hospital Emergency Operations Center. Gives overall direction for hospital and medical center operations, and if needed, authorizes evacuation.

Incident Commander's Staff:

4.1 [.] Public Information Officer

Provides information to news media.

4.2 [.] Liaison Officer

Functions as contact person for representatives of other community emergency authorities and agencies. Keeps organization apprised of information from local ICC's. 4.3 [.] Safety and

Security Officer(s)

Monitors and has authority over the safety of rescue operations, and hazardous conditions. Organizes and enforces scene and facility protection, crowd and access control, and traffic security.

Note: Some jobs may be given other titles in specific plans and hospitals. Only those with [.] are fixed by the ICS standards.

EFFECTIVE DATE: 6/03 **SUBJECT: HEICS Command Structure: Hospital Wide**

REVISION DATE: **POLICY NUMBER: 4072 Page 3 of 6**

CROSS REFERENCE:

REVIEW DATE: 12/05 **APPROVAL:**

5.0 LOGISTICS SECTION

[.] Logistics Chief: Organizes and directs those operations associated with maintaining and repairing the physical care environment, assuring adequate levels of food, shelter, and supplies to support the medical objectives of the organization during emergency operations.

- 5.1 **Facility Unit Leader:** Maintains the integrity of the physical facility to the best level possible, provides adequate environmental control to perform the medical mission.
- 5.2 **Damage Assessment Officer:** Provides sufficient information regarding the operational status of the facility, and information to decide whether full or partial evacuation is needed. Identifies safe areas where patients and staff may be moved, if needed.
- 5.3 **Sanitation Systems Officer:** Manages sanitary systems, and replacement systems if the sewer and/or water systems are damaged. Manages the patency of existing sewage and sanitation systems. Activates pre-established alternate methods of waste disposal, as necessary.
- 5.4 **Communications Unit Leader:** Organizes and coordinates all internal and external communication systems. Manages the communications systems within the facility, and assists with backup systems as necessary.
- 5.5 **Transportation Unit Leader:** Provides for Organizes and coordinates the transport of all patients, ambulatory and non-ambulatory. Arranges for the transportation of materials and supplies to and from the facility.
- 5.6 **Materials Supply Unit Leader:** Organizes and supplies medical and non-medical supplies and materials, and equipment. Manages supplies and makes arrangements for additional supplies as needed.
- 5.7 **Nutritional Supply Unit Leader:** Organizes food and beverage stores, prepares and distributes food, and manages rationing during periods of anticipated or actual shortages. Manages food and beverage supplies, and makes arrangements for additional supplies as needed.

6.0 PLANING SECTION

[.] Planning Chief: Organizes and directs all aspects of planning operations. Relays information to, and carries out the directions of the Incident Commander. Anticipates future conditions and needs based on current information and/or conditions.

6.1 **Situation – Status Unit Leader:** Obtains and maintains current status information for all chiefs and officers. Maintains a written record of the organizations emergency planning and response to the incident. Develops the organizations internal information system. Monitors and maintains the computer systems used to manage the emergency.

6.2 **Personnel Pool Unit Leader:** Collects, manages, and inventories available staff and volunteers at a central point. Receives requests to assign available staff as needed. Maintains an adequate reserve of both patient care and support personnel. Arranges to call additional staff as needed, based on current needs, and the anticipated future conditions. Assesses and assists in the maintenance of staff morale.

6.3 **Medical Staff Pool Unit Leader:** Collects, manages and maintains a log of physicians, nurses and other medical staff at a central point. Credentials volunteer health care professional as needed. Assists in assignment of available health care professional staff as needed.

6.4 **Nursing Unit Leader:** Coordinates and manages the nursing and direct patient care staff.

6.5 **Patient Tracking Officer:** Maintains records of all patients at all times.

6.6 **Patient Information Officer:** Maintains information about patients, for use of outside agencies and internal planning processes.

7.0 FINANCE SECTION

[.] **Finance Chief:** Monitors the utilization of financial assets. Oversees the acquisition of the supplies and services necessary to carry out the organizations medical mission. Supervises the documentation of expenditures relevant to the emergency.

7.1 **Time Unit Leader:** Responsible for documentation of daily personnel time records. Includes the monitoring and reporting of regular and overtime hours worked.

7.2 **Procurement Unit Leader:** Responsible for administering accounts receivable and payable to contract and non-contract vendors.

7.3 **Claims Unit Leader:** Responsible for receiving, investigating, and documenting all claims reported to the organization during the emergency, and alleged to be the result of an incident or action on organization property.

7.4 **Cost Unit Leader:** Responsible for providing cost analysis data for declared emergency incidents. Maintains accurate records of incident costs.

8.0 OPERATIONS

[.] **Operations Chief:** Organizes and directs aspects relating to the provision of medical care and services. Caries out the directives of the Incident Commander, and supervises the Medical Services, Ancillary Services, and Human Services activity. Reports needs and status to the Incident Commander and Planning Chief as directed.

8.1 **Medical Care Director:** Organizes and directs the overall provision and delivery of medical care in all areas of the organization.

8.2 **In-Patient Areas Supervisor:** Organizes and supervises treatment of inpatients, and manages inpatient care areas. Provides for a controlled patient discharge, as appropriate.

EFFECTIVE DATE: 6/03 **SUBJECT: HEICS Command Structure: Hospital Wide**

REVISION DATE: **POLICY NUMBER: 4072 Page 5 of 6**

CROSS REFERENCE:

REVIEW DATE: 12/05 **APPROVAL:**

8.3 **Surgical Services Unit Leader:** Organizes and maintains surgical capabilities to the best practical level, in respect to current conditions, in order to meet the need of inpatients, and newly admitted patients.

8.4 **Maternal-Child Unit Leader** Organizes and maintains the obstetrical, labor and delivery, nursery and pediatric services to the best practical level in respect to current conditions, in order to meet the need of inpatients, and newly admitted patients.

8.5 **Critical Care Unit Leader:** Organizes and maintains the intensive and critical care services to the best practical level in respect to current conditions, in order to meet the need of inpatients, and newly admitted patients.

8.6 **General Nursing Care Unit Leader:** Organizes and maintains the general patient care services to the best practical level in respect to current conditions, in order to meet the need of inpatients, and newly admitted patients.

8.7 **Outpatient Services Unit Leader:** Organizes and maintains the outpatient care services to the best practical level in respect to current conditions, in order to meet the need of inpatients, and newly admitted patients.

8.8 **Treatment Areas Supervisor:** Organizes and supervises the categorization and immediate treatment of incoming patients, and manages the emergency patient care areas.

8.9 **Triage Unit Leader:** Organizes and maintains the treatment of casualties according to triage categories, and manages the initial treatment area(s).

8.10 **Immediate Treatment Unit Leader:** Organizes and maintains the coordination of care given to patients received from the Triage Area. Assures adequate staffing and supplies in the Immediate Treatment Area. Facilitates the treatment and disposition of patients in the Immediate Treatment Area.

8.11 **Delayed Treatment Unit Leader:** Organizes and maintains the coordination of care given to patients received from the Triage Area. Assures adequate staffing and supplies in the Delayed Treatment Area. Facilitates the treatment and disposition of patients in the

8.12 **Minor Treatment Unit Leader:** Organizes and maintains the care given to patients received from the Triage Area. Assures adequate staffing and supplies in the Minor Treatment Area. Facilitates the treatment and disposition of patients in the Minor Treatment Area.

8.13 **Discharge Unit Leader:** Organizes and maintains the coordination of the controlled discharge (or observation and discharge) of patient received from all areas of the organization. Facilitates the process of final patient discharge by assuring adequate staff and supplies in the Discharge Area.

8.14 **Morgue Unit Leader:** Organizes and maintains the coordination of the collection protection, and identification of deceased patients. Assists the Discharge Planning Unit in appropriate patient discharge.

8.15 **Ancillary Services Director:** Organizes and manages the ancillary medical services, to assist in provision for the optimal functioning of these services. Monitor the use and

conservation of these resources.

8.16 **Laboratory Unit Leader:** Organizes and maintains laboratory services, blood and blood products at appropriate levels. Prioritize and manage the activity of the Laboratory staff.

8.17 **Radiology Unit Leader:** Organizes and maintains imaging and diagnostic services appropriate levels. Prioritize and manage the activity of the Imaging staff.

8.18 **Pharmacy Unit Leader:** Organizes and maintains provision of pharmacy services at appropriate levels. Prioritize and manage the availability of emergency, incident specific, pharmaceutical and pharmacy supplies.

8.19 **Cardiopulmonary Unit Leader:** Organizes and maintains cardiopulmonary services at levels sufficient to meet the emergency incident needs.

8.20 **Human Services Director:** Organizes and manages the provision of services associated with the social and psychological needs of the patients, staff, and their respective families. 8.21 **Staff Support Unit Leader:** Organizes and maintain the provision of social services as needed.

8.22 **Psychological Support Unit Leader:** Organizes and assures the provision of psychological, spiritual, and emotional support to the patients, staff, volunteers, dependents, and guests. Initiates and organizes the stress debriefing processes.

8.23 **Dependent Care Unit Leader:** Initiates and directs the sheltering and feeding of staff and volunteer dependents.

Tri-City Medical Center
Oceanside, California

Emergency Preparedness Management

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

EFFECTIVE DATE: 6/03

SUBJECT: Introduction to Disaster/HEICS – An Overview: Hospital Wide

~~**REVISION DATE:**~~ ~~**POLICY NUMBER: 4073 Page 1 of 2**~~

Department Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

~~**CROSS REFERENCE:**~~

~~**REVIEW DATE: 10/05**~~ ~~**APPROVAL:**~~

~~INTRODUCTION~~

~~Disasters can occur with or without warning. Disasters cannot be predicted with any exactness as to time, size, nature or character. The Hospital's role in caring for disaster victims is to utilize existing services and supplies in such a manner as to handle a large influx of casualties efficiently and quickly while providing continuous centralized patient care.~~

~~The time of day, nature and extent of the disaster, and the estimated number of causalities that will be directed to or removed from the facility will determine the course of action taken and whether or not assistance will be needed from outside services.~~

~~Some disaster situations that may trigger an organizational response are:~~

- ~~**Internal Disaster:** Disasters within the hospital (i.e., fire, explosion)~~
- ~~**External Disasters – Minor:** Involves a small number of casualties in the immediate or nearby community (i.e., storm, flood, fire, transportation accident) which could be handled by Emergency Department personnel with minimal assistance and department staffing, but does not necessitate full disaster procedures. This decision will be made by the Code Triage Activation Team.~~
- ~~**External Disasters** – Major: A disaster involving a large number of casualties or major influx of patients into the Emergency Department stressing the system and requiring additional response and resources.~~
- ~~**Disaster Threats:** Threatens the hospital or the whole community such as impending storms, floods, and bomb threats.~~
- ~~**Disasters in Neighboring Communities**~~

~~INTRODUCTION TO HEICS~~

~~Due to the varying types and magnitudes of emergency events, Tri-City Medical Center has adopted the command structure of the **Hospital Emergency Incident Command System (HEICS)**. This structure~~

provides a comprehensive, standardized approach to the management of emergency events. Once the decision has been made to activate the Disaster Plan the Hospital Emergency Incident Command System (HEICS) becomes the standard operating procedure. The Hospital Emergency Incident Command System

EFFECTIVE DATE: 6/03 **SUBJECT: Introduction to Disaster/HEICS – An Overview: Hospital Wide**

REVISION DATE: **POLICY NUMBER: 4073 Page 2 of 2**

CROSS REFERENCE:

REVIEW DATE: 10/05 **APPROVAL:**

---

is a proven crisis management system used by various hospitals nationwide. HEICS was developed by law enforcement agencies to coordinate management involvement from multiple disciplines of community safety organizations (Police, Fire, National Guard, Military, etc.).

The attributes of the Hospital Emergency Incident Command System (HEICS) include:

- Predictable chain of command.
- Provides a common language that acts as a universal link to outside resources.
- Prioritizes duties, using the Job Action Sheets which explains the emergency response tasks.
- Has flexibility in mobilization of positions/sections, can be adjusted to meet each situation.

HOSPITAL EMERGENCY INCIDENT COMMAND SYSTEM
JOB ACTION SHEETS

The Job Action Sheets, or job descriptions, found in this section are the essence of the HEICS program. This is the component that tells responding personnel "what they are going to do; when they are going to do it; and, who they will report it to after they have done it."

ORGANIZATIONAL CHART

Typical Incident Command Structure Attached

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

ISSUE DATE: 07/05

SUBJECT: ~~Code Orange—~~Chemical Disaster: Emergency Department Specific

~~REVIEW DATE:~~
REVISION DATE:

POLICY NUMBER: 4078

Emergency Operations Procedure Expert Approval:	**09/22**
Environmental Health and Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To outline a plan to ensure facility response in the event of a disaster or an emergency involving chemical exposure.

B. **POLICY:**

1. It is the intent of this document to provide safe and proper delivery of medical care to patients who have been exposed to chemical materials and to limit the spread of contaminated material. It is also the intent of this document to protect Tri-City Medical Center personnel and others from chemically contaminated material.

C. **PROCEDURE:**

1. Initial notification:
   a. Upon pre-hospital notification the MICN will notify the Charge Nurse and she will dial "66" and inform the operator that we have a "code orange" in the Emergency Department with a chemical exposure. The physician on duty will also be notified immediately. The operator will page the following personnel
      i. -Administrative Coordinator at pager 0375
      ii. -Environmental Safety Officer at pager 0225
      iii. -Facilities at pager 0720
      iv. -Security at pager 0312
      v. -Lift Team at pager 4444
      vi. -Emergency Department Clinical Manager at pager 0640
      vii. -Public Relations at pager 0668
      viii. -Environmental Services at pager 0835 and 0841
      ix. -Pulmonary at pager 0344
2. Decontamination:
   a. When 5 patients or less require decontamination the decontamination shower in the Ambulance bay will be utilized.
   b. When 6 or more patients require decontamination the "Decontamination Tent" will be utilized.
   c. Patients will be decontaminated according to the Decontamination policy for chemical exposure.
3. Supplies:
   a. Personnel Protection Gear of Decontamination Staff

i. 3M Breathe Easy 10 Butyl Rubber Hood system with belt-mounted unit (rechargeable battery and filter).
ii. Yellow Tyvex Suit
iii. Yellow Tyvex Boots
iv. Two sets of gloves

b. Personnel Protection Gear of Post-Decontamination Staff
i. White Tyvex Hood
ii. White Tyvex suit
iii. Two sets of gloves

c. Decontamination Tent and supplies will be located in the storage container next to the Security building and will be opened by facilities or security personnel.

4. Personnel:
a. All staff involved in the decontamination process will be medical monitored according to Appendix B.
b. Staff members will be identified in 1 of 3 categories
i. Non-medical---will don green vests
ii. Medical—will don Blue vests
iii. EMT's—will don Red vests
c. Departmental Responsibilities:
i. Emergency Department Physicians will:
1) Determine if notification of governing authorities is indicated and inform the Charge Nurse.
2) Physician instructs the Triage nurses along with the Charge Nurse on recommendations along with signs and symptoms of suspected chemical exposure. (Also see NBC manual). - Activate Physician call tree for assistance.
3) Agencies to contact are
a) San Diego County of Epidemiology: Monday-Friday 619-515-6620 and Weekends and after hours call 858-565-255
b) FBI field office 619-565-1255
c) HIRT Team call 91 1(Hazardous Incident Response Team)
ii. Emergency Department Charge Nurse will:
1) Coordinate staff and communicate with ED Physician(s) for the decision tree of staging areas.
2) Obtain "Code Orange Chemical Exposure" policy along with disaster and NBC manual for immediate reference.
3) Assign staff to areas as indicated in the "Action Plan"
4) Communicate with the AC and MICN.
5) Assure Logs are maintained
6) Assign Tent Commander, Ambulance Screener, Contamination Screener, and Field Triage RN
iii. Emergency Department Nursing Staff will:
1) Follow the direction of the Charge Nurse in assignment of duties.
2) Don the protective equipment which is indicated for a chemical exposure -Follow the "Chemical Decontamination Procedure".
3) Provide assistance in the care, treatment and flow as indicated in the Action Plan
iv. Environmental Services will:
1) Provide all available personnel to the staging area for deployment
2) Retrieve the Disaster carts form Materials and deliver to the patient treatment area in the Emergency Department.
3) Assist in the setup of the Decontamination areas according to the "Chemical decontamination Procedure"

4) Assist staff in the provision of patient flow and disposition of patients and their belongings.

v. Facilities will:
1) Provide all available personnel to the staging area for deployment. Open the storage container next to security and deliver decontamination supplies to the staging area.
2) Assist in the setup of the Decontamination area and tent if indicated.
3) Assist staff in the provision of patient flow and the disposition of patients and their belongings.

vi. Security will:
1) Provide all available personnel to the staging area for deployment. -Secure the patient treatment area and restrict access to the area to all but required personnel.
2) Secure the entrance and assist in directing emergency vehicles to the proper destination.
3) Assist in the setup of the Decontamination area and tent if indicated.
4) Assist staff in the provision of patient flow and the disposition of patients and their belongings.

vii. Lift Team will:
1) Provide all available personnel to the staging area for deployment.
2) Assist in the setup of the Decontamination area and tent if indicated.
3) Assist staff in the provision of patient flow and the disposition of patient and their belongings.

viii. Registration will:
1) Provide all available personnel to the staging area.
2) Assist staff with labeling personal belongings and registration.

ix. Nuclear Medicine will:
1) Provide a technician at the Ambulance Entrance and Main ED who will screen for possible radiological exposure.

5. Patient Treatment Area:
a. Triage- Patients will be seen by the RN and categorized as non-urgent or green, delayed/urgent-yellow, and immediate/acute-red.
b. Disaster response plan will be implemented. Also refer to "Code Orange Action Plan"

6.. Recovery Actions:
a. Personnel in the Contaminated area will egress from the area in accordance with the Decontamination policy.
b. All involved personnel, including ambulance personnel, will be monitored for contamination prior to leaving the controlled areas.
c. Ambulances and equipment will be surveyed for contamination.
d. Ensure all paperwork is completed and all records are collected and retained.

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
RESPONSE AND ASSIGNMENT OF PERSONNEL

ISSUE DATE: 06/15 **SUBJECT:** Authorization for Volunteer Caregivers During Disasters

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

A. **PURPOSE**:
1. To establish guidelines for authorization of volunteer caregivers during disasters.

B. **POLICY**:
1. Upon activation of the Disaster Plan, the Incident Commander is empowered to authorize the use of volunteer caregivers to assist hospital staff in the event that the organization is unable to fully meet immediate patient needs without such volunteers. Such authorization may be given on a case-by-case basis.
2. Occupations considered volunteer caregivers are listed below. Occupations that fall under Practitioner and Allied Health Professional (AHP) are covered under the Medical Staff Bylaws covering disaster privileges.
   a. Volunteer Caregivers
      i. Registered Nurse
      ii. Licensed Vocational Nurse
      iii. Certified Nursing Assistant
      iv. Clinical staff in these specialties:
         1) Lab Sciences
         2) Pharmacy
         3) Imaging and diagnostics
         4) Rehabilitation Services
         5) Behavioral Health Services
   b. Practitioners
      i. Physician (Medical Doctor or Doctor of Osteopathy)
      ii. Dentist
      iii. Psychologist
      iv. Podiatrist
   c. AHPs
      i. Nurse Practitioner/Physician Asst.
      ii. Certified RN Anesthetist
      iii. Certified Nurse Midwife
      iv. Perfusionist / RNFA

C. **PROCEDURE**:
1. Once the volunteer caregiver has been authorized to assist, he/she will be under the direct supervision of the department manager or his/her designee to whom the volunteer caregiver has been assigned. The department manager or his/her designee must oversee the "just in time

orientation" and professional performance of the volunteer care-giver who has been assigned disaster responsibilities through direct observation, mentoring, and/or clinical record review. Based on situation and need, consider assigning volunteer physicians in a "buddy" situation until competency is clearly evaluated. When possible utilize volunteers in a secondary triage, managing worried well, and handling family of injured patients, phone advice and other useful but low risk assignments.

2. At a minimum, volunteer caregivers must present a valid government-issued photo identification issued by the state or federal agency (example, a driver's license or passport) and at least one of the following:
   a. A current hospital picture identification card that clearly identifies professional designation.
   b. A current license, certification, or registration.
   c. Primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession).
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal emergency response organizations or groups.
   e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
   f. Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.
3. The Human Resources department will begin the verification process within 72 hours from the time the volunteer caregiver presents him/herself to the organization and has been authorized to provide care by the incident commander or designee. In the extraordinary circumstances that primary source verification of licensure, certification, or registration (if required by law and regulation to practice a profession) cannot be completed within 72 hours (e.g. no means of communication or lack of resources), it is expected to be completed as soon as possible.
4. The following must be documented:
   a. Why primary source verification could not be performed in the required time frame.
   b. Evidence of a demonstrated ability to continue to provide adequate care, treatment, and services.
   c. An attempt to rectify the situation as soon as possible.
5. The hospital makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours from the start of the assignment of the volunteer caregiver if the services of the volunteer caregiver are still needed.
6. Authorized volunteer caregivers will be provided with an identification badge indicating their name, professional degree, and specialty. The volunteer caregiver's assignment and authorization to provide patient care will be automatically terminated when the incident commander determines the hospital's emergency plan is no longer in effect or when the immediate needs of the patients can be met by the hospital without the volunteer caregiver's assistance.

D. **FORM(S):**
1. Temporary Disaster Privileges Application

E. **REFERENCE(S):**
1. The Joint Commission EM.02.02.13

CHEMICAL EXPOSURE

CHEMICAL EXPOSURE:

Move to Related Document
Emergency Operations Procedure
Manual: Chemical Disaster
Emergency Department Specific

LEVEL OF PROTECTIVE GEAR: (circle appropriate respi

HOT ZONE	CLEAN ZONE
3M breathe easy butyl hood system	N-95 mask
N-95 mask	surgical mask
Surgical mask	
WILL wear yellow tyvex suit	**WILL** wear white tyvex suit
Yellow tyvex boots	Yellow tyvex boots
One pair of nitrile gloves	Two pairs of nitrile gloves
Butyl gloves on top	

CLINICAL MANIFESTATIONS:

CNS:

Respiratory:

Cardiovascular:

GI:

Skeletal Muscles:

Ocular:

Skin:

Other:

PATIENTS THAT REQUIRE DECONTAMINATION: (circle all that apply) Skin manifestations – burning, redness, blister formation

Eyes – burning

Other:

ALWAYS DECON

1. Victims whose skin or clothing is contaminated with the liquid chemical agent
2. Any patient with a p[ositve result on the HAZMAT STRIP - Test for cyanide, arsenic, chlorine, nerve, fluoride, sulfide, oxidizers and pH
3. Any patient with a positve result with the M9 Chemical Tape -Test for nerve and mustard agents
   -Positive results changes from green to pink, red or brown

TRAIGE: (special considerations for type of exposure) **Immediate : Red**

(requires lifesaving care within minutes – ie. Airway, life saving saving surgery, needs antidote)

Delayed : Yellow

(severe injuries, but delay of care will not adversely affect the outcome of the injury)

Walking Wounded: Green

(minor injuries)

Expectant: Black

(severe life-threatening injuries who are not expected to survive, or causalities with severe injuries that their chance of survival does not justify expenditure of limited resources)

DECONTAMINATION: WATER **ADD SOAP** (circle if needed)

Time required for decontamination showering: (usually 5 minutes, 8 minutes for oily material)

CLEAN ZONE
LEVEL OF DECONTAMINATION GEAR-

Move to Related Document Emergency Operations Procedure Manual: Chemical Disaster Emergency Department Specific

STATION	POSITION	PERSONNEL	NAME	COLOR VEST and TIME START
1	Apply wristband Hazmat strip, and M9 tape Monitor for Decon for radiological	ES/LIFT/FACILITIES NUC MED TECH		
2	Assess patients and assist for transport	NURSE		
3	Transport to ED			
4	Power washer and Lighting	Facilities		

DECONTAMINATION SHOWER BY ED HOT ZONE OR
CLEAN ZONE

LEVEL OF DECONTAMINATION GEAR-_____

STATION	POSITION	PERSONNEL	NAME	COLOR VEST and TIME START
S	Shower	Nurse		
		EMT		
	Monitor for contamination if radiological exposure	Nuc Med Tech		
T	Ambulance Entrance	Security/Lift/Facilities/ES		

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
RESOURCE MANAGEMENT AND PREPARATION

ISSUE DATE: 06/15 **SUBJECT:** Damage Assessment

~~**REVIEW DATE(S):**~~
REVISION DATE(~~S~~):

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

A. **POLICY:**

1. In the event of an internal disaster or emergency situation such as fire, earthquake, flooding, etc., damage to the facility must be assessed as soon as possible to protect the lives of patients and staff.

B. **PROCEDURE:**

1. Upon recognition of an internal disaster situation, the Engineering staff will conduct an assessment of:
   - a. Immediate threat to patients and staff
   - b. Potential threat to patients and staff from structural damage
   - c. Implement Search and Rescue of injured persons in the event of major structural impact.
   - d. Evaluation of disruption of essential services;
     - i. Air Conditioning
     - ii. Electricity
     - iii. Elevators
     - iv. Essential Medical equipment
     - v. Food Preparation
     - vi. Natural Gas
     - vii. Other Medical Gases
     - viii. Oxygen
     - ix. Steam Boilers
     - x. Telephones
     - xi. Vacuum
     - xii. Water
   - e. Institute salvage of essential supplies
   - f. Document damage assessment and situation status on "HICS Facility System Status Report" and forward to Administration or Command Center if activated as soon as possible
   - g. Institute Evacuation procedures as indicated.
     - i. Immediate evacuation of affected areas in the event of fire
     - ii. Planned evacuation of patients and staff from areas with major structural damage
     - iii. Planned evacuation of areas unable to continue to function due to actual or potential damage

h. Implement plans to mitigate disruption of essential services.
i. Refer to procedures for Disaster Policy Code Red and Disaster Policy – Disaster Procedure for Earthquake".

C. RELATED DOCUMENT(S):

1. Disaster Policy Code Red
2. Disaster Policy – Disaster Procedure for Earthquake

D. REFERENCE(S):

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.01, EM.03.01.03, EP5

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
RESOURCE MANAGEMENT AND PREPARATION

ISSUE DATE: 06/15 **SUBJECT: Disruption of Services**

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s):~~	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s):~~	~~06/15~~ n/a
Board of Directors Approval ~~Date(s):~~	06/15

A. **POLICY:**

1. In the event disruption of services should occur, as a result of an internal or external situation, Tri City Medical Center shall exercise a plan to provide for the safety and welfare of patients, visitors, and staff.
2. Alternative sources for provision of essential utilities shall be identified and planned for in order to maintain the hospital's ability to provide for patient care when essential utilities are disrupted.

B. **PROCEDURE:**

1. Authority:
   a. The Chief Executive Officer or Administrator On-call will be notified immediately of any actual or anticipated disruption of services that impairs the facility's ability to deliver safe care. They will report to the hospital immediately to assume responsibility for evaluating the situation and determining an appropriate course of action including possible evacuation, transfer, or relocation of patients.
   b. Department Leaders may be recalled the hospital to participate in the response to the incident.
2. Reporting:
   a. The Chief Executive Officer or designee shall be responsible for informing the California Department of Public Health (CDPH), by telephone, immediately upon being notified of the disruption of services or the need to discontinue services due to earthquake, fire, power outage, or other calamity that causes damage to the facility or threatens the safety or welfare of patients.
3. Bed Limitation:
   a. Transfers of patients from this facility to another because of lack of beds or staff will not occur until all measures to accommodate the patient have been exhausted and documented.
   b. Decisions to limit admissions will be made by the CEO, in consultation with the Chief of Staff, after evaluation of all efforts to accommodate the patients.
4. Physician Notification:
   a. Physicians shall be notified if a decision is made to restrict admissions and when the closure of the facility or portions of the service are imminent. Staff will determine from the physician whether in-patients currently in the facility may be discharged or may require transfer to another facility.
5. Essential Services and Utilities:
   a. Contingency plans are in place to address management of loss of essential utilities and

services including power, water, medical gases, and sewer.

i. If the interrupted service has been due to loss of electricity, the on-duty Engineering Department personnel shall, proceed immediately to the emergency generator to ensure that on hand associated systems are operating satisfactorily. When proper operation has been verified, he/she shall then inform the Director of Engineering or designee and notify the CEO or designee.

ii. Appropriate utility companies shall be notified without delay when their services are required to repair or assist with returning services to proper functioning levels.

C. RELATED DOCUMENT(S):

1. Engineering Policy – Code Green
2. Engineering Policy – Disruption of Services Natural Gas
3. Engineering Policy – Elevator Failure and Passenger Evacuation
4. Engineering Policy – Failure of Heating, Ventilation, Air Conditioning (HVAC) System
5. Engineering Policy – Failure of Internal Plumbing Lines
6. Engineering Policy – Failure of Medical Air System
7. Engineering Policy – Failure of Nurse Call System
8. Engineering Policy – Failure of Vacuum System
9. Engineering Policy – Failure of Water Distribution
10. Engineering Policy – Medical Gas System Failure Oxygen

D. REFERENCE(S):

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.09

HAZARDOUS SUBSTANCE FLOWCHART

DELETE: follow Emergency Operations Procedure Manual Policy: Emergency Operation Plan

Mass Casualty Incident Involving the Release of Hazardous Substances

Are criteria met for hospital to Rely on OSHA First Receiver Guidelines?

1. Release not in close proximity
2. Elapsed time from victim exposure to arrival > 10 minutes
3. Decontamination plan initiated promptly on victim arrival, etc.
4. Minimize risks of Secondary Exposure: Outdoors/proper ventilation, Control of Medical Waste/Wastewater

YES

Continue with Hazmat Response Plan Monitored by Hazmat Branch Director/Safety Officer who has Authority to cease operations if:

- Situation causes unforeseen risk to staff
- Staff develop symptoms/signs of exposure
- Hazardous material requires higher level of PPE than originally anticipated

Or modify operations as needed:

- Adapt response for Biological Containment
- Downgrade level of response if hazard is less than initially perceived

NO

Hospital IC/Hazmat Branch Director/Safety Officer to:

- Stop response
- Have victims self-decontaminate
- Isolate them from staff until personnel with appropriate PPE are available (e.g. specially trained and equipped hospital personnel, fire/hazmat specialists)
- Re-evaluate situation

Tri-City Medical Center
Oceanside, California

EMERGENCY PREPAREDNESS MANAGEMENT
INITIATION OF EMERGENCY PREPAREDNESS

ISSUE DATE: 11/88

SUBJECT: Location of Disaster Work Stations

REVIEW DATE~~(S)~~: 11/91
REVISION DATE~~(S)~~: 01/94, 3/97, 05/00, 04/03, 11/05

Department Approval ~~Date(s):~~	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Committee Approval ~~Date(s)~~:	06/15

A. <u>DISASTER STATION LOCATIONS</u>:

1. Administrative Coordinator - Nursing Administration – Staffing Office.
2. Business Office - Pavilion first floor and Emergency Department.
3. Cardiology - Center Tower first floor.
4. Child Care Center - Cardiac Wellness Center.
5. Decontamination Area - Immediately external to the Emergency Department/adjacent to Security Trailer.
6. Incident Command Center (ICC) - French Room 1 & 2. Alternate area designated as Security Trailer. In the event that neither is available due to the nature of the disaster, the Incident Commander will designate an alternate location.
7. Emergency Department Base Station - Emergency Department.
8. Emergency Department - First floor, west side of hospital.
9. Minor Care - North wing first floor PT Gym located in Acute Rehab area.
10. Morgue – West of the Magnetic Resonance Imaging (MRI) building.
11. Private Branch Exchange (PBX) - Center tower, lower level.
12. Physician Labor Pool – Physician dining area.
13. Alternate Operating Room – Women and Newborn Services - Labor & Delivery Operating Room Suite.
14. Mass Casualty Tent – Parking lot.
15. Triage Area
    a. Ambulance entrance area.
        i. In the event any of the above areas are involved as a disaster site, the Incident Commander will designate alternative site.
        ii. Security will be notified and be responsible for signage and detouring traffic

EMERGENCY (RED) PHONE: (all phones need outside line access via dialing 80 first)	
LOCATIONS	NUMBER
E/R Radio Room	1-760-724-0896
Nursing Administration/Admin Coordinators	1-760-724-1067
Administration	1-760-724-1518
PBX #1	1-760-724-1690
PBX #1	1-760-724-1832
1 Tower 1East Nurse Station	1-760-724-8412
2 Tower 2East Nurse Station	1-760-724-8413
3 Tower 3East Nurse Station	1-760-724-8414
4 Tower 4East Nurse Station	1-760-724-8415
2 PAV Nurse Station	1-760-724-8416
3 PAV Nurse Station	1-760-724-8417
4 PAV Nurse Station	1-760-724-8418
Women Center	1-760-724-8419
1 North Nurse Station	1-760-724-8420
2 South Nurse Station	1-760-724-8421
BHU Nurse Station	1-760-724-8422
Surgery Nurse Station	1-760-724-8423
Lab	1-760-724-8880
Radiology	1-760-724-8881
SPD	1-760-724-8882
Material Distribution	1-760-724-8883
French Room 1 (5536)	1-760-724-8884
French Room 1 (5537)	1-760-724-8885
French Room 1 (5538)	1-760-724-8886
French Room 1 (5539)	1-760-724-8887
Facilities	1-760-724-8972
Lift Team Room	1-760-724-8973
BAMS Building	1-760-724-8974

Patients that Require Decontamination: (Circle all that apply)

Move to Related Document Emergency Operations Procedure Manual: Chemical Disaster Emergency Department Specific

Skin manifestations – burning, redness, blister formation

Eyes – Burning

Other: _____

_____

ALWAYS DECON

1. Victims whose skin or clothing is contaminated with the liquid chemical agent
2. Any patient with a positive result on the HAZMAT STRIP
   a. –Test for cyanide, arsenic, chlorine, nerve, fluoride, sulfide, oxidizers, and pH.
3. Any patient with a positive result with the M9 Chemical Tape
   a. –Test for nerve and mustard agents
   b. –Positive results changes from green to pink, red or brown

TRIAGE: (special considerations for type of exposure)

MMEDIATE: RED _____

_____

(requires live saving care within minutes – ie. Airway, life saving surgery, needs antidote) **DELAYED: YELLOW**

_____

_____

(requires live saving care within minutes – ie. Airway, life saving surgery, needs antidote) **WALKING WOUNDED:**

GREEN _____

_____

(minor injuries) **EXPECTANT: BLACK** _____

_____

(sever life-threatening injuries who are not expected to survive, or casualties with severe injuries that their chance of survival does not justify expenditure of limited resources)

DECONTAMINATION: **WATER** **ADD SOAP** (circle if needed)

Time required for decontamination showering: _____
(usually 5 minutes, 8 minutes for oily material)

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
GENERAL INFORMATION

ISSUE DATE: 06/15 **SUBJECT:** Personnel Expectations

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

A. **POLICY:**
1. Tri-City Healthcare District staff shall be trained to respond to the incident in accordance with guidance provided in the plan. Medical Center staff, regardless of position, is expected to report to the hospital for duty as soon as it is feasible to travel.

B. **RULES OF CONDUCT:**
1. All personnel shall wear a hospital badge for identification, which shall be displayed to officials and will ensure passage to the hospital through mass casualty lines.
2. Keep to the right in corridor traffic.
3. Do not become an observer.
4. Do not crowd around treatment areas.
5. Maintain a quiet and orderly atmosphere. Remain calm and cooperate in performance of duties assigned to you.
6. Be willing to perform all tasks asked, regardless of usual roles.
7. When called in, proceed through to the appropriate area for briefing and assignment.
8. Remain in working areas unless otherwise instructed.

C. **PROCEDURE:**
1. Personnel may be assigned to perform duties outside their usual roles. They may be asked to perform jobs, which are vital to an effective disaster response utilizing their individual abilities.

D. **REFERENCE LIST:**
1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.07

PROCEDURE FOR DECONTAMINATION TENT

Move to Related Document Emergency Operations Procedure Manual: Chemical Disaster Emergency Department Specific

1. Lighting
2. Set up tent 2-4 people
3. Install Showers
4. Attach power washer
5. Place soap in power washer and attached water supply
6. Place 2 tables on each side of tent's entrance, with a chair behind each table at Station??
7. Place 4 chairs in each corner of tent
8. Place 1 or 2 ????Gurneys with no mattress pad in center shower
9. Place 4 chairs on each side of tent's entrance and exit (total 16)
10. Place signs in appropriate locations
    - -Ambulance Entrance
    - -Ambulance Exit
    - -Above shower stalls – Women Men Handicapped
    - -Information signs behind each table and along ambulatory patient entrance -Information signs about procedure after showering at patient exit Station??
11. Place bags for patient belongings and cards (?? Cards and wrist bands?) at tables at Station???
12. Place patient gowns, towels and shoes at exit at Station???
13. Place Decontamination bands at exit at Station??
14. Place transportation carts at tent's exit at Station???
15. Place bags for Morgue patients and biohazard tape at Station???
16. Place containers to hold patient belongings at Station???
17. Put on appropriate decontamination gear as directed by?????
18. Assign People to Stations
    - -Station A # people
    - -Station B #
    - -Station Cand etc. I do not have the stations I had placed on the map and I would also put on the direction sheet which are the security stations such as the entrance to the hospital and the person in charge of patient belongings and morgue patients.

Tri-City Medical Cen
Oceanside, California

DELETE – incorporated into the Emergency Operations Procedures Manual: Emergency Operations Plan

Emergency Operations Procedure Manual
General Information

ISSUE DATE: 06/15 **SUBJECT: Purpose and Authority**

REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~03/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~03/~~22~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

~~A. PURPOSE:~~

~~1. Disasters can and do occur anytime and anywhere. They may vary in severity, number of victims involved and impact on the physical plant of the hospital facility. The community expects its hospital will always be ready and able to respond efficiently and effectively to any and all situations.~~

~~2. The objective of the Emergency Operations Plan is to provide a structured method for hospital personnel to follow in mobilizing for response to a disaster situation. The plan is designed to provide for maintaining a high standard of care when normal demands for service are exceeded and to provide for a safe working environment for staff. The plan establishes procedures for the maximum utilization of our facilities and personnel, as well as integration with local community, county, and regional resources.~~

~~B. POLICY:~~

~~1. Tri-City Healthcare District (TCHD) shall establish and maintain an emergency action plan, referred to as the Emergency Operations Plan, to permit appropriate response to internal and external disasters. The staff shall be trained to respond to the incident in accordance with guidance provided in the plan. A Disaster Exercise will be conducted at least twice a year to test and evaluate the plan~~

~~C. PROCEDURE:~~

~~1. Organization:~~

~~a. In times of crisis, the facility will operate under the Hospital Incident Command System (HICS) as developed by the State of California Emergency Medical Services Authority.~~

~~b. The HICS Plan consists of a chain of command, which incorporates four sections under the overall leadership of an Emergency Incident Commander. Each of the four sections: Logistics, Planning, Finance, and Operations, has a chief appointed by the Incident Commander and responsible for their sections. The Chiefs' in turn designate directors and unit leaders to subfunctions. This structure limits the span of control of each manager in the attempt to distribute the work.~~

~~c. Each position on the organizational chart has a prioritized Job Action sheet written to describe the important duties of each particular role. The duties on the Job Action sheets are put into categories of "Immediate", "Intermediate", and "Extended".~~

~~2. Authority:~~

~~a. The overall authority and direction of the Emergency Preparedness Plan rests with the Chief Executive Officer or Administrator On Call. In the absence of the CEO, the~~

~~Administrator On-Call or the Administrative Supervisor on duty will be in charge. This person is responsible for declaring the phase of the disaster and will direct and coordinate all hospital activities until relieved by Administrative Authority.~~

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

~~1. Title 22: Section 70741, 70743, 70745, 70746~~
~~2. The Joint Commission EM.02.01.01~~

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
SPECIAL CIRCUMSTANCES

ISSUE DATE: 06/15 **SUBJECT: Response to Wild Fires**

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	..n/a
Administrative Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

A. **PURPOSE:**
1. To be aware of the hazards associated with a variety of large scale exterior fire situations. Wild fires and large residential fire storms have the ability to affect and alter how the organization functions and provides treatment to affected patients. This policy follows Tri-City Healthcare District (TCHD) all hazards approach to a variety of emergency situations contained within the Emergency Management Program and Emergency Operations Plan manual.
2. Wild fires have the potential to impact the facility with an influx of patients. Residential fire storms can occur when extreme low humidity levels coupled with strong wind conditions and careless acts occur.

B. **POLICY:**
1. For unusual influx of patients due to wild fires, refer to the Emergency Operations Plan and High Census Action Plan policies for direction on managing the event.
2. When extreme low humidity conditions coupled with high winds (Santa Ana affect) occur, processes that create an open flame condition will also be reviewed for suspension. Examples may include welding, cutting and other construction practices.
3. TCHD will rely on the City of Oceanside Fire Department for direction for sheltering in place, suspension of specific practices and possible evacuation orders during residential fire events near the hospital complex.

C. **PROCEDURE:**
1. For situations involving wild fires or residential fire storms, refer to the Emergency Management Program policy and procedure manual for specific direction and actions to be implemented in an emergency situation.

D. **RELATED DOCUMENTS:**
1. Emergency Operations Procedure Manual General Information - Emergency Operations Plan
2. Emergency Operations Procedure Manual Patient Management – High Census Action Plan

~~Tri-City Medical Cen~~
~~Oceanside, California~~

~~Emergency Operations Procedur~~
~~General Information~~

DELETE – incorporated into the Emergency Operations Procedures Manual: Emergency Operations Plan

ISSUE DATE: 06/15 **SUBJECT:** Scope of Response

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~03/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	..~~N/A~~n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

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

~~1. The scope of response initiated will be dependent on the type and size of the disaster incident and upon its impact to the physical plant.~~

~~**B. DEFINITIONS:**~~

~~1. External Disaster:~~

~~a. Multiple Patient Incident: (Minor) Any incident that involves 10 or less victims with at least one or more "Immediate" category patient.~~

~~b. Multiple Casualty Incident: (Moderate) Any incident that involves over 10 victims and up to 100 victims.~~

~~c. Mass Casualty Incident: (Large) Any incident that involves over 100 victims and involves significant infrastructure damage.~~

~~2. Mutual Aid Response:~~

~~a. Any incident involving Multiple Casualty or Mass Casualty numbers of victims resulting in the expansion of treatment areas to receive casualties transferred from the stricken community or the sending of personnel and supplies, upon request to provide medical support in the affected community.~~

~~3. Internal Disaster:~~

~~a. Any incident that impacts the physical plant or internal functioning of the facility: fire, earthquake, flood, security breach, etc.~~

~~**C. FLEXIBILITY OF RESPONSE:**~~

~~1. One of the attributes of the HICS plan is its flexibility in the implementation of individual sections or branches which can be customized to meet the needs of a particular crisis. The activation of positions for a mass casualty accident may differ from those activated for an internal disaster affecting the physical plant. There may be minimal activation of positions in the initial stages of an incident to begin management and other positions added as more personnel arrive. A person might be required to perform more than one job and as more staff becomes available they can be relieved of multiple assignments.~~

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

~~1. Title 22: Section 70741, 70743, 70745, 70746~~

~~2. The Joint Commission EM.02.01.01 EP 2~~

TRIAGE DISASTER BOX

Supplies:

DELETE: follow Emergency Operations Procedure Manual Policy: Chemical Disaster Emergency Department

1. Gloves – small, medium, large
2. 10 white tyvex suits
3. Hazmat smart strips (50)
4. M9 Chemical tape
5. Flip chart of information on Chemical and Radiological agent exposure
6. Patient log

Procedure:

1. In the event of an explosion and possibility it may involve a chemical agent or radiological exposure will have one triage nurse at the Emergency Department Lobby entrance and one at the ambulance entrance.
2. A Nuclear Medicine Tech will be at each entrance.
3. Will dress in white tyvex suit and double gloves.
4. Apply Hazmat strip and M9 Chemical tape to tyvex suit.
5. Review signs and symptoms for agent exposure.
6. Review triage criteria for agents.
7. For Chemical Agent exposure apply Hazmat strip and M9 chemical tape to patients' clothes and observe for 2 minutes to see if any color change. Remove the M9 chemical tape from the patient after finish monitoring.
8. Also interview patient for signs and symptoms for exposure.
9. The Nuclear Medicine Tech will use the Geiger counter to evaluate for radiological exposure.
10. Monitor 10 patients for exposure, then consult the Charge Nurse if need to continue to evaluate patients.
11. Place patient's name, age and chief complaint into log.
12. Charge nurse will decide when to stop monitoring patients with considering reports from the scene and evaluation from the triage nurse.
13. If any patient is positive for chemical agent exposure notify the charge nurse immediately. Place all patients from the scene in a quarantined area away from the hospital doors with assistance from security.
14. All patients involved in a chemical agent exposure from the scene may need decontamination.
15. Any patient involved with a chemical agent that requires decontamination is not allowed into the hospital until decontaminated.
16. Any patient that is positive for a radiological exposure, notify the charge nurse immediately and call a Code Yellow.
17. Any patient involved in a radiological exposure incident that requires emergency medical treatment is to enter room 26 from the outside entrance door. They will be stabilized then decontaminated.
18. Any patient that is stable from a radiological exposure should be decontaminated prior to entering the hospital.
19. For Decontamination procedure refer to disaster manual for Decontamination procedure and for radiological exposure also refer to Code Yellow.
20. For Decontamination may use shower outside room 26, and if greater than 5 patients involved call for decontamination tent to be set up.

UNIDENTIFIED PATIENTS

MORGUE LOG NUMBER	NAME	SEX	AGE	DATE OF BIRTH	IDENTIFYING MARKS, TATTOS, ETC.
JD 1001				**DELETE: follow Hospital Incident Command System (HICS)**	
JD 1002					
JD 1003					
JD 1004					
JD 1005					
JD 1006					
JD 1007					
JD 1008					
JD 1009					
JD 1010					

TRI-CITY MEDICAL CENTER
Utilities Emergency Response Reference

Move to Related Document Engineering Policy: Utility Management Plan

THE FOLLOWING ISSUES ARE CRITICAL. DIAL 66			
Failure of	**What to Expect**	**Who to Contact**	**Responsibili**
Electrical Power Failure: Emergency Generators Work	Many lights are out; only RED plus outlets work	Dial 66	Ensure that (RED outle… Complete surgical cases in progress ASAP. Use flashlights
Elevator Stopped Between Floors	Elevator alarm bell sounding	Dial 66	Keep voice contact with personnel still in elevator and let them know help is on the way.
Medical Gases	Gas alarms; no O_2, medical air, or nitrous oxide (NO_2)	Dial 66	Hand ventilate patients; transfer patients if necessary; use portable 0_2 and other gases; call for additional portable cylinders.
Medical Vacuum	No vacuum; vacuum systems fail and in alarm progress.	Dial 66	Call SPD for portable vacuum; obtain portable vacuum from crash cart; finish surgical cases in
Natural Gas; Failure or Leak switches,	Odor, no flames on burners, etc.	Dial 66	Open windows to ventilate; turn off gas equipment; don't use any spark-producing devices, electric motors,
Electrical Power Failure – Total	Failure of all electrical systems	Dial 66	Use flashlights; hand ventilate patients; manually regulate IV's; don't start new surgical cases unless STAT
THE FOLLOWING ISSUES ARE NON CRITCAL. DIAL EXTENSIONS LISTED			
Air Conditioning	System Down	Engineering. Ext. 7148	Use portable fans
Computer Systems	System Down	Information Systems Ext 7247	Use backup manual/paper systems
Elevator Out of Service	All vertical movement will have to be by stairwells.	Engineering Ext. 7148	Review fire and evacuation plans; establish services on first or second floor, use carry teams to move critical patients and equipment to other floors.
Nurse Call System	No patient contact	Engineering. Ext. 7219 PBX (Stores Bells)	Use bedside patient telephone if available; move patients; use bells; detail a rover to check patients.
Patient Care Equipment/ Systems	Equipment/system does not function properly	Biomedical Engineering Ext 7792	Replace, tag and isolate defective equipment. Fill out Quality Review Form.
Sewer Stoppage	Drains backing up	Engineering Ext 7148	Do not flush toilets; do not use water.
Steam Failure	No building heat or hot water; sterilizes inoperative, limited cooking	Engineering Ser 7148	Conserve sterile materials and all linens; provide extra blankets; prepare cold meals.
Telephones	No phone service	Information Systems Ext 7247	Use overhead paging, pay phones, and runners as needed.
Water	Sinks and toilets inoperative	Engineering Ext 7148	Institute Fire Watch; conserve water, use bottled water for drinking; be sure to turn off water in sinks, use RED bags in toilet.
Water Non-Potable	Tap water unsafe to drink	Engineering. 7148 Foods Services Ext. 7210 Directors	Place "Non-Potable Water – Do Not Drink" signs at all drinking fountains and wash basins.
Ventilation	No ventilation; no heating or cooling	Engineering Services Ext 7148	Open windows (institute Fire Watch) or obtain blankets if needed; restrict use of odorous/hazardous materials.

Phone Numbers				Pager #
Engineering:	Ext 7148	Resp. Therapy:	Ext 3066	0344
Biomed:	Ext 7792	EOC/Safety Officer:	Ext 7357	0225
Food & Nutrition:	Ext 7210	Security	Ext 3366	0312
Information Systems:	Ext 7247	SPD	Ext 7288	

Safety\Utility.mgm

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
PATIENT MANAGEMENT

ISSUE DATE: 06/15 **SUBJECT: Victim Tracking**

~~**REVIEW DATE(S):**~~
REVISION DATE~~(S)~~:

Department Approval ~~Date(s)~~:	~~05/15~~09/22
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	~~06/15~~09/22
Medical Executive Committee Approval ~~Dates(s)~~:	..n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/15

A. **POLICY:**

1. The disaster plan will provide a mechanism for identifying and tracking disaster patients during the treatment process. This process is used for regular Hospital facilities and alternate care sites alike.

B. **PROCEDURE:**

1. All patients arriving during a disaster will be identified at the Triage Area using a Medical Emergency Triage Tag (METTAG) Disaster Tag.
2. The METTAG number will serve as the patient identifier throughout the Triage and Treatment process.
3. At Triage, an assistant will be assigned to log all patients onto the "Victim List". Information logged will include triage category, name (if known), and treatment destination.
4. At each treatment location clerical personnel shall be assigned to maintain a Victim List and a Disaster Control Board for their own treatment area. It is important to maintain a log for identification of all persons treated as part of the disaster response.
5. The Victim Lists should be updated as patient conditions change and dispositions are made.
6. Periodically, copies of the updated Victim Lists should be routed to the Planning Section of the Emergency Operations Center. Origin of the list and time of the update should be clearly noted. At the termination of the response the list in its final form should be forwarded to the Planning Section of the Emergency Operations Center.
7. The Patient Tracking Officer in the Planning Section will maintain the "HICS Patient Tracking Sheet". Information will be shared with the Public Information Officer.
8. At the completion of the disaster, all victims treated must be logged into the Emergency Department Log, and all transfers must be logged into appropriate transfer logs.

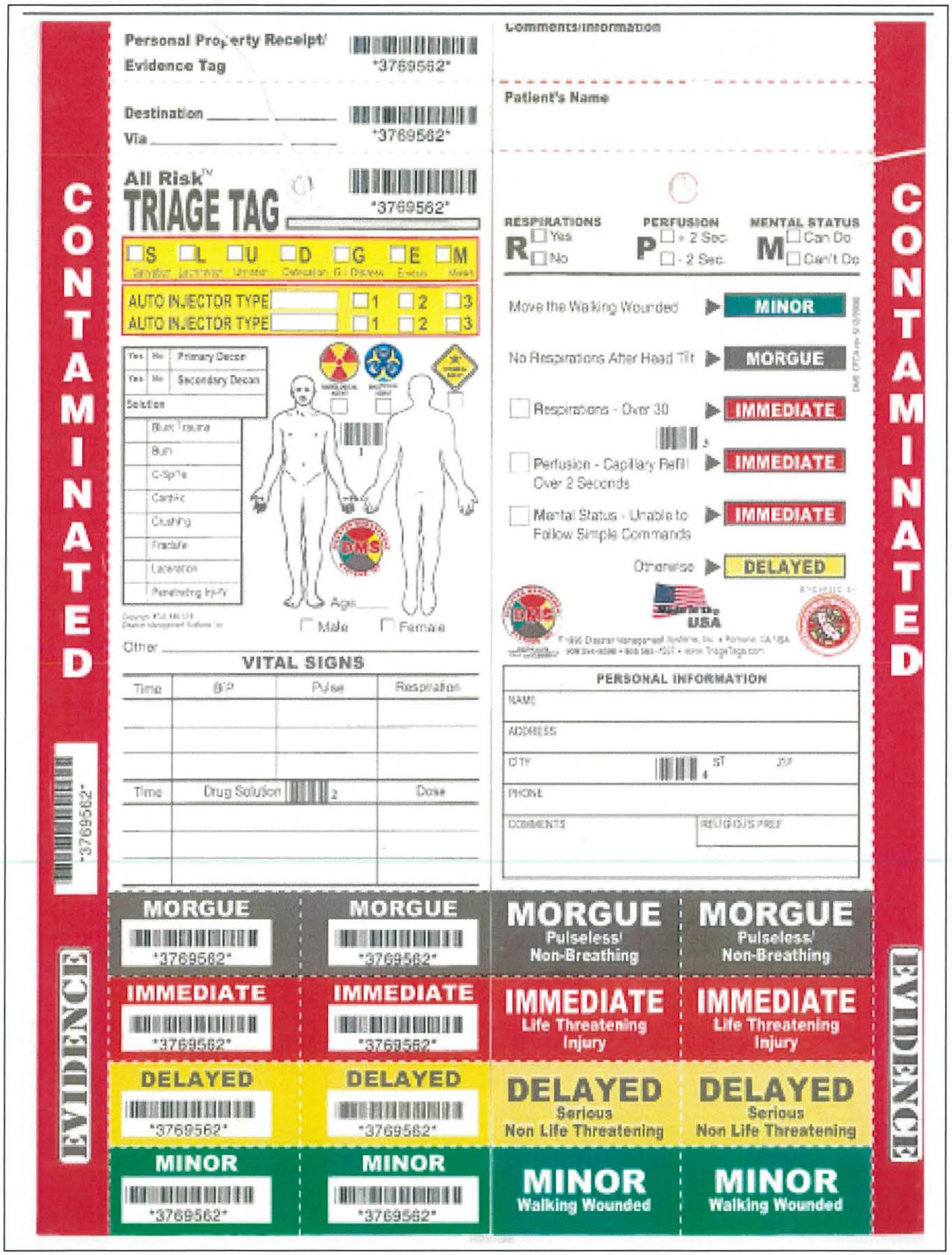
C. **ATTACHMENT(S):**

1. Sample of METTAG

D. **REFERENCE(S):**

1. Title 22: Section 70741, 70743, 70745, 70746
2. The Joint Commission EM.02.02.11, EP 8

Sample METTAG



Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
GENERAL INFORMATION

ISSUE DATE: **NEW** **SUBJECT: 1135 Waiver, Requesting**

REVISION DATE:

Department Approval:	**06/22**
Environmental Health & Safety Committee Approval:	**09/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**..n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. The purpose of 1135 waivers are to ensure that federal regulations do not needlessly infringe on an immediate need to provide health and medical services to individuals effected by a large-scale disaster.
2. The purpose of this policy is to:
   a. Identify the process for requesting a waiver Section 1135 of the Social Security Act.
   b. Ensure the provision of care and treatment of patients are maintained when an 1135 waiver is implemented.
   c. Ensure sufficient health care items and services are available to meet the needs of Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

B. **SCOPE:**
1. The President of the United States has declared a federal disaster that includes the service area of our facility and the Health and Human Services (HHS) Secretary has declared a public health emergency within our service area; and the Chief Executive Officer (CEO), or designee, has determined that certain regulatory flexibilities are necessary to help Tri-City Hospital District (TCHD) fulfill our mission and to service the healthcare needs of area residents, visitors and disaster victims.
2. This policy applies to all TCHD onsite and offsite locations.
3. The policy shall be reviewed annually by the Environmental Health and Safety Committee (EHSC).

C. **DEFINTIONS:**
1. 1135 waivers - Emergency, temporary waivers granted by the US HHS Secretary to healthcare facilities or blanket waivers for specific disaster area, during the time of disaster. These waivers are authorized under section 1135 of the Social Security Act. Waivers can only be issued following a Presidential disaster declaration under the Stafford Act or National Emergencies Act and the HHS Secretary has declared a public health emergency
2. Emergency Situation – A sudden, unexpected or impending situation that may cause injury, loss of life, damage to the property, and/or interference with normal business operations, therefore requiring immediate attention and/or remedial action.

D. **POLICY:**
1. During disasters, TCHD may need to request a 1135 waiver to address care and treatment of patients as identified by emergency management officials or to receive temporary administrative

flexibility from various federal regulations including Medicare, Medicaid, Children's Health Insurance Program, Health Insurance Portability and Accountability Act.

2. Waivers can only be issued following a Presidential disaster declaration under the Stafford Act or National Emergencies Act and the HHS Secretary has declared a public health emergency.
3. Waivers or modifications may be issued to ensure that in an emergency area, during an emergency period, sufficient care items and services are available to the maximum possible extent to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that services in good faith who are unable to comply with certain statutory requirement are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.
4. Emergency Medical Treatment and Active Labor Law (EMTALA)
    a. Waivers for EMTALA (for public health emergencies that do not involve a pandemic disease) and Health Insurance Portability and Accountable Act (HIPAA) requirements are limited to a 72-hour period beginning upon implementation of a hospital disaster protocol.
    b. Waiver of EMTALA requirements for emergencies that involve a pandemic disease last until the termination of the pandemic-related public health emergency.
5. Examples of possible 1135 waivers or modifications include the following:
    a. Conditions of participation or other certification requirements
    b. Program participation and similar requirements
    c. Preapproval requirements
    d. Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
    e. EMTALA sanctions for direction or relocation or of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate state emergency preparedness plan (or in the case of a public health emergency involving pandemic infectious disease, a state pandemic preparedness plan) or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.
        i. A waiver of EMTALA requirements is effective only if actions under the waiver do not discriminate on the basis of a patient's source of payment or ability to pay.
    f. Stark self-referral sanctions
    g. Performance deadlines and timetables may be adjusted (but not waived).
    h. Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers
6. The 1135 waiver authority applies only to Federal requirements and does not apply to State requirements for licensure or conditions of participation.
7. 1135 waivers are not a grant or financial assistance program
    a. Do not allow reimbursement for services otherwise not covered
    b. Do not allow individuals to be eligible for Medicare who otherwise would not be eligible
    c. Should NOT impact any response decisions, such as evacuations
    d. Do not last forever and appropriateness may fade as time goes
8. Waiver Duration
    a. Typically end no later than the termination of the emergency period, or – 60 days from the date the waiver, or modification is first published unless the Secretary of HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.
        i. TCHD will resume compliance with normal rules and regulations as soon as they are able to do so.

E. **PROCEDURE:**

1. The CEO or designee will determine the need to request a 1135 waiver

2. The CEO or designee will submit a request for a 1135 waiver using the electronic CMS 1135 Waiver / Flexibility Request and Inquiry form. The form can be accessed using the following: https://cmsqualitysupport.servicenowservices.com/cms_1135. Prior to completing the electronic form:
   a. Review the CMS, Quick Reference Guide. For questions, submit an 1135 Waiver / Flexibility Request for assistance to complete the electronic
   b. For questions related to the form use the above CMS web site may be use or contact the Region Office
      i. Regional Office State Agency for Health Care Administration
         1) Located in San Francisco ROSFOORA@cms.hhs.gov
3. The following information must be provided:
   a. Provider Name/Type
   b. Full Address (including county/city/town/state)
   c. CMS Certification Number (CCN) e.g., Medicare provider number
   d. Contact person and contact information for follow-up questions should Region need additional clarification.
   e. Brief summary of why waiver needed
4. Consideration (type of relief/regulatory requirement seeking to be waived)

F. **RELATED DOCUMENT(S):**
1. Emergency Operations Procedure Manual
2. Evacuation Plan

G. **EXTERNAL LINK(S):**
1. CMS 1135 Waiver / Flexibility Request and Inquiry form https://cmsqualitysupport.servicenowservices.com/cms_1135

H. **REFERENCES:**
1. Centers for Medicare and Medicaid Services (CMS). (2021). 1135 waivers. Retrieved from 1135 Waivers | CMS
2. Centers for Medicare and Medicaid Services (CMS). 1135 waivers and The Emergency Preparedness Rule Presentation. Retrieved from 1135 Waivers | CMS
3. The Joint Commission (TJC). (2020). 1135 waivers. Retrieved from PowerPoint Presentation (jointcommission.org)
4. Centers for Medicare and Medicaid Services (CMS). Quick reference guide. Submit an 1135 waiver/flexibility request. Retrieved from https://www.cms.gov/files/document/covid-1135-waiver-application-quick-start-guide.pdf
5. Centers for Medicare and Medicaid Services (CMS). (n.d.) 1135 waiver-at a glance. https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf

Tri-City Medical Center	Infection Control Manual
PROCEDURE:	**ENVIRONMENTAL & WASTE MANAGEMENT FOR EBOLA VIRUS DISEASE**
Purpose:	To define infection control processes from an environmental cleaning & waste management perspective.
Supportive Data:	CDC, CDPH, ASPR, DOT: The California Waste Management Program regulates th of medical waste by providing oversight u Management Act.
Equipment:	See PPE and Cleaning Supply List

DELETE - Follow Infection Control Policy: Ebola Plan

A. **BACKGROUND AND TRANSMISSION:**

1. Ebola virus is transmitted through direct contact with blood or body fluids/substances of an infected person with symptoms or through exposure to objects that have been contaminated with infected blood or body fluids. Transmission of Ebola through the environment has not been established. However, due to the severity of the disease, higher levels of precaution are necessary to reduce any potential risk posed by contaminated surfaces.

B. **PRECAUTIONS:**

1. All personnel, including environmental services staff, are to wear recommended personal protective equipment (PPE) designated for use for a suspect or confirmed EVD patient. All personnel will be carefully instructed in the proper use of PPE, including proper sequencing of donning and doffing. See Room Diagram, PPE Guidance Matrix for EVD, Putting on PPE Properly for Ebola (N95), and Removal of PPE Properly for Ebola (N95).
   a. Refer to IC Bloodborne Pathogen Exposure Plan

C. **GUIDANCE AND MANAGEMENT:**

1. All guidance for environmental and waste management regarding patients who are suspect or confirmed with Ebola Virus Disease will be directed by CDPH and the CDC.
   a. Contracted company to handle contaminated waste:
      i. Infection Control will work with the Director of Safety/Environment of Care Officer to initiate contact with the designated hazardous waste representative (Steri-Cycle) who will initiate process with DOT & obtain Special Permit for handling & packaging Ebola contaminated waste, unless directed otherwise by the CDPH, CDC or DOT.
2. A US Environmental Protective Agency (EPA) registered disinfectant with a label claim for a non-enveloped virus will be utilized for cleaning. Refer to approved EPA list for disinfectants against Ebola.
   a. Go to https://www.epa.gov/sites/production/files/2015-09/documents/ebola-list-l-aug2015.pdf for the list.
   b. List L: EPA's Registered Antimicrobial Products that Meet the CDC Criteria for Use Against the Ebola Virus (dated September 1, 2015) Use most current version of information published. https://www.epa.gov/pesticide-registration/list-l-disinfectants-use-against-ebola-virus
3. Refer to Ebola Virus Disease Medical Waste Management Interim Guidelines (dated March 4, 2016) (or most current version published) for specific guidance on the management of Ebola contaminated medical waste based on federal guidelines and standards including guidance on packing, labeling and treatment.
   a. Go to:
      http://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/2013/Ebola%20

Department Review	Infection Control Committee	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	B
10/2009/22	10/2009/22	n/a	n/a	11/22	n/a	

medical%20waste%20management-CDPH%20interim%20guidance-28%20Oct%202014.pdf

4. Ebola virus is a classified as a Category A infectious substance regulated by the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported offsite for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, used healthcare products such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets; and used PPE (gowns, masks, gloves, goggles, face shields, respirators, booties, etc.) or byproducts of cleaning contaminated or suspected of being contaminated with a Category A infectious substance.6, 7 (see question 8).

D. **CLEANING AND DISINFECTING:**

1. Cleaning and disinfection of hard, non-porous surfaces will be done by using an EPA registered antimicrobial that meets CDC criteria for use against the Ebola Virus. Use the cleaning and disinfection products according to usual label instructions and any specific instructions related to inactivation of a non-enveloped virus (norovirus, rotavirus, adenovirus, poliovirus) follow label instructions for use of the product that are specific for inactivation of that virus. Refer to List L: EPA's Registered Antimicrobial Products that Mmeets the CDC Criteria for Use Against the Ebola Virus (dated September 1, 2015)
   a. Use most current version of information published
2. All cleaning cloths, mop cloths, PPE, wipes, microfiber cloths, linens, food service, privacy curtains will be disposed of and placed in leak proof red biohazard bags and placed in a rigid waste receptacle designed to support the bag to help minimize contamination of the bag's exterior. All waste will be handled as Category A waste and contained in primary and secondary red biohazard bags, whose respective outside surfaces have been disinfected with bleach wipes and placed into a specified rigid container with a tight fitting lid.

E. **SPILLS OF BLOOD OR OTHER BODY SUBSTANCE:**

1. The basic principles for blood or body substance spill management are outlined in the United States Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standards (29 CFR 1910.1030).
2. CDC guidelines recommend removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient. An EPA-registered hospital disinfectant with label claims for non-enveloped viruses (norovirus, rotavirus, adenovirus, poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids should be used according to those instructions.
   a. Refer to IC Bloodborne Pathogen Exposure Plan

F. **WASTE PACKAGING AND TRANSPORTING:**

1. All waste is packaged and transported in accordance with the U.S. DOT Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 71-180). Individual plastic red biohazard bags film will weigh no more than 10 kg (22 pounds). Red biohazard bags must meet the Federal Department of Transportation (DOT) Requirements for impact and tear resistance. Do not overfill the biohazard bags. It is suggested that the bags only be filled with Ebola contaminated waste no more than half of its total volume.
2. Sharps and Pharmaceutical Waste:
   a. Sharps and pharmaceutical waste is placed in authorized single use sharps containers, which are closed and sealed. Do not reuse sharps container system. When the sharps container is ready for disposal, close and securely lock the container. Disinfect the exterior of the sharps waste container with bleach wipes, and place in a red biohazard

bag. Securely tie off the biohazard bag, disinfect the exterior surface of the bag with bleach wipes and place into a rigid container with a tight fitting lid for transportation.

3. Suction Canister Waste:
   a. Do not reuse suction canister system, once used on suspect or confirmed EVD patient. Do not add solidifier to liquid contents of a suction canister and agitate to mix because of the potential to create aerosols. Seal/close the canister and disinfect the outside surface of the canister with bleach wipes. Then place sealed canister in red biohazard bag. Securely tie bag. Disinfect exterior surface of bag and place in rigid container with tight fitting lid.
4. Other Waste: Linens etc:
   a. Place all other waste in red biohazard bags, no more than half full. Securely close the bag with a knot. Disinfect the exterior surface of the bag with bleach wipes and place into a second bag. Tie off the second bag, disinfect the exterior of the second bag with bleach wipes and place into a rigid container with a tight fitting lid.
5. Incineration (or autoclaving) as a waste treatment process is effective in eliminating viral infectivity and provides waste minimization. If disposal requires transport offsite then this should be done in accordance with the U.S. Department of Transportation's (DOT) Hazardous Materials Regulations (HMR, 49 CFR, Parts 171-180).6, 7 Guidance from DOT has been released for Ebola.
   a. Stericycle, the contracted company will be responsible for managing, containing and transporting all contaminated waste as directed by DOT.

G. **FORM(S):**
1. Potential Exposure Contract List – Sample
2. Observer Tracking Form – Sample

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

I. **REFERENCES:**
1. http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html
2. https://www.cdph.ca.gov/certlic/medicalwaste/Documents/MedicalWaste/2013/Ebola%20medical%20waste%20management-CDPH%20interim%20guidance-28%20Oct%202014.pdf

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
HAZARDOUS MATERIALS MANAGEMENT

ISSUE DATE: 10/94

SUBJECT: Hazardous Material Waste Training Procedures

POLICY NUMBER: 6002

REVISION DATE~~(S)~~: 08/97, 07/00, 04/03, 05/15

Department Approval ~~Date(s)~~:	**~~04/15~~09/22**
Environmental Health and Safety Committee Approval ~~Dates(s)~~:	**~~04/15~~09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~05/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**05/15**

A. **PURPOSE**

1. To outline the ~~process~~**guidelines** for training **of** personnel who are required to handle hazardous ~~chemicals~~**substances**.

B. **POLICY**

1. All employees who handle hazardous ~~materials~~**substances will be** ~~and waste are~~ trained **prior to handling the substance, to include each time a new chemical is introduced into job tasks, receiving a new** ~~in~~ SDS, **if the new information indicates significant increase risks to employees, or measures necessary to protect employee health.** ~~which contain the following:~~
   - a. **Employee shall be informed of any operations in their work area where hazardous substances are present**
   - b. **Employee shall be informed of the location and availability of the written hazard communication program, including lists of the hazardous substances and SDSs required by this section.**
   - c. **Employees shall be trained in the methods and observations that may be used to detect the presence or release of hazardous substances in the work area (such as monitoring conducted by the employer, continuous monitoring devices, visual appearance or odor of hazardous substances when being released)**
   - d. **Employees shall be trained in the physical and health hazards of the substances in the work area, and the measure they can take to protect themselves from these hazards, including specific procedures the employer has implemented to protect employees from exposure to hazardous substances, such as appropriate work practices, emergency procedures, and PPE to be used**
   - ~~2.~~e. **Employees shall be trained in the details of the hazard communication program developed by the employer, including an explanation of the labeling system and SDS, and how employees can obtain and use the appropriate hazard information.**
   - ~~a. The Hazard Communication/Global Harmonization/Right to Know Law.~~
   - ~~b. Symptoms associated with overexposure to hazardous materials.~~
   - ~~c. First Aid treatment.~~
   - ~~d. How to read Safety Data Sheets.~~
   - ~~e. Use of personal protective equipment. Location, availability, type, use and limitations.~~
   - ~~f. Standard operating procedures.~~
   - ~~g. Hazards of chemicals to workers involved in non-routine tasks such as in the cleaning.~~

~~h. Emergency procedures.~~
~~i. Storage practices.~~
~~j. Identify what and where hazardous chemicals are found in the work area.~~

C. **EMPLOYEE RESPONSIBILITIES**

1. Obey established safety rules.
2. Use personal protective equipment as required.
3. Inform your supervisor of:
   a. Any symptoms of overexposure that may possibly be related to hazardous chemicals.
   b. Missing labels on containers.
   c. Malfunctioning safety equipment.
   d. Any damaged containers or spills must be reported immediately.

D. **DOCUMENTATION:**

1. All documentation is tracked and maintained in NetLearning.

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE:	**04/3/06**	**SUBJECT:**	**Clinical Nutrition Dietitian Staffing**
REVISION DATE:	**10/11, 03/18**		

Department Approval:	**~~10/21~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~n/a~~09/22**
Administration Approval:	**~~05/22~~11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/22**

A. **DEFINITIONS:**

~~A.~~1. Clinical Dietitian/Clinical Staffing refers to a Registered Dietician (RD) who has completed department specific competencies.

B. **POLICY:**

1. Clinical dietitians are scheduled to assure continuity and consistency of nutrition care provided to patients.
2. Clinical dietitians are scheduled daily to assure consistency of care to patients.
3. A dietitian is scheduled for weekend coverage.
4. A dietitian is scheduled for holiday coverage.
5. Staffing of clinical dietitians is adjusted to patient census and workload

C. **EMERGENCY OPERATION CLINICAL NUTRITION STAFFING**

1. **Phase 1 (Conventional Capacity)**
   a. In-patient - Clinical staffing at least 80% with dietitians working regularly scheduled hours.
      i. Follow ~~currently approved~~ facility nutrition assessment policy~~.~~ **and identify opportunities for potential adjustments.**
      ~~i. Review clinical care processes and associated documentation to identify opportunities for potential adjustments.~~
   b. Outpatients
      i. If facility remains open to outpatients, continue business as usual
      ii. Implement tele-health nutrition MNT options
2. **Phase 2 (Decreased~~Crisis~~ Capacity)** Clinical staffing at **51-**79% ~~or less~~ and/ or volume of patients with nutrition concerns is elevated.
   a. Inpatients
      i. **Follow facility nutrition assessment policy and** ~~A~~adjust assessment and reassessment time frames to prioritize severe nutrition risk patients including and limited to:
         1) Ventilated patients
         2) Patients on new nutrition support
         3) Malnutrition/Pressure Injuries Stage III & IV/ BMI < 18
         4) In the event that all severe nutritionally at risk patients are addressed, Dietitian will prioritize additional patients per clinical judgement.
      ii. Outpatients
         1) Closed

3. **Phase 3 (Crisis Capacity) Clinical staffing at 50% or less and/ or volume of patients with nutrition concerns is elevated.**
   a. **Inpatients**
      ~~iii.~~**i. Follow facility nutrition assessment policy and adjust assessment and reassessment time frames to prioritize severe nutrition risk patients including and limited to:**
         1) New v**entilated patients**
         ~~D.~~**2) Patients on new enteral feeding**
         ~~1)~~**3) New TPN, if consulted by consulted Pharmacy**
         ~~2)~~**4) Consultation ordered that meet criteria for severe malnutrition**
         ~~3)~~**5) Pressure Injuries Stage III & IV**
      ii. Documentation will be completed in an abbreviated form
      iii. Reassessments will be completed per clinical judgement or if consulted through the EMR.
      iv. In the event that all severe nutritionally at risk patients are addressed, Dietitian will prioritize additional patients per clinical judgement.
   b. **Outpatients**
      ~~v.~~**i. Closed**

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE:	**05/88**	**SUBJECT:**	**Emergency Preparedness: Food & Nutrition Plan**
REVISION DATE:	**2/09, 01/10, 10/11, 02/12**		

Food and Nutrition Department Approval:	**~~03/18~~09/22**
~~**Medical Staff Department or Division Approval:**~~	~~**..n/a**~~
Environmental Health & Safety Committee Approval:	**~~11/18~~09/22**
Pharmacy & Therapeutics Committee Approval:	**..n/a**
Medical Executive Committee Approval:	**..n/a**
Administration Approval:	**~~01/19~~11/22**
Professional Affairs Committee Approval:	**..n/a**
Board of Directors Approval:	**01/19**

A. **PURPOSE:**

1. Tri-City Medical Center will have the means to:
   a. **As**~~En~~sure efficient Food & Nutrition services and to maintain adequate availability of personnel in the event of disaster.
   b. Provide nutritional assistance to staff and patients.
   c. Maintain proper management of food and supplies.

B. **DEFINITION(S):**

1. Emergency: An unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services. **This may include, but not limited to, loss of water supply, electricity, or natural gas as well as increased patient census.**

C. **POLICY:**

~~1.~~ The facility maintains **an inventory of** ~~at least~~ (7) days **shelf stable** ~~staple~~ and (2) days perishable foods**, water, and disposables**~~. in inventory. Within our supply, we maintain a minimum of (4) days (96 hour) diaster meals, bottled water and disposable supplies in the facilities secured warehouse area.~~

~~2.~~**1.** A Nutrition Service Disaster and e**E**mergency **P**~~p~~lan **is available and reviewed annually with all department employees.** ~~is prominently posed in the food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences and emergency/disaster. It is possible that any or all of these services may be interrupted.~~

~~3.~~**2.** The **Food and** Nutrition Service Director, Dietitian, or Food Service **designee** ~~staff member~~ in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration. If needed, all or part of the emergency meal plan will be implemented to **as**~~en~~sure provisions of nutritious meals to patients**, staff, and guests** despite the limitations of the disaster. The Meals for All Emergency Solution menu may be used during and emergency/disaster at the discretion of the Food and Nutrition Service **Director, Dietitian, or designee,** ~~Department~~, House Supervisor, or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, the **Clinical** Registered Dietitian **Team** will be notified.

D. **NOTIFICATION:**

1. Food & Nutrition Services will be notified of the disaster plan activation when the PBX operator announces "Code Orange" or "Code Yellow" utilizing the overhead page.
2. Food Service **Director**/Supervisor/**Designee**~~Charge~~ Responsibilities:
   a. Locate the Unit Leader Responsibilities found in the Department Disaster binder **(Section #3)**. The charge duty responsibilities will transfer to the ~~Manager/~~Director of Food and Nutrition Services upon their arrival to the facility and briefing with the Command Center.
   b. A completed staff inventory form and emergency incident message form will be delivered to the Incident Command Center~~ via staff~~. These forms can be located in the **Food and Nutrition** Department Disaster Binder located in the **Food and Nutrition Director's Office.** ~~patient food service supervisors' office and in the main Food & Nutrition Services office~~.
   c. ~~The Incident Command Center is located in the French rooms.~~ If the Incident Command Center is not set up, then staff is to notify the Emergency Department for further instructions.
   d. All Food Service staff will be recalled ~~staff~~ from breaks for standby to report to disaster priority areas when assigned.

E. **PROCEDURE**

1. The Director of Food and Nutrition Services will initiate the departmental disaster call-in roster, if the situation warrants it and requested by the Incident Command Center.
   a. In the event of a major disaster situation, all off duty personnel are required to report to the designated ~~I~~Labor pool for further direction.
2. All on-duty employees are to report immediately to the department for instructions.
   a. Information regarding staffing levels and available staff resources is completed on the Incident Emergency Message form **(Section # 3)** and **delivered**~~taken~~ to the Incident Command Center.~~ in the French rooms.~~
3. Staff will begin to inventory and document all food products and disposable supplies. They will report their findings to the Director of Food and Nutrition or ~~their~~ designee
4. Meals will be served in the cafeteria when possible unless circumstances prevent the use of that area. If this occurs, then other serving areas and times will be designated by the Food and Nutrition Director or designee.
5. In the event the emergency/disaster situations affects the normal operation of patient food service, the Director of Food and Nutrition or designee will be responsible for any changes necessary to serve food to the patients and will notify all the affected departments. The Command Center shall also be notified of the changes as well.
   a. See Appendix A: Procedure for Disaster Control **(Section # 8)**
   b. See Appendix B: Disaster Menu – **See Meals for All Binder**
6. Disposable ware will be utilized in the event the emergency/disaster situation when normal food service operations are disrupted. ~~.~~
7. The list of current vendors **and phone numbers** who can provide emergency refrigeration, water, and food supplies is kept on file in the Department Disaster Binder **(Section #5)**. ~~Emergency phone numbers for contacting vendors at night or on weekends for all of the vendors is in the Department Disaster Binder as well.~~
8. In the event that the kitchen can not be accessed or utilized, one option may be the Meals for All (Nutricopia) which has an inventory of **to feed patients, staff, and guests for 7 days.** ~~7800 meals as well as 1950 snacks for patients, staff and visitors.~~ Refer to Meals for All Implementation procedures.
9. The Director of Food and Nutrition or designee will update the Command Center on an hourly basis, unless extreme circumstances warrant and immediate notification.
10. ~~A beverage station will be set up, upon request, for the Command Center.~~
11. ~~11.~~**10.** The Food and Nutrition Departmental Disaster Plan will be updated and reviewed on an annual basis.

~~12.~~**11.** The Food and Nutrition Department maintains an emergency water supply which is kept in the basement storage and disaster cage. This includes:
   a. 80 five gallon jugs or approximately 400 gallons
   b. 9500 gallons of canned water

~~13. Water may be accessed from the City of Oceanside. In the event that this water is inaccessible, water from the City of Vista would be accessed. Water may also be accessed from two 10,000 gallon drums located on the roof of the medical center. Details of how this water would be accessed are found in the Disaster Manual Engineering specific policy (Failure of H20 Distribution). Alternative sources for water include commercial water suppliers, i.e. Rayne and Arrowhead.~~

~~14.~~**12.** Disaster supplies and food designated for disaster use are stored separately from **the** ~~-~~Food and Nutrition Services **Department**, in a room in the basement under the Operating Room Suites.

~~15.~~**13.** In the event that the kitchen cannot be utilized for meal preparation, alternative sites are available:
   a. Occupational Therapy kitchen
   ~~b. Pavilion kitchen~~
   ~~c.~~**b.** Disaster tents may be set up and utilized as needed

F. **ATTACHMENT(S):**
1. Appendix A: Procedure for Disaster Control
2. Appendix B: Disaster Menu

G. **RELATED DOCUMENT(S):**
1. Food & Nutrition Services Disaster Call Tree
2. Disaster Call List for Vendors

Appendix A
Procedure for Disaster Control

A. Procedure for Handwashing Dishes: **If unable to use flight dish machine**
~~1. Use two (2) lanterns~~
~~2.~~**1.** Strip and stack dirty trays, etc.
~~3.~~**2.** Handwash dirty trays~~, etc.,~~ in portable sinks as follows:
   a. Sink #1 (WASH) - add Pantastic Detergent according to manufacturer's instructions to hot water (at least ~~110~~**110** degrees F)
   b. Sink #2 (RINSE) - plain hot water (at least 110 degrees F)
   c. Sink #3 (SANITIZE) - add Quat Sanitizer solution according to manufacturer's instructions to hot water (at least 110 degrees F)
   d. Dry on rack

B. Waste Disposal
1. Garbage will be placed in closed containers **and placed in trash dumpster. If trash dumpster unable to be removed by City of Oceanside, Food and Nutrition Director will consult with Command Center to execute additional action plans.** ~~and removed since garbage disposals could not be used. If garbage and trash could not be removed, they would need to be buried in a pit on the property~~.

C. Emergency Power
1. If on emergency power, **refrigeration, freezers, and steam tables should function.** ~~most equipment is still functioning~~. If ~~pilot~~ gas is available, gas grills, gas ovens, convection ovens (without blowers), gas stoves, deep fat fryers and **steamers will** ~~boilers can~~ be utilized.
2. ~~Food items that can be prepared include any type of frozen entree, grill items, frozen items that are fried, soups, frozen vegetables and gravies that could be cooked on the stove~~.
~~3. If boiler gas~~ **only steam** ~~only~~ is available, steamers and steam kettles **will** ~~could~~ be used. ~~Food items that can be prepared include frozen entree, frozen vegetables, fish potatoes, dehydrated potatoes, soups and gravies, and freeze dried coffee.~~
~~4.~~**3.** Flashlights are kept in the supervisors' office. Battery-operated lanterns are kept in the storeroom.

D. Reserve Water
1. **If no water is available and we need to use the disaster supply water, disposable trays will be used.** ~~Using the reserve water supply, all china, glassware and utensils would be replaced by disposable paper goods, and we would~~. **Essential items will be washed in the three compartment sink.** ~~handwash only the essential items such as serving utensils and pots and pans~~.

E. Communications **if Electronic Medical Record on downtime procedures**
1. **Nursing responsible for communicating discharges, admissions and diet orders via phone or paper requisition.** ~~Food Service would rely on telephones in house to keep updated on the discharge and admissions of patients to the nursing floors and would modify the diets according to the foods available under the circumstances.~~

F. Security
1. Kitchen Supervisors are responsible for assessing the need to lock refrigerators or freezers.
~~1.~~**2. Vendors will be contacted for additional refrigeration and or freezers or trucks if necessary..** ~~Only Supervisors have the keys to the refrigerators and freezers. All would be locked except for those in use.~~
~~2. The doors to the kitchen would be locked to prevent outsiders from coming into the kitchen.~~
~~3. The walk in freezer and the walk in refrigerator would be locked until a freezer truck and a refrigeration truck could be obtained from Hollandia, if necessary~~. ~~However, most freezers and refrigerators are on emergency power.~~
~~4.~~**3.** Supervisors would only allow authorized personnel into the walk-ins and the storeroom.

G. Employees
1. The manager will initiate the departmental call tree if necessary.

2. If telephone service is available, they would be called.
3. If phone service is out, an employee would be sent to the homes of those living nearest the hospital.
4. Shifts would be arranged for people to work and rest out in the cafeteria, take naps and sleeps when needed.
5. Moderate amounts of water and towels would be provided for washing.

H. Concerns

1. The most immediate concern is proper sanitation and handling and storage of perishable food items, **proper** disposal of **waste,** ~~refuse~~ and the comfort and well being of the patients and employees.

Appendix B
Disaster Menu

The following food supplies will last a minimum **of (7) days** ~~96 hours~~ and are located in the OR basement or in the Disaster Storage Container. The menu is planned for a census of 180 patients, 400 staff and 85 visitors for each meal.

If food within the department is not available, Meals for all are available as a supplement to foods within the department~~; 7800 meals are kept on site in the OR basement or in the Disaster Storage Container.~~ These meals may be utilized as needed for patients on all regular and therapeutic diets, staff, and the **visitors**~~community~~. Patients on liquid diets are to be provided Boost Plus, 1 can/meal and one snack with bottled water ~~—to provide 1420 kcal, 56 gm protein.~~ Boost Glucose Control is provided for insulin dependent diabetics on full *liquids ~~(10 cases/25 pack);~~ Resource Fruit Beverage is provided for clear liquids ~~(3 cases/24 pack);~~ Nepro is available as an appropriate supplement for renal patients. Patients on a puree diet will also receive supplemental Boost* Plus with each meal. Thickened juices ~~(1 case)~~ and thickener ~~(1 case)~~ are available for those patients with dysphagia who require thickened liquids.

Type of Diet	Type of "Disaster Food" Provided/meal
Regular, soft, mechanical soft	Meals for All
Cardiac	Meals for All
Low sodium, NAS	Meals for All
Renal	Meals for All with Nepro
Pureed	1 Thick & Easy Puree meal with 4 oz pureed fruit 1 can Boost Plus
Full liquid	Boost Plus (diabetic FL receive 1 can Boost Glucose Control)
Clear liquid	Resource fruit beverage
Enteral feedings	Fibersource, **Replete, and** Nepro are available

A. Procedure for Food Preparation and Service for Disaster Where No Power Available:
   1. Dietitians' Office - Use one (1) lantern
   2. Diet Clerks' Office - Use one (1) lantern
   3. Patient Food Service
      a. Pour HOT water into 5 - 2 1/2 gallon Containers, using individual tea bags and freeze-dried coffee for beverages.
      b. Trayline - push trays manually.
      c. Use disposable ware for patient tray service with regular tray.
      d. Supervisors: Check temperature of hot water.
   4. Cooks
      a. Boil water for coffee and tea for patient food service and cafeteria.
      b. Keep foods warm in ovens.
      c. Dish up small amounts of food to be served on trayline and in cafeteria.
      d. Replenish foods frequently.
   5. Dishroom - Using 2 lanterns, handwash dirty trays, etc., in portable sinks:
      a. SINK #1 (WASH): Add Pantastic Detergent according to manufacturer's instructions to hot water (at least **110**~~110~~ degrees F)
      b. SINK #2 (RINSE): Plain hot water (at least 110 degrees F)
      c. SINK #3 (SANITIZE): Add Quat Sanitizer solution according to manufacturer's instructions to hot water (at least 110 degrees F)

B. Procedure for Specific Disaster, Mass Casualties and for Disruption of Service
   1. There shall be controlled traffic through flooded area.
      a. Outside of the department, Environmental Services personnel will reroute traffic away from flooded areas.

b. Within the department, all employees will be required to leave and relocate to an uncontaminated area as designated by the supervisor.
c. If it is impossible to relocate traffic, area will be sanitized with a sanitizing agent to prevent contamination.

2. There shall be communication to all departments regarding contaminated area.
   a. The switchboard shall notify all departments to discourage employees from going to the cafeteria, and/or to notify them of alternate routes.
   b. The department will call the nursing units if patient tray service will be interrupted. Patients who require food before trays can be sent from the kitchen will be served food from the supply available on the nursing units.
3. All food processing preparation and delivery shall be halted in contaminated areas.
   a. All food carts and related equipment should be relocated to an uncontaminated area, if possible.
   b. Coffee service may be provided to employees **if department staffing available.** .
4. There shall be an orderly and organized plan of clean up and enough personnel so that the most vital areas are cleaned first.
   a. Environmental Services and Facilities Management personnel will assist designated Food & Nutrition Services personnel to clean **areas following this priority: Patient food service area, food production, receiving area, diet office, dishroom, cafeteria serving area, cafeteria, storerooms and dietary offices.**
   ~~a. the kitchen areas, hallways to elevators, hallways to stairwells, cafeteria area, restrooms and offices, respectively.~~
   b. ~~Within the kitchen and cafeteria, the areas shall be cleaned in the following order: Patient food service area, food production, receiving area, diet office, dishroom, cafeteria serving area, cafeteria, storerooms and dietary offices.~~
5. All contaminated equipment and floors shall be cleaned and sanitized using appropriate disinfectant. All personnel should be extra conscious of hand washing techniques.
6. Once clean up in the kitchen is complete, food preparation and processing may resume. Food carts may be delivered to the floors when hallways are free of contamination. Staff will call nursing floors to notify them of delivery of patient trays.
7. The switchboard will notify all departments when contaminated hallways have been cleaned and sanitized.

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES
EMERGENCY PREPAREDNESS

ISSUE DATE: 02/19 **SUBJECT:** Emergency Preparedness – Meals For All/Nutricopia

REVISION DATE~~(S)~~:

Food and Nutrition Services Department Approval:	~~04/18~~09/22
Environmental Health & Safety Committee:	~~11/18~~09/22
Medical Staff Department/Division Approval:	n/a
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~01/19~~10/22
Administration Approval:	~~01/19~~11/22
Professional Affairs Committee:	n/a
Board of Directors:	02/19

A. **PURPOSE:**

1. Tri-City Medical Center will have the means to provide nutritional assistance to staff, **patients, and limited visitors**~~and patients for~~ **a minimum of** 96 hours in the event of a disaster or emergency situation.

B. **DEFINITIONS:**

1. An emergency **is an** ~~as~~ 'unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in sudden, significantly changed or increased demand for the organization's services.'

C. **POLICY:**

1. The facility maintains at **a minimum 96 hours of** ~~least a seven days~~ **perishable and nonperishable** ~~staple and two days perishable~~ foods, **disposable supplies, and water** in inventory. ~~Within that supply, we maintain four days (96 hour) emergency meals, bottled water and disposable supplies in the Food and Nutrition secured cage located in the facility basement.~~
~~2.~~ A Nutrition Service disaster and emergency plan is **available** ~~prominently posted~~ in **the** food service department and reviewed by all department employees at least annually. This plan will be referred to when the facility experiences a loss of water supply, electricity, natural gas, or experiences an emergency/disaster. ~~It is possible that any one or all of these services may be interrupted.~~
~~3.~~**2.** The Nutrition Service Director, ~~or~~ Dietitian, **or designee** ~~or Food Service staff member~~ in charge will consult with the House Supervisor or Administrator to determine the nature of the emergency and the anticipated duration.
~~4.~~**3.** If needed, all or part of this emergency meal plan will be implemented to ensure provision of nutritious meals to patients, **staff, and visitors** despite the limitations of the disaster. The Meals for All Emergency Solution menu may be used during an emergency/disaster at the discretion of the Food & Nutrition Service department, House Supervisor or Administration. In the event the emergency/disaster is anticipated to last beyond one meal, **a** ~~the~~ Registered Dietitian will be notified.

D. **AFFECTED PERSONNEL/AREAS:**

1. Governing Board; Medical Staff; all hospital employees; volunteers

E. **EQUIPMENT:**

1. Food preparation tool box.

F. PROCEDURE:

1. At least once a year, the Food & Nutrition department **provides education**~~conducts an in-service session~~ on disaster plans and emergency procedures in regards to the nutritional assistance that will be provided to patients**, staff, and visitors**. The Quick Guide to Emergency Feeding guidelines **is**~~will be~~ **available** ~~posted~~ in **the** ~~food service~~ **Director of Food and Nutrition office, Kitchen Supervisor Office, and Clinical Dietitian Office.** ~~and the house supervisor office~~. A copy of the **Meals For All** ~~disaster and~~ emergency procedures will be stored with the Meals for All emergency food and supplies.~~ ready reference. (See attachment I - Quick Guide to Emergency Feeding Guidelines)~~

G. HEATING SOURCE FOR WATER:

1. If no heating source is available, Meals for All may be reconstituted using unheated potable water. All food items are fully cooked and safe to serve at room temperature.
2. ~~Do not attempt to cook or boil water over an open flame whenever gas leaks are possible.~~

H. FOOD TEMPERATURES / FOOD SAFETY:

1. For best palatability, hot foods are best served at 135°F or more, cold foods are best served at 41° or colder.
2. However, all foods on this menu may be safely served at room temperature between 41° - 135° if opened, prepared and served within four hours.

I. HANDWASHING FOR FOOD PREPARERS:

1. Proper hand washing, when water is scarce requires the use of two basins, one with approved sanitizing agent, and one with clear rinsing water. Approved hand sanitizer may also be utilized.

J. FOOD PREPARATION:

1. Follow instructions on the Meals for All containers for proper preparation. See attachment II

K. EMERGENCY FOOD ITEMS STORAGE:

1. The Meals for All emergency meals and other emergency supplies will be secured in the facility storage warehouse and easily accessible during an emergency or disaster situation. All food items are dated by the manufacturer and have a ten year shelf life. During the final year of the expected shelf-life, the Food and Nutrition Services Director will determine if the facility will donate the Meals for All to a charitable organization or may utilize for a facility disaster exercise **or any other purpose deemed appropriate.**.

L. EQUIPMENT FOR FOOD PREPARATION:

1. The equipment needed for food preparation is secured and stored in the Food and Nutrition cage located in the facility basement area. The equipment is in its own marked container and located next to the Meals for All pallets. The equipment toolbox includes but not limited to:
2. ~~4 gray~~ **Serving** scoops,~~(4oz)~~, **and** ~~4 green scoops~~ (3oz), ~~4~~ spoodles (4oz), ~~2~~ serving spoons, ~~2~~ slotted serving spoons, ~~4~~ ladles (3oz), ~~2~~ rubber spatulas, ~~4~~ tongs, ~~2~~ sets measuring spoons, ~~2~~ measuring cups, ~~4~~ mixing bowls, ~~2~~ containers (12 quart), disposable aluminum pans, ~~2~~ spot lights, ~~6~~ headlamps; ~~3~~ lantern**s**, ~~10~~ flashlights, ~~72~~ (D) batteries, disposable gloves, ~~2~~ can openers, ~~4~~ thermometers, ~~2~~ boxes storage bags,~~2~~ boxes hairnets, ~~2~~ box cutters & extra blades, black markers, 2 scissors, 2 lighters, masking tape 72 (D) batteries, 2 boxes storage bags, ~~2 cases~~ disinfectant wipes, ~~2 boxes~~ alcohol wipes, ~~4 bottles~~ hand sanitizer, black markers, ~~2~~ scissors, ~~2~~ lighters, masking tape , garbage bags.

M. INVENTORY AND VERIFICATION:

1. The Meals for All Emergency Menu Inventory and Supply list will be maintained in the Food and Nutrition Services Director's Office and a copy will be placed in the Food and Nutrition Services Disaster Manual. The inventory and supply list will be inspected on a semi-annual basis to

determine all items are present in the quantities specified. The Emergency Supply Inventory Verification form (attached) will be utilized for documenting the inventory which will include;

a. Date of inventory check.
b. Results of the inventory.
c. Corrective action if needed.
d. Signature of person performing the supply inventory.

2. The Emergency Supply Inventory Verification form will be kept in the Director of Food and Nutrition Services office and available upon request. (see attachment IV Inventory Verification form)

N. DECENTRALIZED FOOD PREPARATION:

1. The Food and Nutrition Services Director or designee in charge may designate some or all of the emergency food preparation to be conducted at decentralized or on each nursing unit or at a remote location from the facility. The Meals for All are packaged to be easily transportable in the event of an evacuation and can be set up in any decentralized location.

O. MEAL SERVING HOURS:

1. The meal serving hours for the Meals for All, will be modified or staggered depending on the emergent situation and will be determined by the Incident Commander, Food and Nutrition Services Director or designee. It will be taken into consideration the necessary amount of batch cooking to prepare in order to serve in large quantities to the patients and staff members. The meals may be served tableside to facilitate having a limited staff to efficiently prepare and serve during an emergency situation. If emergency circumstances warrant, the meals may be served directly from the cooking container directly to the patient, ~~/~~staff, **or visitor**.

P. USE OF EMERGENCY MENUS:

1. Depending on the time of day and expected duration of the emergency, the Food and Nutrition Services Director or designee may implement the Meals for All emergency menus and may be used for a single meal or for several days. ~~(see attachment III - 4 Day Emergency Menu)~~

Q. MENUS AND THERAPEUTIC DIETS:

1. The Meals for All menus has been planned to provide basic nutrients and meet the needs of most therapeutic healthcare diets. The Meals for All menu and products have been specially prepared to allow their use for most healthcare therapeutic diets. The therapeutic menu is appropriate for Regular, Mechanical Soft, Cardiac, Sodium Restricted, Diabetic and Renal diets. Specific Therapeutic ~~Diets modifications are as follows:~~**by following the Emergency Menu Serving instructions.**

~~a. Consistent Carbohydrate, Diabetic Gestational Diabetes and Low/No concentrated Sweets Diets may be served all menu items except the puddings are omitted. Offer sugar substitute and diet jelly if available.~~

~~b. Low Cholesterol/ Low fat Diets may be served on all menu items.~~

~~c. No Added Salt/Low Salt Diets may be served on all menu items but the salt packets are omitted.~~

~~d. 2 Gram Sodium Diets may be served on all menu items but the salt packets are omitted.~~

~~e. Calorie Controlled diets 1500 Calorie or less and Consistent Carbohydrate or Diabetic Diets may be served on all menu items except portions of milk, cracker biscuits and snacks are reduced and the puddings are omitted. Offer sugar substitute and diet jelly if available.~~

~~f. Renal and Hepatic Diets may be served on all menu items except the milk, pudding and salt packets are omitted. Limit beverages if fluid restriction is prescribed.~~

~~g. Resident's allergies will be accommodated by knowledgeable staff by offering suitable foods from the Meals for All Emergency menu. Diets may be deficient in one or more nutrients.~~

~~h.~~**a.** ~~Powdered milk is included in the Meals for All to meet nutritional needs.~~

~~i.~~**b.** Puree **and Full Liquid** diets will receive 1 can boost **(boost glucose control for diabetics)**

~~j. Full liquid diets will receive one can boost (boost glucose control for diabetics~~

~~k.~~**c.** Enteral feedings – ~~Fibersource~~**Replete and ~~,~~ Novasource Renal**~~Nepro~~ available **as needed.**

~~l.~~**d.** Clear Liquid Diets shall receive broth, gelatin, and clear soda stocked on the nursing units. Nutritional supplements may be ordered to increase calories and nutrient values **if needed**.

R. BEVERAGES / CONDIMENTS:

1. **Water and/or** ~~B~~beverages will be provided ~~as requested or available~~ during an emergency situation. Patients needing thickened liquids will be served **pre-thickened** beverages **if available or nursing will thicken beverages on the unit, following manufacturers guidelines.** ~~thickened to the appropriate level. Substitute dehydrated milk mixed with water for fluid milk if needed.~~ Condiments ~~such as salt, pepper and sugar are made available when possible and not contraindicated by the prescribed diet order. Consistent Carbohydrate or Diabetics shall receive sugar substitute. Sodium-restricted, Hepatic and Renal diets will not receive salt packets.~~**provided per therapeutic diet restrictions.**

S. WATER STORAGE GUIDELINES:

1. The facility will maintain designated emergency water for the Meals for All in a secured storage location. The water will be stored in a cool, dry area away from heat sources and staff will be instructed not to utilize for any other purpose except an emergency situation. One gallon of water per person per day for proper hydration will be stored. This allows two quarts for drinking water and two quarts for food preparation. ~~However,~~ Meals for all dehydrated emergency foods require approximately one quart of water per person per day for reconstitution. ~~Refer to Water Requirements appendix in 4–Day Meal Plan Guide for water requirements table for exact amounts of water per can. Storing one gallon of water per person per day is adequate to meet emergency water needs.~~

T. MEAL/WATER ALLOCATION:

MEAL/WATER ALLOCATION DAY 1		MEAL/WATER ALLOCATION DAY 2		MEAL/WATER ALLOCATION DAY 3		MEAL/WATER ALLOCATION DAY 4	
Patients	180	Patients	180	Patients	180	Patients	180
Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400	Staff / Physicians	400
EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85	EMS / Visitors	85
Total gallons	665	Total gallons	665	Total gallons	665	Total gallons	665

A MINIMUM OF 1 GALLON PER PERSON PER DAY.
(2660 gallons emergency water total)

U. ATTACHMENT(S):

1. Appendix I: Quick Guide to Emergency Feeding
2. Appendix II: Meal Preparation
3. Appendix III: Four Day Emergency Meal Menu
4. Appendix IV: Inventory Verification Form

V. REFERENCE(S):

1. Nutricopia – Meals for All Emergency Solutions

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services Disaster Manual

APPENDIX I

QUICK GUIDE TO EMERGENCY FEEDING

1. Notify Food & Nutrition Service Director or Clinical Nutritional Manager using the emergency call back list or appoint alternate to be in charge.

2. Determine nature of emergency or interruption:

   - ELECTRICITY - continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NATURAL GAS - Use alternate heating source if safe. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - WATER SUPPLY - affects ware washing and cooking, so conserve water and liquids. Continue usual meal plan, modify as needed. May substitute *Meals for All* as needed.
   - NO POWER OR WATER - Use alternate heating source if safe. Affects ware washing and cooking, so conserve water and liquids. Substitute *Meals for All* as needed.

3. SELECT MENU PLAN TO FOLLOW:

   - Usual Menu with needed adaptations (uses perishable supplies first)
   - Meals for All emergency solution.

4. DIET MODIFICATIONS refer to usual menu, if using

   - Follow "Emergency Menu Serving Instructions" when using Meals for All.
   - Be aware of those with food allergies
   - Modify texture for chewing/swallow needs (e.g. mince or mash foods, serve thickened liquids.)

5. LOCATE NEEDED ITEMS:

   - Emergency procedures and menus are posted in Nutrition/Food/Dietary Department, Emergency food storage area, and House Supervisor's office.
   - Emergency food supplies are located at ~~SVMC warehouse~~**TCMC storage area**.
   - Emergency disposable supplies are located at ~~SVMC warehouse~~ **TCMC storage area**.
   - Preparation supplies are located in emergency toolbox at **TCMC storage area**~~SVMC warehouse~~.
   - Water supply is located at **TCMC storage area**~~SVMC warehouse~~.

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services Disaster Manual

APPENDIX II

MEAL PREPARATION

Refer to label on each product for specific instructions.

General Instructions for Hot Foods:

1. Open can and discard oxygen absorber* packet.
2. Boil water amount as directed OR mix with room temperature water if no heating source.
3. Stir dry contents of can or cans into boiling water.
4. Cover and remove from heat.
5. Allow to stand for 15 minutes for boiling water, 1 hour if room temperature water utilized.
6. Stir and serve 1 1/3 cup (2 x No. 6 Scoop) or as directed

Instructions for Ready to Eat Items (Fruit, Vegetables, Crackers):

1. Remove oxygen absorber* packet.
2. Ready to eat from packaging.
3. If desired, rehydrate as above using cold water for fruit

Instructions for Pudding Preparation:

1. Open can and discard oxygen absorber* packet.
2. Stir dry contents of one can into cold water, amount as directed.
3. Whisk thoroughly to mix. Allow to stand for 15 minutes.
4. Stir and serve #8 scoop for ½ cup or as directed.

Non-Fat Milk, to prepare:

1. Add water as directed on label, allow to stand 15 minutes, stir and serve 8 ounces or as directed.

Notes:

1. Food Safety Note: food should be consumed within 2 hours of preparation unless maintained at 135° or higher or below 41° for cold foods.
2. No heating methods: Allow 1 hour to rehydrate when using cold or room temperature water.
3. Product shelf life is ten years when properly stored in a cool, dry environment.
4. *Contains a non-toxic oxygen

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services Disaster Manual

APPENDIX III

MEALS for ALL EMERGENCY MENU FOUR DAY				
DAY ONE	DAY TWO	DAY THREE	DAY FOUR	VEGETARIAN
BREAKFAST				
Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified	Apple Cereal, Fortified
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
MID-				
Beef & Mushrooms with Noodles	Turkey & Potatoes with Cranberry	Southwestern Chicken & Rice	Chicken Curry with Rice	Spaghetti with Mushrooms
Green Peas	Corn Niblets	Green Beans	Garden Mixed Vegetables	Green Peas
Apples Diced	Peaches Diced	Applesauce	Peaches Diced	Applesauce
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)	Milk (NFDM)
DINNER				
Chicken Curry with Rice	Spaghetti with Mushrooms	Beef Stew with Potatoes	Macaroni & Cheese	Macaroni & Cheese
Carrots	Garden Mixed Vegetables	Broccoli	Green Peas	Green Beans
Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits	Cracker-Biscuits
Chocolate Pudding	Banana Pudding	Vanilla Pudding	Banana Pudding	Vanilla Pudding
Beverage	Beverage	Beverage	Beverage	Beverage
SNACK				
Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers	Peanut Butter and Crackers

Tri-City Medical Center
Oceanside, California

Food and Nutrition Services Disaster Manual

APPENDIX IV

Master Inventory List for Emergency Menu*
25 Person Serving Units

Case Number	Day	Meal	7-Day Emergency Menu Items	Servings per can	Number of cases on hand
1A	1	Breakfast	1 Multigrain Cereal, Fortified	25	
	1	Breakfast	1 Cracker-Biscuits	25	
	1	MidMeal	1 Creamy Chicken w/ Rotelle & Vegetables	12.5	
	1	MidMeal	1 Creamy Chicken w/ Rotelle & Vegetables	12.5	
	1	MidMeal	1 Garden Mixed Vegetables	25	
	1	MidMeal	1 Peaches, Diced	25	
1B	1	MidMeal	1 Cracker-Biscuits	25	
	1		1 Macaroni & Cheese	12.5	
	1		1 Macaroni & Cheese	12.5	
	1		1 Green Peas	25	
	1		1 Cracker-Biscuits	25	
	1		1 Vanilla Mousse	25	
2A	2	Breakfast	2 Apple Cereal, Fortified	25	
	2	Breakfast	2 Cracker-Biscuits	25	
	2	MidMeal	2 Turkey & Potatoes with Cranberries	12.5	
	2	MidMeal	2 Turkey & Potatoes with Cranberries	12.5	
	2	MidMeal	2 Corn	25	
	2	MidMeal	2 Peaches, Diced	25	
2B	2	MidMeal	2 Cracker-Biscuits	25	
	2		2 Spaghetti with Mushrooms	12.5	
	2		2 Spaghetti with Mushrooms	12.5	
	2		2 Garden Mixed Vegetables	25	
	2		2 Cracker-Biscuits	25	
	2		2 Banana Pudding	25	
3A	3	Breakfast	3 Apple Cereal, Fortified	25	
	3	Breakfast	3 Cracker-Biscuits	25	
	3	MidMeal	3 Southwestern Style Chicken & Rice	12.5	
	3	MidMeal	3 Southwestern Style Chicken & Rice	12.5	
	3	MidMeal	3 Green Beans	25	
	3	MidMeal	3 Applesauce	25	
3B	3	MidMeal	3 Cracker-Biscuits	25	
	3		3 Beef Stew with Potatoes & Gravy	12.5	
	3		3 Beef Stew with Potatoes & Gravy	12.5	
	3		3 Broccoli	25	
	3		3 Cracker-Biscuits	25	

	3		3 Vanilla Pudding	25	
4A	4	Breakfast	4 Apple Cereal, Fortified	25	
	4	Breakfast	4 Cracker-Biscuits	25	
	4	MidMeal	4 Chicken Curry with Rice	12.5	
	4	MidMeal	4 Chicken Curry with Rice	12.5	
	4	MidMeal	4 Garden Mixed Vegetables	25	
	4	MidMeal	4 Peaches, Diced	25	

Master Inventory List for Emergency Menu* 25 Person Serving Units					
Case Number	Day	Meal	7-Day Emergency Menu Items	Servings per can	Number of cases on hand
4B	4	MidMeal	4 Cracker-Biscuits	25	
	4	Evening	4 Macaroni and Cheese	25	
	4	Evening	4 Macaroni and Cheese	12.5	
	4	Evening	4 Green Peas	12.5	
	4	Evening	4 Cracker-Biscuits	25	
	4	Evening	4 Banana Pudding	25	
5A	4	Breakfast	5 Apple Cereal, Fortified	25	
	4	Breakfast	5 Cracker-Biscuits	12.5	
	4	MidMeal	5 Beef & Mushrooms with Noodles	12.5	
	4	MidMeal	5 Beef & Mushrooms with Noodles	25	
	4	MidMeal	5 Carrots	25	
	4	MidMeal	5 Apples, Diced	25	
5B	5	MidMeal	5 Cracker-Biscuits	25	
	5	Evening	5 Turkey & Potatoes with Cranberries	25	
	5	Evening	5 Turkey & Potatoes with Cranberries	12.5	
	5	Evening	5 Broccoli	12.5	
	5	Evening	5 Cracker-Biscuits	25	
	5	Evening	5 Chocolate Pudding	25	
6A	5	Breakfast	6 Apple Cereal, Fortified	25	
	5	Breakfast	6 Cracker-Biscuits	12.5	
	5	MidMeal	6 Southwestern Style Chicken & Rice	12.5	
	5	MidMeal	6 Southwestern Style Chicken & Rice	25	
	5	MidMeal	6 Green Peas	25	
	5	MidMeal	6 Applesauce	25	
6B	6	MidMeal	6 Cracker-Biscuits	25	
	6	Evening	6 Spaghetti with Mushrooms	25	
	6	Evening	6 Spaghetti with Mushrooms	12.5	
	6	Evening	6 Green Beans	12.5	
	6	Evening	6 Cracker-Biscuits	25	
	6	Evening	6 Vanilla Pudding	25	

7A	6	Breakfast	7 Apple Cereal, Fortified	25	
	6	Breakfast	7 Cracker-Biscuits	12.5	
	6	MidMeal	7 Beef Stew with Potatoes & Gravy	12.5	
	6	MidMeal	7 Beef Stew with Potatoes & Gravy	25	
	6	MidMeal	7 Corn Niblets	25	
	6	MidMeal	7 Peaches, Diced	25	
7B	7	MidMeal	7 Cracker-Biscuits	25	
	7	Evening	7 Macaroni and Cheese	25	
	7	Evening	7 Macaroni and Cheese	12.5	
	7	Evening	7 Garden Mixed Vegetables	12.5	
	7	Evening	7 Cracker-Biscuits	25	
	7	Evening	7 Banana Pudding	25	

25 Person Serving Unit

~~Inventory List (Four Day Emergency Menu)~~

~~Case Number~~	~~Day~~	~~Meal~~	~~4-Day Emergency Menu items~~	~~Servings Per Can~~	~~Number of Cases in Inventory~~
~~1-A~~	~~1~~	~~Breakfast~~	~~Apple Cereal, Fortified~~	~~25~~	
	~~1~~	~~Breakfast~~	~~Cracker-Biscuits~~	~~25~~	
	~~1~~	~~Mid-meal~~	~~Beef & Mushrooms with Noodles~~	~~12.5~~	
	~~1~~	~~Mid-meal~~	~~Beef & Mushrooms with Noodles~~	~~12.5~~	
	~~1~~	~~Mid-meal~~	~~Green Peas~~	~~25~~	
	~~1~~	~~Mid-meal~~	~~Apples Diced~~	~~25~~	
~~1-B~~	~~1~~	~~Mid-meal~~	~~Cracker-Biscuits~~	~~25~~	
	~~1~~	~~Evening~~	~~Curry Chicken and Rice~~	~~12.5~~	
	~~1~~	~~Evening~~	~~Curry Chicken and Rice~~	~~12.5~~	
	~~1~~	~~Evening~~	~~Carrots~~	~~25~~	
	~~1~~	~~Evening~~	~~Cracker-Biscuits~~	~~25~~	
	~~1~~	~~Evening~~	~~Chocolate Pudding~~	~~25~~	-
~~2-A~~	~~2~~	~~Breakfast~~	~~Apple Cereal, Fortified~~	~~25~~	
	~~2~~	~~Breakfast~~	~~Cracker-Biscuits~~	~~25~~	
	~~2~~	~~Mid-meal~~	~~Turkey and Vegetables~~	~~12.5~~	
	~~2~~	~~Mid-meal~~	~~Turkey and Vegetables~~	~~12.5~~	
	~~2~~	~~Mid-meal~~	~~Corn~~	~~25~~	
	~~2~~	~~Mid-meal~~	~~Peaches, Diced~~	~~25~~	-
~~2-B~~	~~2~~	~~Mid-meal~~	~~Cracker-Biscuits~~	~~25~~	
	~~2~~	~~Evening~~	~~Spaghetti & Mushrooms~~	~~12.5~~	
	~~2~~	~~Evening~~	~~Spaghetti & Mushrooms~~	~~12.5~~	
	~~2~~	~~Evening~~	~~Garden Mixed Vegetables~~	~~25~~	
	~~2~~	~~Evening~~	~~Cracker-Biscuits~~	~~25~~	-

	2	Evening	Banana Pudding	25	
3-A	3	Breakfast	Apple Cereal, Fortified	25	
	3	Breakfast	Cracker-Biscuits	25	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Southwestern Chicken & Rice	12.5	
	3	Mid-meal	Green Beans	25	
	3	Mid-meal	Applesauce	25	-
3-B	3	Mid-meal	Cracker-Biscuits	25	
	3	Evening	Beef Stew	12.5	
	3	Evening	Beef Stew	12.5	
	3	Evening	Broccoli	25	
	3	Evening	Cracker-Biscuits	25	
	3	Evening	Vanilla Pudding	25	-
4-A	4	Breakfast	Apple Cereal, Fortified	25	
	4	Breakfast	Cracker-Biscuits	25	
	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Curry Chicken and Rice	12.5	
	4	Mid-meal	Garden Mixed Vegetables	25	
	4	Mid-meal	Peaches, Diced	25	-
4-B	4	Mid-meal	Cracker-Biscuits	25	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Macaroni & Cheese	12.5	
	4	Evening	Green Peas	25	
	4	Evening	Cracker-Biscuits	25	
	4	Evening	Banana Pudding	25	-
Milk	1	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	2	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	3	B'fast & Mid-Meal	Non Fat Dry Milk	50	
	4	B'fast & Mid-Meal	Non Fat Dry Milk	50	-
Snack	1	Snack	Peanut Butter	25	
	1	Snack	Cracker-Biscuits	25	
	2	Snack	Peanut Butter	25	
	2	Snack	Cracker-Biscuits	25	
	3	Snack	Peanut Butter	25	
	3	Snack	Cracker-Biscuits	25	-
Snack	4	Snack	Peanut Butter	25	
	4	Snack	Cracker-Biscuits	25	-

Tri-City Medical Center
Oceanside, California

FOOD AND NUTRITION SERVICES

ISSUE DATE:	**09/07**	**SUBJECT:**	**Nutritional Care & Assessment for Infants Admitted to NICU**
REVISION DATE~~(S)~~:	**11/07, 07/08, 11/08, 10/10, 10/11 02/12, 08/19**		

Food and Nutrition Services Department Approval:	**~~03/18~~05/22**
Perinatal Collaborative Practice Approval:	**~~03/19~~08/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/19~~09/22**
Administration Approval:	**~~07/19~~11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **DEFINITIONS:**

1. Malnourished or Nutritionally at Risk:
   a. Acute weight loss of greater than 10% of body weight
   b. Weight below 3rd percentile on growth chart
   c. Decreased percentile scores of height and/or weight
   d. Low birth weight or prematurity
   e. Inadequate provision or tolerance of nutrients
   f. Chronic lung disease/bronchopulmonary dysplasia
   g. Congenital heart disease
   h. ~~Necrotizinig~~**Necrotizing** enterocolitis (NEC)
   i. Short bowel syndrome
   j. Small for gestational age (SGA)
   k. Intrauterine growth retardation (IUGR)
   l. Rickets of prematurity
   m. Cholestasis
   n. Failure to thrive
   o. Inadequate weight gain (</= 20 gm) after day of life 14
   p. Inappropriate or inadequate weight gain x 4 days after day of life 14

B. **POLICY:**

1. Function: A systematic method for the CCS-paneled Clinical Registered Dietitian to collaborate with the physician 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.
2. Circumstances:
3. Setting: All patients admitted to or being treated at Tri City Medical Center's Neonatal Intensive Care Unit
4. Supervision: None required
5. **Consults for Neonatal Dietitian are automatically generated from the EMR upon admission.** ~~Referrals for a nutrition assessment are generated if certain criteria are met via the neonatal admission assessment in Compass Power Chart~~.
6. The CCS-paneled Clinical Registered Dietitian (RD) will **complete a Neonatal Nutrition Assessment** ~~screen~~ for nutritional risk within 48-72 hours of hospital admission.~~, and will complete~~

~~a comprehensive nutritional assessment of triggered patients within 48-72 hours of referral. and within 72 hours of admission~~, per CCS guidelines. This assessment to include age of patient, disease states, nutrition history, medical history, medical therapies/treatments, laboratory values, and recommendations for enteral and parenteral nutrition support, addition of supplements, and education of patients/families regarding appropriate nutrition intervention for a particular disease state

C. **PROCEDURE:**

1. **The CCS-paneled Clinical Registered Dietitian (RD) will complete a Neonatal Nutrition Assessment within 48-72 hours of hospital admission.**
2. **The Clinical Registered Dietitian will document on the Neonatal nutrition assessment form.**
3. **Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team:**

~~1.~~ **within the electronic medical record** ~~Referrals for nutrition assessment are generated if the following criteria are met upon completion of the NICU admission data base and patient history, as requested by physician, and/or as identified during multidisciplinary rounds, or at any point during the NICU stay:~~

~~a. Extremely Low Birth Weight (ELBW) less than 1000gm~~
~~b. Very Low Birth Weight (VLBW) less than 1500gm~~
~~c. Chronic lung disease/bronchopulmonary dysplasia~~
~~d. Congenital heart disease~~
~~i. Necrotizing enterocolitis (NEC)~~
~~ii. Short bowel syndrome~~
~~iii. Small for gestational age~~
~~iv. Intrauterine growth retardation~~
~~v. Rickets of prematurity~~
~~vi. Cholestasis~~
~~vii. Patients on TPN for more than five days~~
~~viii. Intolerance to enteral feeds~~
~~ix. Failure to thrive~~
~~x. Inadequate weight gain (less than or equal to 20 grams) after day of life 14~~
~~xi.~~**4.** ~~Inappropriate or inadequate weight gain for 4 days after day of life 14~~
~~2.~~**5.** The Clinical Registered Dietitian will complete the assessment **upon admission and monitor the following:** ~~with consideration of~~:

a. Nutrition order (TPN versus gavage feedings versus nipple feedings versus breastfeeding)
b. Diagnosis
c. Chronological age and/or gestational age
d. Weight **and weight for height percentile or weight for age/weight for height percentile**
e. length,
~~d.~~**f. Head circumference, and head circumference percentile**
~~e. Length~~
~~f. Head circumference as appropriate~~
g. Macronutrient and micronutrient requirements
~~g.~~**h.** Food allergies
~~h.~~**i.** Birth weight - if available
~~i.~~**j.** History of weight changes
~~j.~~**k.** Potential drug nutrient interactions
~~k.~~**l.** Laboratory and biochemical values **pertinent to nutrition assessment**
~~l.~~**m.** Psychosocial, physiological, social and or environmental issues
n. Clinical assessment changes
o. Feeding concerns
p. Weight change percentile (postnatal growth for the premature infant should mimic in utero fetal growth rates - ~1.5% (15g/kg) increase per day.

q. Estimation of calories are based on the neonate's age, weight, disease state, and nutrition status
r. Grams of protein per day
s. Fluid requirements
~~m.~~**t. Z- Score**
~~n. Any other general nutrition concerns~~

~~3.~~**6.** ~~The Clinical Registered Dietitian will document in the Neonatal nutrition assessment form of the medical record. Assessments will be based on information provided by admission assessment, review of history and physical, physician notes, other disciplines' notes, and interview with parents, nursing, or other members of health care team:~~
~~a. Nutrition order~~
~~b. Diagnosis~~
~~c. Age (gestational age and adjusted age)~~
~~d. Weight, length, head circumference~~
~~e. Macronutrient and micronutrient requirements~~
~~f. Food allergies~~
~~g. Laboratory and biochemical values: pertinent to assessment~~
~~h. History of weight changes~~
~~i. Feeding problems~~
~~j.~~**a.** Psychosocial, physiological, social, and or ~~environmental issues~~**environmental issues**

~~4. The Clinical Registered Dietitian will further document in the Neonatal Nutrition Assessment form in the medical record. The Dietitian will also calculate the following:~~
~~a. Weight for height percentile or weight for age/weight for height percentile.~~
~~b. Head circumference percentile~~
~~c. Weight change percentile (postnatal growth for the premature infant should mimic in utero fetal growth rates ~1.5% (15g/kg) increase per day.~~
~~d. Estimation of calories is based on the neonate's age, weight, disease state, and nutrition status~~
~~e. Grams of protein per day~~
~~f. Fluid requirements~~

~~5.~~**7.** A nutrition care plan will be developed and individualized based on assessment and will meet specific needs of patient. Goals will be individually determined with delineation of methods of achievement of goals and time frames. Goals will be documented in the electronic medical record.

Energy, Protein, Fluid Requirements of the Pre-term Infant			
	Protein g/kg/d	Kcal/Kg/d	Water ml/kg/d
Enteral Preterm fed ~~Enterally~~	2.5 - 4	105-130	120-200*
Preterm fed parenterally	3-4	90-120	140-160*

*Dependent upon clinical condition (i.e. less with PDA or BPD)

~~6.~~**8.** The Clinical Registered Dietitian will confer with **Neonatologist** ~~physician~~, RN, and/or Pharmacist regarding pertinent factors affecting nutrition status (i.e. medication, I&O, intake, etc.).

9. The Clinical Dietitian will provide follow-up for patients **every (7) days dependent on nutritional risk status and document on the Neonatal Nutrition Assessment form.**

~~7.~~**10.** ~~. assessed at risk daily and will~~:
~~a. Document at least every seven (7) days depending on medical status and nutritional status and revise therapy as indicated.~~

~~b. Follow-up assessment is documented in the Neonatal Nutrition Assessment form of the medical record, to include nutrient intake, tolerance to feedings, weight changes, laboratory parameters, and I&O.~~

~~c.~~ Follow-up assessments may be **scheduled for less than (7) days if** ~~triggered sooner as~~ warranted by

a. ~~change~~**a change** in nutritional status and/or medical condition.

~~8.~~**11.** The Clinical Registered Dietitian will provide nutrition counseling and education explaining rationale to parent(s) as ordered by **P**~~p~~hysician, as requested by nursing, or family, or as deemed appropriate by RD.

a. Documentation of education is completed in the physician progress notes.

b. Education may include, but is not limited to, formula preparation, appropriate recommendations related to infant feedings and formulas. Referrals for outpatient medical nutrition therapy will be generated as appropriate, i.e. specialty formulas, feeding issues, growth concerns.

D. **REFERENCE(S):**

1. "The Science and Practice of Nutrition Support: A Case based Core Curriculum," ed. Gottschlich, MM, 2001.
2. Tsang, RC. "Nutrition of the Preterm Infant: Scientific Basis and Practical Guidelines" Cinicinnati, OH: 2005.
3. Koletzko, B., R. Vavay. "Nutritional Care of Preterm Infant". Frieburg Im Breisagua: Kerger. S, 2014.

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

~~TRI-CITY Healthcare District~~
~~Oceanside, California~~
~~UNIT SPECIFIC POLICY MANUAL~~
~~HOME HEALTH~~

ISSUE DATE: 01/~~29~~/07	**SUBJECT: Anticoagulation Therapy**
REVISION DATE: 01/~~29~~/07, 10/~~28~~/08, 05/09, 03/11, 02/13	**POLICY NUMBER:** 326

Home Health Care Approval:	**05/22**
Pharmacy and Therapeutics Approval:	**07/22**
Medical Executive Committee Approval:	**09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/13**

~~ISSUE DATE: 1/29/07~~ ~~SUBJECT: Anticoagulation Therapy~~

~~REVISION DATE: 6/08 , 3/09~~ ~~POLICY NUMBER: 326~~

~~REVIEW DATE: 6/08, 3/09, 12/10, 1/11, 1/12~~ ~~APPROVAL: 1/29/07, 10/28/08, 5/09, 3/11, 2/13~~

A. **PURPOSE**:
1. To define the parameters of care when admitting a patient on long term anticoagulants and the use of PT/INR monitors.

B. **POLICY**:
1. It is the policy of the Agency to delineate the PT-INR blood monitoring for all patients who are admitted to service, or during the course of home care, are placed on anticoagulant therapy.

C. **PROCEDURE**:
1. At start of care the physician will be asked who will be monitoring the therapy, requesting draws and dosing. This will be done verbally or via fax.
2. All PT-INR's results will be called or faxed to the ordering physician. (see Critical Test/Critical Value Policy).
~~3. Monitoring of the orders and reporting time will be done via audit and the results reported to the QI Committee.~~
~~4.~~**3.** Education will be ~~given~~ **provided** to all patients on anticoagulation therapy~~. verbally and written~~.

D. **SPECIAL PRECAUTIONS/ CONSIDERATIONS**:
1. Medications such as Amiodarone Hydrochloride and all antibiotics potentiate the effects of anticoagulant therapy and should be monitored.
2. Lovenox dosing is 1 milligram per kilogram rounded to 10 milligrams every 12 hours.
3. A PT-INR can be elevated 1-1 ½ days before full protection.
4. Patients should not be told to stop eating green leafy vegetables. Dosing is determined on a patient's normal diet.

~~5.~~E. **PT/INR MONITOR - COAGUCHEK XS PLUS**:
~~6.~~**1.** INR results below 3.1 shall be called **immediately** ~~immediately~~ and **faxed** to the physician **by end of business day.**

~~7.~~**2.** If the reading of the PT/INR monitor is 3.1 or greater:

a. The monitor INR value is not reported to the physician unless the test is done after hours, on weekends, or the lab report would not be timely and the clinician deems it necessary the physician be informed.

b. A Protime/INR shall be drawn via venipuncture and taken to the lab

c. The physician will be notified if unable to obtain specimen via venipuncture **or patient refuses venipuncture**.

d. The lab value shall be **documented in patient medical record and** reported to the physician.

Tri-City Medical Center	~~Distribution: Patient Care Services~~ Home Health Care
PROCEDURE:	**CENTRAL VENOUS ACCESS DEVICES**
Purpose:	**To outline the nursing responsibility in:** **1. Dressing Changes** **2. Flushes** **3. Blood Draws** **4. Accessing or De-accessing Implantable Venous Access Ports** **5. Removing PICC Lines** 6. ~~Accessing Double Lumen Subclavian/Internal Jugular VasCath/PermCath for Dialysis~~
Supportive Data:	Proper monitoring and routine dressing changes allows detection of potential infections, complications in the functioning of the catheter, and in the patients' skin integrity. ~~"~~Transparent dressings are changed every 7 days. Gauze dressings (including if gauze is used under transparent dressing) are changed every Monday, Wednesday, Friday. Anytime dressings are loose, soiled or moisture noted underneath, ~~change dressing~~**the dressing will be changed.** ~~Newly~~ **For newly** inserted PICC's, the original dressing is changed 24 hours post placement with transparent dressing**, unless a Biopatch dressing has been placed. The Biopatch dressing should not be changed until 7 days post insertion, unless necessary. Injection caps and extension ~~tubing,if~~tubing, if indicated, are also changed with weekly dressing changes.** ~~**At SOC, each end caup will be replaced to regular injection cap supplied by IV pharmacy. CLC2000 cap will be changed at SOC to a regular injection cap supplied by the IV pharmacy providing supplies.."**~~
Equipment:	**Refer to individual sections below for details.**
Issue Date	12/94

A. **EQUIPMENT**:
1. Non sterile gloves
2. Sterile gloves
3. Sterile ¼ steri strips (optional)
4. ~~PPE~~ **Personal Protective Equipment** attire as situation dictates
5. Central venous catheter kit package containing gauze dressing
6. 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG/**Alcohol**).~~,~~ **CHG/Alcohol** is the preferred antiseptic, (Use provodone iodine if patient is allergic to CHG/**Alcohol**). ~~Do not use CHG/Alcohol on infants <2 months old **OR in NICU**~~
7. Transparent dressing. **Transparent dressings are the dressing of choice except gauze may be used as the initial dressing post placement of a ~~enteral~~central line and for patients who are neutropenic (absolute count less than 200mm^3)**
8. ~~5~~ **3-6** Alcohol wipes
9. **Injection cap**
10. **Extension Tubing, if indicated.**
11. **Biopatch if indicated**
~~9.~~**12. Alcohol injection cap/s if indicated.**

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

B. **PICC LINE**:
1. **Transparent Dressings:**
   a. **Explain procedure to patient.**
   ~~a.~~b. **Open and assemble equipment.**
   c. **Don mask.** ~~**and goggles or face shield, mask and sterile gloves.**~~

~~1~~

Home Health Care Review	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/22	07/22	09/22	11/22	n/a	05/95, 008/95, 7/97, 02/99, 05/03, 03/05, 03/07, 07/07, 08/12, 01/13

i. **Avoid talking over open site. Have patient turn head away from area to prevent contamination via droplets.**

d. **Place limb on sterile drape.**

e. Wear clean gloves to remove transparent dressing. Lift from the edge and stretch film laterally to inspect the site for infection, redness or purulent drainage. **Remove securement device if applicable.**

~~1.~~**f. Inspect for intact sutures, kinking, leaking, or compromised integrity of catheter. Remove non-sterile gloves and perform hand hygiene.**

~~e.~~**g. Don Sterile gloves~~ble.~~**

~~2.Inspect for intact sutures, kinking, leaking, or compromised integrity of catheter. Remove non-sterile gloves and perform hand hygiene.~~

~~3.Open and assemble equipment.~~

~~4.Don sterile gloves.~~

~~5.Don mask and goggles or face shield, and mask~~ **and sterile gloves.**

~~Avoid talking over open site. Have patient turn head away fro area to prevent contamination via droplets.~~

~~6.~~**h.** Cleanse exit site using antiseptic solution~~.~~ **o**~~O~~**f** 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG/**Alcohol**), ~~is~~ **(**the preferred antiseptic**)**. Cleanse area and under flange thoroughly **for 30 seconds** with a ~~scrubbing~~ **back and forth** motion **concentric circle away from site.**~~.~~ **Allow to dry for 30 seconds before placing transparent dressing.**

~~e.~~**i.** Cleanse **catheter** tubing ~~of ports~~ with alcohol from ~~proximal to distal end of port~~**exit site to distal end.**

j. **Apply securement device (if applicable) per manufacturer's guidelines. Position Biopatch over exit site of tubing.** ~~**Apply securement device (if applicable) per manufacturer's guidelines.**~~

k. **Position tubing in a loop.**

l. **Center transparent dressing over exit site and apply by removing backing one portion at a time.**

m. **Write date of dressing change and your initials directly on to the transparent dressing.** ~~**Record on IV sheet.**~~

n. **Change initial gauze dressing 24 hours post insertion with transparent dressing on Day 2. Change transparent dressing at least every 7 days.**~~**Change transparent dressing Q 7 days or PRN.**~~

o. **Biopatch dressings which are placed at insertion are not to be changed until 7 days post insertion,unless necessary, and every 7 days thereafter, using same procedure with transparent dressing change, except a new Biopatch drsg is placed around the insertion site, and under the transparent dressing. This affects only patients from the TCMC District that have Biopatch placement, and patients with IV pharmacies that provide the Biopatch dressings.**

~~f.~~**p. Discard Personal Protective Equipment.**

~~8.Gauze dressings:~~

~~a.Apply split 2x2 gauze to site around catheter and apply another 2x2 or 4x4 gauze over slightly looped proximal portion of catheter.~~

~~b.Cover dressing with tape to make occlusive~~

~~c.Position tubing in a loop and secure.~~

~~d.Gauze dressings (or if gauze is found under tegaderm) are changed Monday, Wednesday, and Friday and adhere laterally to edges.~~

~~e.Remove handles and use to reinforce dressing and/or secure tubing in a loop.~~

~~f.Write date dressing is placed o the dressing.~~

~~g.Change transparent dressing Q 7 days.~~

2. **Gauze dressing: When patient does not tolerate tegaderm (need MD order)**

a. **Open and assemble equipment.**

b. Don mask and goggles or face shield and mask.
   i. Avoid talking over open site. Have patient apply mask or turn head away from area to prevent contamination via droplets.
c. Wear clean gloves to remove gauze dressing. Inspect the site for infection, redness or purulent drainage. Remove securement device if applicable.
d. Inspect for intact sutures, kinking, leaking, or comprised integrity or catheter. Remove non-sterile gloves.
e. Perform hand hygiene.
f. Don sterile gloves.
~~Don mask and goggles or face shield and mask and sterile gloves.~~
~~Avoid talking over open site. Have patient turn head away from area to prevent contamination via droplets.~~
~~Inspect for intact sutures, kinking, leaking, or comprised integrity or catheter. Remove non-sterile gloves.~~
~~14. Wear clean gloves to remove gauze dressing. Inspect the site for infection, redness or purulent drainage. Remove securement device if applicable.~~
~~Inspect for intact sutures, kinking, leaking, or comprised integrity or catheter. Remove non-sterile gloves.~~
~~Open and assemble equipment.~~
~~Don sterile gloves.~~
~~Don mask and googlesgoggles or face shield and mask and sterile gloves..~~
~~Avoid talking over open site. Have patient turn head away from area to prevent contamination via droplets.~~
g. Cleanse exit site using antiseptic solution of 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG/Alcohol), (the preferred antiseptic). Cleanse area and under flange thoroughly with a ~~scrubbing~~ back and forth motion for 30 seconds circling away from entry site.~~.~~ Allow to dry for 30 seconds before placing gauze dressing.
h. Apply Biopatch.
i. Cleanse catheter tubing with alcohol from exit site to distal end.
j. Apply securement device (if applicable) per manufacturer's guidelines.
k. Apply split 2x2 gauze to site around catheter and apply another 2x2 or 4x4 gauze over slightly looped proximal portion of catheter.
l. Cover dressing with tape to make occlusive (Do not use transparent dressing as *tape*).
m. Write date of dressing change and ~~your~~ initials directly on to the ~~transparent~~occlusive dressing. ~~Record on IV sheet~~.
n. Gauze dressing ~~(or if gauze is found under tegaderm) is changed Monday, Wednesday, and Friday~~.every 2 days
~~15.~~o. Discard Personal Protective Equipment.
p. Perform Hand Hygiene.

3. Implanted Venous Access Devices / Vita Ports / Medi-Ports:
~~Implanted Venous Access Devices/Vita Ports/Medi-Ports:~~
   a. Place folded 2x2 gauze under wings only if wings are not flush with skin.
   b. Secure wings with sterile steri strips.
   c. Use transparent dressing to cover.
      i. Do not cover insertion site with gauze. Gauze should be placed under wings to allow visibility of insertion point.

~~PICC lines:~~
~~Change initial gauze dressing 24 hours post insertion with transparent dressing on Day 2. Change transparent dressing every 7 days.~~
~~Biopatch dressings which are placed at insertion are not to be changed until 7 days post insertion, and every 7 days thereafter using same procedure with transparent dressing change,except a new Biopatch drsg is placed around the insertion site, and under the~~

~~transparent dressing. This affects only patients from TCMC District that have Biopatch placement, and patients with IV pharmacies that provide the Biopatch dressings.~~

4. **Statlock Picc Dressings:**
   a. **Using non-~~sterlie~~sterile gloves, remove transparent dressing.**
   b. **Apply sterile gloves, remove anchor pad using alcohol pad to dissolve pad away from skin.**
   c. **Stabilize catheter with finger~~; open~~; open retainer doors and carefully remove catheter from retainer.**
   d. **Cleanse insertion site with 2%chlorhexidine gluconate/70% Isopropyl Alcohol (Chloroprep).**
   e. **Apply skin protectant to securement site, allowing to dry.**
   f. **Place suture holes into posts on new Statlock ~~dressing,closed~~dressing, close retainer doors, then peel backing, and apply in place.**
   g. **Apply transparent dressing over insertion site and Statlock dressing. Label with initials/date.**
   h. **Dressing changes are done at least every 7 days.**

~~9.Discard PPE, wash hands.~~

~~10. Implanted Venous Access Device/Vita Ports:~~

~~a.Place folded 2x2 gauze under wings only if wings are not flush with skin.~~

~~b.Secure wings with sterile steri-strips.~~

~~c.Use transparent dressing to cover.~~

~~1)Do not cover insertion site with gauze. Gauze should be placed under wings to allow visibility of insertion point.~~

~~11.PICC lines:~~

~~a.Change initial gauze dressing 24 hours post insertion with transparent dressing on Day 2. Change transparent dressing every 7 days.~~

C. **FLUSHES:**

1. Supportive Data:
   a. Proper flushing of catheters promotes integrity of catheter, prevents clotting and maximizes functioning of system. Appropriate technique decreases potential subsequent complications and expenses.
2. Equipment:
   a. Non-sterile gloves
   b. Alcohol wipes
   c. Sterile field **(may use 4X4 sterile ~~guaze~~gauze)**
   d. Sterile flush solution dependent on type of catheter
   e. 10ml Sterile Normal Saline filled syringe (always use at least 10ml size syringe due to the greater amount of ~~PSI~~{ pressure per square inch}**, PSI,** exerted with smaller syringes.)
   f. ~~Injection cap for each lumen for LTVC~~**Anti reflux valve for each lumen.**
   ~~6.~~**g. Alcohol injection cap for each lumen not in continuous use.**
3. Procedure:
   a. Obtain a physician's order prior to accessing any central venous catheter if patient is admitted with diagnosis of sepsis or suspicion of line sepsis.

   ~~2.Verify that x-rays indicate proper placement on newly placed central venous catheters.~~

   ~~3.~~**b.** ~~Flush using~~**Always use** only 10ml syringes or larger for all central catheter lines on adults ~~and use only 3ml or smaller syringe for newborns~~ **due to the greater amount of pressure per square inch exerted with smaller syringes.**~~.~~

   ~~4.~~**c.** Briskly flush catheter ~~, except for newborns,~~ with
      i. Minimum of ~~10cc~~**10ml** Normal saline after blood draws, backflow of blood in catheter, before aspirating blood from a lumen, which has had TPN infusing, and after TPN infusing, **after medication administration and discontinued IV**

fluids. ~~.~~ **Normal saline is not necessary if the medication is compatible with Heparin.** ~~**(see attached list)**~~

d. Flush unused ports as indicated by guidelines for specific catheters~~s~~ **and** ~~.~~ **apply alcohol injection cap.**

~~**The CLC 2000 is discontinued for home therapy unless the patient or MD requests otherwise.**~~

~~**d.**~~**e.** Change ~~**cassettes**~~**infusion per MD order/Pharmacy preparation for infusion.**~~solutions every 96 hours~~**4 days for commercially prepared solutions and every 24 hurshours for solutions** ~~_____~~ **in the hospital (per Standards of Care).**~~Place a completed time strip on all continuous infusions~~

~~b.IVPB are to be labeled by pharmacy and initialed and dated by RN upon hanging~~

~~c.Label tubing with the corresponding color coded label and write date in which to be changed.~~

~~**e.**~~**f.** **Place a completed time strip on all continuous infusions**

~~**f.**~~**g.** **Label tubing** ~~**with the corresponding color coded label and write date in which to be changed**~~ **with every** ~~**cassette**~~**infusion change.**

h. Change tubing and any attached devices **(extension tubings, anti reflux valves, etc.)** every ~~96 hours~~**47 days.**

i. **If central line is not being used, record date that anti reflux valve is changed in clinical record**~~**on MAR**~~ **in conjunction with routine flushes and change every 7 days.**

j. ~~**Blood tubing may used to infuse 2 separate units on blood/blood products. The maximum hanging time for blood tubing is 24 hours.10**~~**10. .New Replace t tubing** ~~**may**~~**is used to administer lipid emulsions** ~~**within 24 hours of hanging the solution**~~**with each bag.11. Tubing used for TPN without lipids is to be changed every** ~~**4 days.**~~**24 hours**

~~Replace tubing used to administer blood, blood products, or lipid emulsions within 24 hours of hanging the solution.~~

~~b.Tubing used for TPN without lipids is to be changed every 96 hours.~~

~~**8.**~~**k.** Use an infusion pump for:

i. TPN

~~**d.**~~**ii.** ~~Administration of KCL replacement~~**Any IV's with KCL** ~~**additives**~~**additives**

~~**ii.**~~**iii.** **Continuous infusions**~~Continuous infusions~~

~~**d.**~~**iv.** All titrated medications

~~e.All pediatric and newborn patients~~

~~**9.**~~**l.** If air gets into infusion tubing, **clamp** tubing distally, **aspirate** fluid and air with a syringe from **Y** port. **Never purge** infusion line into patient.

~~**10.**~~**m.** Turn ~~-~~off infusions during any blood draws from central venous line.

~~**11.**~~**n.** Maintain constant flow rate to insure hydration. Change containers at least 50ml. **DO** NOT ALLOW CONTAINERS TO RUN DRY~~.~~

~~**12**~~**17.** ~~Maintain all keep open rates at 10ml~~ **20ml** ~~hour.:~~

~~a.For children under 1 year run at 5ml/hour~~

~~b.For newborns run at rate ordered~~

4. Steps:

~~Cleanse exit site using antiseptic solution. Of 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG), is the preferred antiseptic. Cleanse area and under flange thoroughly with a scrubbing motion.~~

~~**2.**~~**a.** Don non-sterile gloves.

~~**3.**~~**b.** Identify type of catheter and gather appropriate flushing solution. Assess for allergy to Heparin.

~~**4.**~~**c.** Explain procedure to patient.

~~**5.**~~**d.** Prepare appropriate syringe.

~~6.~~**e.** Cleanse ~~injection cap thoroughly by using 3 alcohol wires and cleaning aggressively~~**anrtianti-reflux valve thoroughly using 3 alcohol wipes(if alcohol injection cap not in use)**.

~~7.~~**f.** Briskly flush catheter~~, except for newborns,~~ with **5-**~~-~~10ml Normal saline. Then follow with catheter specific flush.

~~8.~~**g.** Flush with minimum of ~~5cc~~ **5ml** Normal Saline after medications, IV fluids or for maintenance. Then follow with catheter specific flush.

~~9.~~**h.** Repeat **flush** procedure for each catheter lumen~~ if flushing being done for multiple lumen catheters~~.

i. Flushing is to be done after accessing or per catheter specific flush times whenever line is not being used. (at least every 24 hours). Apply alcohol injection cap.

D. **CATHETER SPECIFIC FLUSHES:**

1. Special Considerations for Multiple Lumen Short Term Catheters (Triple Lumen)

a. Flush each *unused* lumen every *8*~~*2*~~*4* hours.

b. Flush each lumen with ~~2~~3ml heparin (100 units/ml) total ~~20~~300units heparin

i. Recommendation for use of exit ports for the following:~~**Groshongs:** (Flush Groshongs once a week)~~

~~10ml Syringe~~

~~5ml Normal Saline~~

~~**PICCs:** (Flush each unused lumen every twelve (12) hours – 24 hours acceptable for home care flushing)~~

~~10ml Syringe~~

~~2ml Heparin (10 units/ml) per each lumen every 8 hours~~

~~**Hickman Tunneled Catheters:** (Flush every 24 hours)~~

~~2.7ml Normal Saline with 0.3ml of 1000:1 Heparin (total 300 units/3ml~~

~~**Triple Lumen Short term Catheters:** (Flush each lumen every 8 hours)~~

~~2ml Heparin (10 units/cc)~~

~~**Implanted VAD's:** (Flush VADs once a month)~~

~~1)Groshong~~

~~10ml syringe~~

~~5 ml Normal Saline~~

~~2) Vita Ports~~

~~10ml Syringe~~

~~2.7ml Normal Saline with 0.3ml of 1000:1 Heparin (300 units)~~

~~3) Hickman~~

~~10cc Syringe~~

~~4.5ml Normal Saline with 0.5ml of 1000:1 Heparin (500 units)~~

~~4)Vas Caths: (must aspirate Heparin prior to use) Flush once a week – requires physician order to use.~~

~~1cc Normal Saline with 0.5ml of 10,000:1 Heparin (total 5,000 units in 1.5ml)~~

~~5)Special Considerations for Multiple Lumen Catheters~~

~~b. Use exit ports for the following:~~

c. Proximal Port:

~~d.~~**i.** First choice for drawing blood, routine IV administration, and medication.

~~2)~~**d.** Medial Port:

i. TPN, or reserved for future TPN, medications only if TPN is not being given or not anticipated.

~~3)~~**e.** Distal Port:

i. Alternative site for blood drawings; administration of viscous fluids, i.e. Blood products, colloids, albumin; CVP monitoring; continuous fluid administration.

2. PICCs: (Flush PICCS every ~~12 hours; 24~~ hours ~~acceptable~~ for home care)

a. Flush each lumen with ~~2~~3ml heparin (10~~0~~ units/ml) total ~~20~~300 ~~units~~units' heparin

3. **Groshongs: (Flush Groshongs once a week)**
   a. **10ml Normal Saline**
4. **Hickman Tunneled Catheters: (Flush every 24 hours)**
   a. **~~.~~3ml of 100 units/ml = 300 units/3 ml or Heparin 300 units pre-filled syringe.**
5. **Implanted VADs (Ports) (Flush Ports once a month)**
   a. **Groshong:**
      i. **10ml Normal Saline**
   b. **Vita-Ports**
      i. **3ml of Heparin 100 units/1ml or Heparin 300 units pre-filled syringe.**
   c. **Medi-Ports**
      i. **5ml of Heparin 100 units/~~1~~ml or Heparin 500 units pre-filled syringe.**
   d. **Vas Caths: (must ~~apirate~~aspirate Heparin prior to use)**
      i. **Flush once a week – requires physician order to use. 1ml Normal Saline of 0.5ml of 10,000 units,~~:~~ 1ml ~~-~~Heparin (total 5,000 units in 1.5ml) or as directed by physician.**

E. **BLOOD DRAWS FROM VENOUS ACCESS DEVICES:**

1. Supportive Data:
   a. A qualified RN may perform Blood draws. Following procedure allows for increase in accuracy and reduced complications for the patient. Obtain physician's order for coagulation studies in patients receiving **Intravenous** Heparin therapy. **Maintaining a closed system by drawing blood directly from the anti reflux valve is ~~recommened~~recommended. If the anti reflux valve is removed for blood draws, aseptic technique, including sterile gloves, must be used.**
   ~~a.~~**b. Note: Blood volume waste is to be 5ml-10ml waste. Exception: Waste 10ml when drawing blood specimens for blood cultures, a line which has TPN infusing or when obtaining specimen for coagulation studies. Blood draws for coagulation studies which have heparin infusing or have used heparin as a routine flush, require a physician's order. Peripheral bloods are preferable for coagulation studies.**
2. Equipment:
   a. Sterile field **(may use 4x4 sterile gauze)**
   b. Non sterile gloves
   c. Alcohol wipes (7-8)
   d. Sterile 10ml Normal Saline filled syringe
   ~~4.~~**e. Syringe for particular or special draws provided by phlebotomist**
   ~~e.~~**f.** 10ml syringe (prepared for specific flush s determined by catheter type)
   ~~Syringe for particular or special draws provided by phlebotomist~~
   ~~7.Sterile 10ml Normal Saline filled syringe~~
   ~~8.~~**g.** ~~PPE~~ **Personal Protective Equipment** ~~attire~~ as needed
   ~~9.~~**h.** Blood tubes per laboratory
   ~~10.~~**i.** Multiple sample Luer ~~lock~~ adaptor ~~-(use cannula for direct method only~~**Blood Collection Assembly) for direct method.**
3. Steps:
   a. Explain procedure to patient.
   b. **Preferred position is in supine position**~~RN washes hands.~~
   ~~3.Place patient in supine position.~~
   ~~Position of choice, may be upright or side lying.~~
   ~~4.~~**c.** Determine if patient has veins that may have potential to collapse to determine if direct/indirect method should be used.
      i. Indirect method is recommended for ~~any pediatric~~ patient**s** or persons with veins potentially compromised by previous treatment or condition.
   ~~5.~~**d.** Apply sterile drape to site. Assembly equipment.
   ~~6.~~**e.** Don non-sterile gloves/ **Personal Protective Equipment** attire as needed

~~7.~~**f.** Cleanse injection port and area where port connects to end of catheter with alcohol. Cleanse vigorously with friction for one minute, changing alcohol pad 3 times.**(unless alcohol injection cap in use)**

g. Use at least one alcohol wipe <u>each time</u> any device (Multiple sample Luer adaptor, syringe, etc.) is removed from anti reflux valve to remove blood which may appear at tip of anti reflux valve

~~g.~~**h.** Allow to dry.

~~h.~~**i.** Turn off any continuous infusions.

~~i.~~**j.** Unclamp any lines that contain clamps.

~~11.Use 10ml syringe or larger for blood waste. A blood waste is 5cc except:~~
~~a.For blood cultures~~
~~b.TPN infusing~~
~~c.Coagulation studies (requires no MD order). Then 10cc blood waste is necessary.~~

4. Direct Method: **(Vacutainer)**
   a. ~~With multiple samples Luer adaptor secured to blood tube holder, attach cannula with clockwise twisting method~~**For single or multiple samples, remove blunt plastic cannula from the blood collection assembly unit (detach cannula with clockwise twisting method).**
   b. ~~With cannula attached to blood tube, insert into injection site~~**Keeping tip attached to blood collection assembly, insert into the anti reflux valve using a slight clockwise turning motion.**
   c. **Insert blood specimen tube.** Activate vacuum by fully engaging blood tube into multiple sample Luer adaptor.
   d. Withdraw 5ml**-10ml** of blood and discard.
   e. Insert new blood tube for required specimens, and then remove cannula.
   f. Proceed with flushing.
5. Indirect Method: **(Syringe)**
   a. Attach 10ml syringe to ~~cannula~~**the anti reflux valve**.
   b. Withdraw **5ml to 10ml** blood from ~~injection site using syringe with cannula~~**anti reflux valve using syringe. ~~without blunt plastic cannula.~~ Discard**.
   c. ~~Withdraw 5ml of blood and discard (3cc for pediatric patients). (Pediatric patient: maintain sterility of blood for re-infusion.)~~**Wipe any blood residual off anti reflux valve with alcohol swab.**
   d. ~~Repeat 12 a & b to obtain required specimen~~**Attach 10ml syringe to anti reflux valve and aspirate desired specimen volume.**
   e. ~~Transfer blood sample to blood tube by inserting cannula into multiple sample Luer adapter on blood tube holder~~**Remove syringe and transfer blood sample to blood sample to blood tube.**
      i. Attach ~~blunt plastic cannula to end of syringe~~ syringe ~~and connect to~~ to multiple sample Luer adapter on blood tube holder.
      ii. Place blood tube specimen inside blood collection assembly.
   f. Activate vacuum by fully engaging blood tube onto multiple sample Luer adapter. ~~DO NOT DEPRESS SYRINGE PLUNGER.~~
   g. Proceed with flushing.

~~14.~~**h.** Thoroughly cleanse end of catheter with alcohol.

~~15.~~**i.** For return to continuous infusion proceed by connecting catheter to IV line.

~~16.~~**j.** For heplock/saline locked lines: Flush injection site with 10ml Normal Saline.
   i. Flush with Heparin as specified by catheter using positive pressure method
   ii. Re-clamp appropriate catheters.

~~17.~~**k.** Inspect hub and use an alcohol wipe to remove any residual blood. **Apply alcohol injection cap to end of anti reflux valve.**

~~18.Discard gloves/PPE attire in appropriate receptacles. Only items dripping with blood require red bag disposal. Wash hands.~~

F. **ACCESSING or DE-ACCESSING IMPLANTED VENOUS PORTS:**

1. Supportive Data:
   a. Proper technique in accessing and flushing an implanted venous device aids in patient comfort, decreases risk of complications and promotes proper functioning of catheter.

~~i.~~**2.** Equipment:
   ~~b.~~**a.** Sterile field
   ~~c.~~**b.** Non-coring **safety** (Huber, **Gripper Plus, etc.**) needle with extension tubing (gauge and length determined by patient needs)
   c. Anti reflux valve attached to extension tubing
   ~~3.~~**d.** 10ml syringe filled with Sterile Normal Saline
   ~~4.~~**e.** 3 Alcohol wipes
   ~~5.~~**f.** ~~3 Povidone – iodine wipes~~**2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic (CHG/Alcohol). CHG/Alcohol is the preferred antiseptic. (Use provodone iodine if patient is allergic to CHG/alcohol)**
   ~~6.~~**g.** Transparent dressing
   h. 2x2 sterile gauze (optional)
   ~~**Steri-strips (optional)**~~
   ~~7.~~**i.** Tape
   ~~8.~~**j.** Catheter flush (either Sterile Normal Saline or Heparin per specific catheter)
   ~~9.2 Sterile tongue blades **(de-accessing) (optional)**~~
   ~~10.~~**k. Personal Protective Equipment**~~Body Substance Isolation attire~~ as needed

~~2.~~**3.** Procedure:
   a. Obtain physician's order to use implanted device only if admitting diagnosis of SEPSIS or suspicion of LINE SEPSIS. New lines are to be checked for correct placement via X-ray prior to use.
   b. Check patient's sensitivities to **CHG/Alcohol,** Povidone-iodine or Heparin.
   c. Explain procedure to patient.
   ~~4.RN washes hands.~~
   ~~5.~~**d.** Assemble equipment on sterile field. Prime non-coring needle and extension tubing **(anti reflux valve attached)** with sterile Normal Saline and keep syringe attached **(keep sterile)**~~.~~
   ~~6.~~**e.** Don sterile gloves
   ~~7.~~**f.** ~~Cleanse port site using a circular motion from the port site and moving outward to a 2" diameter. Use 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG)~~**Using CHG/Alcohol, cleanse area over implanted port thoroughly with a scrubbing motion**.
   ~~8.~~**g.** Locate port septum by palpation.
   ~~9.~~**h.** Triangulate port between the thumb and first two fingers of non-dominant hand. Aim for the center of the port.
   ~~10.~~**i.** Insert needle perpendicular to port septum.
   ~~11.~~**j.** Advance needle through skin and septum until reaching the bottom of reservoir.
   ~~12.~~**k.** Verify correct needle placement by blood aspiration (Do not begin injection until proper needle placement has been confirmed)
   ~~13.~~**l.** ~~Before de-accessing and prior to flush: Flush with 10cc Normal Saline after blood return, then follow with catheter specific flush or connect to mainline as ordered~~**Flush with 10ml Normal Saline. Follow with catheter specific flush, clamp and apply alcohol injection cap or connect to IV infusionsate as ordered.**
   m. Apply dressing per "Dressing Change" Section A of this procedure.
   ~~m.~~**n.** Date and initial dressing. **Access**~~Huber~~ needle and dressing are to be changed **every**~~Q~~ 7 days.

~~3.~~**4.** De-Access:
   a. ~~**To de-access port, remove non-coring needle slowly. Stabilize the port with sterile tongue blade during needle withdrawal**~~**ALWAYS flush port with specific flush prior to de-accessing**.

b. ~~Apply transparent dressing to accessed ports and a band-aid for de-accessed port site~~**Wear clean gloves to remove transparent dressing. Lift from the edge and stretch film laterally to inspect the site for infection, redness or purulent drainage. Remove securement device if applicable.**

c. ~~Discard gloves and PPE attire in appropriate receptacles. Only items dripping in blood are disposed in red bag waste. Wash hands~~**Cleanse exit site using CHG/Alcohol, (the preferred antiseptic).**

d. **For Huber needles ~~,~~(non-~~stabilize~~coring) stabilize the port by ~~placing one tongue blade along each side of the needle and holding ends of tongue blades with non-dominate hand.~~the built in mechanism of the needle type.**

e. **Simultaneously, while pushing down on tongue blades, pull needle straight upward. (Not applicable for Gripper Plus or some other safety needles)**

i. **For safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed.**

ii. **A click will be heard indicating the tip of the needle is fully encased in the protective safety apparatus.**

f. **Discard needle in appropriate sharps container.**

g. **Apply small band-aid.**

h. **Discard Personal Protective Equipment in appropriate receptacles.**

G. ~~REMOVE PICC LINE~~**REMOVAL OF NON-TUNNELED CENTRAL LINES: (PICCs ~~,~~ & Multi-Lumen)~~, Vas Cath)~~**

~~4.~~**1.** Supportive Data:

a. Proper discontinuance of peripheral inserted central catheters aids in patient comfort and decreases risk of complications.

~~5.~~**2.** Equipment:

a. 2x2 Gauze, two 4x4 gauze
b. Large Tegaderm dressing
c. Non-sterile gloves
d. **Personal Protective Equipment** ~~Body Substance Isolation attire~~ as needed
e. Barrier-proof absorbent pad
f. 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, CHG
g. Suture removal kit
h. **Coban**~~Tape~~

~~6.~~**3.** Procedure:

a. Verify physician order to discontinue line.
b. ~~RN washes hand~~**Assess need to culture tip of catheter and obtain physician's order if warranted. (Observed, signs and symptoms of infection)**
c. Explain procedure to patient.
d. Assemble supplies. Place absorbent pad under catheter site.
e. Don non-sterile gloves.
f. Have patient lay flat or ~~sit in position of comfort~~**have head of bed no more than 30° if possible.**
g. Remove dressing ~~and discard. Check site for signs of infection. Report as needed~~**by lifting from the edge and stretching film laterally. Discard.**
h. **Check site for signs of infection. Report as needed.**
i. **Remove securement device if applicable.**
~~8.~~**j.** Cleanse ~~area with Povidone-iodine swab by using a circular motion working from exit point to 2" outward circle~~**exit site using CHG/Alcohol.**
k. Carefully remove sutures.

i. **Grasp suture with forceps with non-dominant hand, use the dominant hand to clip suture being careful not to cut catheter or patient's skin.**

~~10.~~**l.** Instruct patient to perform Valsalva maneuver during removal.

i. **If patient unable to perform Valsalva, have bed as flat as possible during removal of line.**

~~11.~~**m.** Carefully and slowly remove catheter ~~by keeping arm straight~~. **For PICCs, have patient keep arm straight.** With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull to remove. As catheter is coming out, place 4x4 over insertion site.

~~12.~~**n.** Once removed, place pressure for 5-10 minutes or until bleeding has ceased.

~~13.~~**o.** ~~Apply sterile pressure dressing~~**Cover with 2x2**, secure with ~~large~~ transparent dressing and **instruct patient to** leave ~~in place~~**dressing on** for **24 hours. Apply coban over site instructing patient to watch for circulatory complications (tingling sensation, loss of feeling). (? this for homecare patients). Advise patient no lifting or straining with affected arm for next 24 hours.**

~~14.~~**p.** Discard catheter, gloves and **Personal Protective Equipment**~~PPE attire~~ in appropriate receptacle. ~~Wash hands.~~

~~15.~~**q.** Instruct patient on signs and symptoms to report.

~~7.~~**4.** Documentation:

a. Record any abnormalities in Interdisciplinary Progress notes.**(Record patient's toleration for homecare patients)**

b. Record removal of ~~PICC~~ **central** lines and condition of site, tolerance to procedure, **length of picc from tip to hub.** ~~in Interdisciplinary Progress notes.~~

c. Document flushes, ~~for Vital Ports, Hickmans, and PICC lines on~~**and changing of anti reflux valve for all Central Lines.** ~~**under Continuing Medications on the** Medication Administration Record.~~

d. Record date of dressing change. ~~on **dressing and on** IV Flow Sheet.~~

e. Record date tubing to be changed on the tubing and change of tubing on the IV Flow Sheet.

f. Record teaching ~~**on the Patient/Family Education Plan/Record.**~~

~~G.~~**H.** **REFERENCE**:

1. Federal Register, Department of Health and Human Services: Centers for Disease Control and Prevention, 2001.
2. Access Device Guidelines, Recommendations for Nursing Practice & Education Oncology Nursing Society, October, 2001.
~~3.Davol Nursing Procedure Manual: Specialty Access Ports, 1993~~
~~4.Davol Nursing Procedure Manual: Bard Access Systems, Feb. 1992~~
~~5.Davol Implanted Ports, Use and Maintenance. Bard Access Systems 1992~~
3. Interlink IV Access System, Baxter, 1998.

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~12/94~~	~~7/03, 7/07, 12/09, 7/10, 1/13~~	~~5/95, 8/95, 7/97, 2/99, 5/03, 3/05, 3/07, 7/07, 8/12, 1/13~~	~~1/95, 3/13~~

~~6.I. 5~~
~~G.~~

~~ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH FOR DIALYSIS~~

~~**SUPPORTIVE DATA:**~~
~~One method of vascular access is a dual lumen catheter. Sterile techniques will be observed and an authorized RN will perform the procedure.~~
~~**EQUIPMENT:**~~
~~1.Chux~~
~~2.Povidone iodine wipes~~

3.2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic (CHG/Alcohol). CHG/Alcohol is the preferred antiseptic. (Use provodone iodine if patient is allergic to CHG/Alcohol). 10ml/12ml syringes containing Normal Saline
4.Syringe containing appropriate Heparin bolus
5.2 Syringes, 10ml or 12ml
6.Roll of 1 inch tape
7.1 Sterile drape
8.Mask
9.Sterile gloves
10.**Personal Protective Equipment**Protective eye glasses and gown

PROCEDURE:

1.Expose limbs of vascath/permcath. Avoid patient contaminating ports with clothes and/or bed covers.
2.Drape patient with Chux to protect clothing. Holding corners, place sterile drape over Chux and place catheter limbs on drape.
3.Thoroughly cleanse arterial and venous cap/catheter connections with 2% chlorhexidine gluconate/70% isopropyl alcohol antiseptic, (CHG), is the preferred antiseptic. Use provodone iodine if patient is allergic to CHG. Do not use CHG on infants <2 months old.
4.Don **Personal Protective Equipment (**mask, gown, glasses and sterile gloves **as appropriate.)**
Clamp line. Remove clave device from arterial limb. Attach 10ml syringe, aspirate 5ml Heparin from arterial limb of catheter, clamp line and discard syringe. Attach 10ml syringe containing saline. Aspirate slightly, flush limb and clamp.
5.Remove cap from arterial limb. Attach 10ml syringe, aspirate Heparin from arterial limb of catheter, clamp line and discard syringe. Attach 12ml syringe containing saline. Aspirate slightly, flush limb and clamp.
6.Using second 10ml syringe, aspirate Heparin from venous limb of catheter, clamp line and discard syringe.
7.Attach 12ml **10ml** syringe containing saline. Aspirate slightly, flush catheter and clamp.
8.Attach syringe containing Heparin bolus, aspirate slightly, inject Heparin, clamp line, remove syringe and discard. Systemic Heparinization of patient reduces change of clotting the dialyzer and lines.
9.Connect arterial line to arterial limb of catheter. Initiate dialysis and drain prime. See procedure for initiating hemodialysis
10.Connect venous line to venous limb of catheter. Extreme care must be used to avoid introduction of air. Catheter limbs must be clamped whenever system is opened to remove caps, syringes or to connect blood lines to catheter.
11.Begin treatment. See procedure for initiating hemodialysis.
12.Secure blood lines with 1" tape **or direct hub to hub connection** to prevent pulling on catheter during treatment.

DOCUMENTATION:

1.Record on Patient Care Record:
a.Time and initial initiation of dialysis
b.Initial Heparin bolus
c.Document any problems or diminished flow

REMOVAL OF SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH FOR DIALYSIS IS NOT APPROPRIATE FOR HOMECARE.

REFERENCE:

1.Hemodialysis Policy and Procedure Manual, Medical Consultants Network, Inc., Lakewood, CO, 1996
2.Standards and Guidelines of Clinical Practice for Nephrology Nursing, American Nephrology Nurses' Association, 3rd Edition, 1999
3.Review of Hemodialysis for Nurse and Dialysis Personnel, 6th Edition, Mosby, pp 112-128, 144-156, 272-281, 1999.
4.Federal Register, DHS, CDC, 2001**2002**

Issued:	Reviewed:	Revised:	Approved:

12/94	7/03, 7-07 12/09, 07/10	5/95; 5/95; 8/95; 7/97; 2/99; 53/03;3/05, 3/07,7-07,8-12	1/95

S:\Home Care\polices & proceduresProcedures Home Care Current\Central Venous Access Device.doc
7-31-07 mvd8/20/12:gam

Tri-City Health Care District
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**06/91**	**SUBJECT:**	**Emergency Preparedness Management Disaster Plan**
REVISION DATE:	**10/94, 03/96, 07/98, 05/99, 06/00, 02/06, 02/08, 09/11, 06/12, 07/13,**	**POLICY NUMBER: 701**	

Home Health Care Approval:	**05/22**
Environmental Health & Safety Committee Approval:	**09/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**07/13**

~~Tri-City Home Health~~	~~Distribution: Clinical Staff~~
~~Policies: UNIT SPECIFIC POLICY MANUAL – HOME HEALTH~~	
~~Subject: EMERGENCY PREPAREDNESS MANAGEMENT DISASTER PLAN~~	
~~Policy Number: 701~~	

A. **PURPOSE**

1. To safeguard patients already receiving Home **Health** Care service, as feasible, depending on patient acuity and severity of the disaster.

B. **INTRODUCTION**

1. Tri-City Home Health is incorporated into Tri-City Healthcare District's Disaster Plan and participates in the Healthcare District's drills. Home Care's disaster activities for homebound patients are supported by the Healthcare District.
2. Tri City Home Health designates an acuity level to every Home Health patient upon admission. This acuity level addresses medical stability, mobility issues, intravenous therapy, and all patients requiring additional assistance in the event of a disaster.
3. Instructions for specific disasters are outlined in the Home Health Emergency Management Activities form.
4. Acuities are changed whenever a patient's status changes. The change is made in the computer. This change of acuity may occur several times during the course of the plan of care, depending on the patient's condition, response to treatment, etc. (IV patients will require a change in status when IV treatment ends and our plan of care is continuing or when IV's are ordered after the SOC).
5. The Emergency Preparedness Summary Report (this includes the acuity level for each patient) is printed daily.

C. **NOTIFICATION:**

1. Chain of Command: 1) Director, 2) Supervisors, 3) Staff.
2. When notified of a Disaster, the Director or designee will immediately initiate the Departmental Emergency Plan, the call-back list, and will inventory supplies in anticipation of potential need.
3. Leadership team immediately prioritizes cases on service utilizing the acuity list.

a. Calls to acuity *"Acute Home Health Patient"* and *"IV Home Health Patient"* will be initiated and visits generate as needed in order to prevent imminent and certain life threatening complications.
b. Patients with other codes may remain stabilized via phone contact.

4. Staff will be informed during the call to either report to the office, report to the Labor Pool in French Room 3 or "stand-by for further instructions".
5. Director or Designee then obtains needed information to fax/report to Hospital Incident Command Center.
6. Information needed to complete the Hospital Incident Command System and be faxed to the Command Center:
   a. Census of Home Health
   b. High risk patient...**all patients identified as acute**~~02 use and that is calling and verifying needs~~
   c. Number of staff on duty
   d. Number of staff available for labor pool
   ~~d.~~**e. Dialysis patients**
7. Employees must wear his/her Tri-City Healthcare District ID Badge. Security will be in effect at the Medical Center, and only individual with appropriate identification will be permitted on the grounds.
8. RN, LVN, or CHHA employees should also bring a stethoscope.
9. **Acuity Codes**

ACUITY STATUS	EXAMPLES
Acute	Will require assistance to quickly and easily remove from home.
Acute Dialysis	Will require assistance to quickly and easily remove from home. May require assistance in arranging for TCMC dialysis
Acute Equipment	Will require assistance to quickly and easily remove from home. May need assistance due to specialized equipment.
Acute IV	Will require assistance to quickly and easily remove from home. May require assistance with IV administration.
Acute 02	Will require assistance to quickly and easily remove from home. May require assistance with O2 removal from home and/or may require assistance with obtaining additional O2.
Stable	Homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home.
Stable O2	Homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home. Patient able to remove and obtain own supply of O2 but may need assistance in obtaining additional O2.
Stable Dialysis	Homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home. May need assistance in obtaining dialysis/dialysis supplies
Stable Equipment	Homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home. May need assistance to remove equipment from the home or to obtain additional equipment outside of home.
Stable IV	Homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home. May require assistance with IV administration and/or obtaining supplies.

D. EMERGENCY SUPPLIES

1. **TCMC maintains emergency supplies in the Medical Distribution Center**

2. In the event of a disaster or other crisis, ~~Home Healthcare Solutions~~ Medline Industries, LP will activate ~~deploy HHS's~~ Medline's Emergency Action Plan (EAP) ~~Response Supplies (ER's)~~ when requested by TCHC. (See attached ~~HHS's Emergency Response Supply Solutions information~~ Medline's disaster preparedness and response plan for the continued availability of essential medical and surgical supplies).

~~ACUITY~~	~~EXAMPLES~~
~~Stable Home Health Patient~~	~~Pt. is homebound but, in the event of a disaster, will be able to leave or be fairly easily assisted out of the home, not on O2 or other "special" equipment.~~
~~Acute Home Health Patient~~	~~Pt. on O2, specialized equipment, etc. that would make quick and/or easy removal from home difficult. Will likely require assistance of Disaster Team to remove from home.~~
~~IV Home Health Patients~~	~~Any patient receiving IV services but not likely to require additional assistance in the event of a disaster.~~
~~IV Home Health (Acute)~~	~~Any IV patient that is likely to require assistance to leave the home.~~

~~ISSUED~~	~~REVIEWED~~	~~REVISED~~	~~APPROVED~~
~~6/91~~	~~2/06, 2/08, 9/11~~	~~10/94, 3/96, 7/98, 5/99, 6/00, 2/06, 2/08, 6/12, 5/13~~	~~2/08, 10/11, 5/13, 7/13~~

Tri-City Medical Center
Oceanside, California

HOME HEALTH CARE

ISSUE DATE:	**10/05**	**SUBJECT:**	**Medication Management**
REVISION DATE~~(S)~~:	**10/05, 01/06, 04/07, 02/08, 02/09, 03/11, 02/13 11/13, ~~3/14, 11/15, 11/16, 7/17, 7/18, 11/19, 11/21, 5/22~~**	**POLICY NUMBER:**	**319**

Department Approval Date~~(s)~~:	**~~10/05, 4/07, 4/08, 5/09, 3/11, 2/13, 11/13, 3/14, 11/15, 11/16, 7/17, 7/18, 11/18, 11/19, 11/21,~~ 05/22**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**07/22**
Medical Executive Committee Approval ~~Date(s)~~:	**07/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**n/a**
Board of Directors Approval ~~Date(s)~~:	**11/13**

~~A. PURPOSE:~~

~~To delineate the management of medication for the Home Health patient.~~

A. **POLICY:**

1. It is the policy of the Agency to clearly explain the medication management process involving multiple services and disciplines with patient safety being the desired outcome.

B. **PROCEDURE:**

1. Patient Specific Information
   a. The following information is obtained during the admission process and is available to all disciplines involved in the medication management of the patient. The information is found either on the referral sheet or on the initial plan of care.
      i. Age
      ii. Sex
      iii. Current medications including herbal and OTC products
      iv. Diagnosis and co-morbidities
      v. Lab values effecting medication adjustment or side effects
      vi. Allergies and past sensitivities
      vii. Height and weight
2. Transcribing/Ordering
   a. The following items are required, when applicable, for every medication order received by a physician.
      i. Name of medication
      ii. Dose
      iii. Frequency
      iv. Route
      v. Dosing for each interval of tapering orders must be exact
      vi. Duration if indicated
      vii. Name of Physician ordering medication
      viii. Name and title of the Clinician receiving order
      ix. Orders in which the dose or dosing interval varies dependent on the status of the patient must be clear, defined and consistent.
      x. Indication for use ~~is included when the order is PRN~~
      xi. Documentation of verbal read-back when taken from a physician or designee
      xii. Incomplete, illegible or unclear faxed orders will be clarified by the case manager.

xiii. New medication profiles are required for all Start of Care, Resumptions of Care and Recertification's.

b. It is not acceptable to document "resume prior medications" on the Physician order

c. Current medication profiles must be sent to the physician of record when the patient is discharged.

3. When a new medication is ordered by a physician other than the attending physician, a client status update note is sent to the attending physician informing them of the change in medications.

4. Preparing and Dispensing
   a. The principles of safety and accuracy will be practiced when skilled nursing is preparing or administrating a medication. This would include, but is not limited to:
      i. Hand Hygiene
      ii. Clean Or Sterile Technique As Appropriate
      iii. Clean Area of preparation or assembly to minimize contamination

5. Administering
   a. The use of two patient identifiers (name and date of birth) when administrating all oral, injectable medication and/or IV's.
   b. Visual inspection of medication integrity, clarity of fluids and verifies medication has not expired.
   c. Verification of correct medication and dose of all IV fluids and parenteral nutrition solutions.
   d. Verification of all medications given to be the correct drug, dose, route and administered at the appropriate time.
   e. Discussion with patient and/or caregiver regarding potential side effects and adverse reactions when administering a new medication.
   f. Provision of adequate instruction, written and/or oral, to patient or caregiver regarding self-administration of oral, intravenous medication or subcutaneous medication.
   g. Observation of adequate return demonstration by patient or caregiver of medication administration and documentation of same.

6. Monitoring
   a. Efficacy of medication is assessed every nursing visit including patients perception of desired or undesired effects.
   b. All untoward effects are reported to the physician and documented.
   c. Symptoms presenting that may indicate multiple drug interactions shall be reported to the physician after the Medication profile has been reviewed with the patient and caregiver to again establish what medications are currently being taken by the patient.
   d. The Home Health Medical Director will be informed when a patient's pain issues have not been responded to by the primary physician.

7. High risk
   a. The Agency receives information from ISMP regarding high-risk drugs. Staff is alerted of high risk drugs used in home health. **The agency deems coumadin and derivatives, insulin, digoxin and narcotics as high alert medications**.

8. Medication reconciliation
   a. All nursing and therapy staff will reconcile the patient's list of medications including prescription and over the counter medications, with the discharge medication list from the receiving entity to verify the medications the patient needs to take.
   b. If the patient does not have a written medication profile from the inpatient stay, skilled nursing facility, or physician, then a written medication profile will be left with the patient upon first contact/admission.
   ~~b.~~**c.** Medication reconciliation will occur at every visit and prescription and over the counter medications are reviewed to determine any new, discontinued or changed medication and documented accordingly.
   ~~c.~~**d.** The attending physician will be contacted if there are any discrepancies noted.
   ~~d.~~**e.** The attending physician will receive a complete medication list upon admission of the patient via the 485.

~~e.~~**f.** Provide the patient (family or caregiver as needed) with written information on the medications the patient should be taking when he or she leaves the organization's care. **Educate patient to take the med list with them to all medical appointments.**

~~f.~~**g.** All changes shall be recorded on the medication profile in the home and clinical record.

9. Acceptable orders
   a. This Agency deems acceptable the following type of orders:
      i. **As needed -** PRN orders
      ii. **Stop order -** orders include a date or time discontinuing a medication
      iii. **Titrating** – orders indicating progressively increasing or decreasing a medication in response to a patient's condition.
      iv. **Range -** for example mild, moderate or severe pain.
      v. **Taper orders -** for example, a Prednisone decreasing dose
      vi. **Medication related device -** for example, a nebulizer
      vii. **Over the counter/herbal products**
10. The Agency does not accept investigational or chemotherapy orders.

C. **REFERENCES:**

1. **Institute for Safe Medication Practices. (2018).** ***ISMP List of High-Alert Medications in Acute Care Settings.*** **Retrieved from https://psnet.ahrq.gov/resources/resource/4829**
2. **The Joint Commission. (2017).** ***Comprehensive Accreditation Manual for Home Care.*** **Oak Brook, IL.**

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Age Specific Guidelines**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**
1. This Guideline has been developed to:
   a. Address the age-specific needs of various groups of patients that may be treated at the Outpatient Infusion Center (Center).
   b. Provide optimal age-specific care for the patient population served in the Center.

B. **POLICY:**
1. The program has been designed to meet the specific medical needs of the adult/ geriatric population.
2. In the event that a patient from another age group is treated at the Center, age-specific guidelines will be utilized to optimize care.
3. Age-related needs will be considered in the plan of care for each patient.
4. Equipment and supplies used in the care of patients will be age-specific.
5. Other resource persons/departments will be consulted as needed to validate and enhance the care provided.
6. Employee performance appraisals will reflect age-specific evaluation.

C. **PROCEDURE:**
1. An age-specific plan of care will be developed for each patient treated at the Center.
2. Age-specific factors/elements of care associated with each age group will be addressed during every encounter by the clinic staff using the tables below.
3. Appropriate intervention specific to each age group will be identified during the initial visit and reviewed periodically for appropriateness and documented in the medical record.
4. Physical limitations/impairments, as well as learning or other deficits, will be considered when implementing educational/training measures and documented in the medical record.
5. The education provided will be given at the level of understanding for each patient.
6. Resource materials, persons and departments will be consulted to ensure appropriateness of the treatment plan.

D. **RELATED DOCUMENT(S):**
1. Age Specific Guidelines are listed below:

Age Specific Guidelines

ADULT (18-65)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Prone to health problems related to an inability to cope with new responsibilities Suicidal tendencies, alcoholism, drug abuse, eating disorders, tobacco abuse may surface Healthcare needs are related to preventative medicine to reduce the occurrence of chronic physical or emotional problems Adjustment to menopause (females) and sexual dysfunction (males) as they approach middle adulthood		Focused on time constraints and only want to learn what is practical for them May be dual caretakers (i.e. parent and children)	Emotional stress due to mate selection, vocational selection, assuming occupational roles, marriage, childbearing, financial pressures, and independence	• Communication: Involve family in patient's care and education. When educating adult patients, explain the benefits of adhering to treatment plan; otherwise, education may not be effective. • Equipment: Refer to manufacturer's instructions.

GERIATRIC (66 and beyond)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Decreased tolerance to heat/cold Increased wrinkles Declining cardiac/renal function Bones become more prominent/stiff joints Increased susceptibility to infection Increased susceptibility to high blood pressure Shrinkage in intervertebral disc Skeletal changes Skin changes Decreased organ functioning; decreased drug clearance and distribution	Decreased mobility Decreased ability to respond to stimuli Decreased visual acuity Hearing loss Decreased tolerance to pain Hesitant to respond; skills declining	Decrease in memory, slowing of mental functions Slower in learning Drop in performance	Concern for health increases Acceptance of death Decreased authority and autonomy Children leave home; become grandparents; reestablish as a couple Retirement/may pursue second career, hobbies Depression related to decreased physical, motor and cognitive abilities Concern related to limited income	• Patient and Family Education: Explain any instructions well to the patient & family. Don't assume that the patient understands anything. Ask the patient questions to verify understanding. Review important points repeatedly. • Communication: Explain all instructions well. Involve the patient in the examination. Use therapeutic touch as appropriate. • Environment/Safety: Keep room clutter-free; orient patient well to surroundings. Frequently assess room temperature to patient comfort. • Use of medical equipment: Refer to manufacturer's instructions.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Data Management**

REVISION DATE:

Department Approval:	~~01/17~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Effective use and management of patient data is crucial to the service appraisal process and enhancement efforts. Properly managed data can provide vital information about:
   a. The population served
   b. Patient progress/outcomes
   c. Resources utilized
   d. Resources needed
   e. Compliance with plan of care
   f. Efficacy of the treatment plan

B. **POLICY:**

1. It is the intent of the clinic to collect and properly manage data to benefit the patients being treated at the Outpatient Infusion Center.
2. Patient information will be handled following all applicable confidentiality regulations and hospital policies.

C. **PROCEDURE:**

1. The patient information to be included in the patient's chart/Cerner **is,** ~~,~~ but is not limited to~~, is~~:
   a. Demographics
   b. Referral source
   c. Clinic physician
   d. Primary care physician
   e. Diagnoses
   f. Wound assessment information
   g. Procedures performed
   h. Insurance information
   i. Patient goals

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Diagnostic Tests**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Timely reporting of diagnostic test results is an important aspect of planning or changing the course of treatment.

B. **POLICY:**

1. Diagnostic test relevant to the diagnosing and planning of the patient's care will be included in the electronic medical record in a timely manner.
2. Ancillary/diagnostic testing may include:
   a. Laboratory
   b. Radiology

C. **PROCEDURE:**

1. The clinician will notify the Outpatient Infusion Center's (Center's) physician/Allied Health Professional (AHP) of significant findings as directed by the physician/AHP (telephone or fax) and document the communication in the medical record.
2. All results will be placed in the physician/AHP folder for review prior to placing in the patient chart. All results will be available on Cerner for review.
3. Once reviewed and initialed by the Center's physician/AHP, the results will be filed in the appropriate section of the patient record by the clinic staff.
4. If the Center's physician/AHP is unavailable for critical or significant values, the patient's primary physician or designated on-call physician will be notified.
5. Critical/significant values will be given to the Center's medical director or designee for follow-up when physician/AHPs involved in the care of the patient are unavailable.
6. Physician/AHPs will review results via Cerner.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Disseminating Medical Information**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Patient privacy and confidentiality regulations prohibit the arbitrary sharing of medical information to protect the patient from indiscriminate use. This policy outlines the procedure the Outpatient Infusion Center (Center) follows when disseminating patient information.

B. **POLICY:**

1. All applicable State and Federal regulations and hospital policies will be adhered to when disseminating or requesting patient confidential medical data.
2. To the extent possible, medical information will be guarded against loss, destruction, tampering, and unauthorized access.

C. **PROCEDURE:**

1. Patient information will be transmitted electronically and via secure carrier from the Center to the Tri-City Healthcare District (TCHD) Medical Records Department. Any information sent via fax will contain a cover sheet requesting that if the information reaches a recipient in error it should not be shared with anyone except with those for whom the information was intended.
2. If it is received in error, it is requested that the Center be notified immediately by telephone and return the original message to us at the address on the form.
3. Request for any and all Center records will be handled, per TCHD policy.

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

1. Administrative: 513 Disclosure of Protected Health Information (PHI)

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Emergency Evacuation**

REVISION DATE: 03/13

Department Approval ~~Date(s)~~:	~~02/16~~02/20
Division of Oncology Approval ~~Date(s)~~:	~~03/17~~ n/a
Environmental Health & Safety Committee Approval:	09/22
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/17

A. **PURPOSE:**

1. To establish evacuation procedures in the event of a fire, earthquake, active shooter, bomb threat or any situation that places employees, patients and others in imminent danger in the Center.

B. **POLICY:**

1. All staff will be trained in emergency evacuation procedure.

C. **PROCEDURE:**

1. In the event of a fire, earthquake, bomb threat, **active shooter,** or any situation that places employees, patients and others in imminent danger, the Center personnel will:
   a. Calm patients and assure their safety.
   b. Remove the patients who are in immediate danger first.
   c. Using the designated emergency exits, evacuate all patients to the designated area as instructed by the appropriate authority.
   d. In the event of an Active Shooter situation the staff should follow the "Run, Hide, Fight model.
   e. The Center's manager/charge person will account for all employees and patients and report to the hospital safety officer or representative and/or fire department staff, if present.

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

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

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Environment of Care**

REVISION DATE:

Department Approval:	**~~02/16~~09/22**
Division of Oncology Approval:	**n/a**
Environmental Health and Safety Committee	**09/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**~~07/17~~ n/a**
Board of Directors Approval:	**07/17**

A. **PURPOSE:**

1. In order to provide a safe environment for patients, visitors and **workforce members** ~~staff,~~ this policy identifies each aspect of the **Tri-City Hospital District's (TCHD)** ~~hospital's safety/~~Environment of Care (EOC) program as it relates to the Outpatient Infusion Center (Center) environment.

B. **POLICY:**

1. Patients, ~~and~~ visitors, **and associates of** ~~to~~ the Center **will have** ~~can expect~~ a safe and **healthy**~~sanitary~~ environment.
2. ~~Associates of the Center will be ensured of a safe and sanitary work environment.~~
3. ~~**Workforce** Mm~~embers ~~of the staff will~~**shall** be competent in the **TCHD** ~~safety/~~EOC standards ~~set forth by Tri-City Healthcare District (TCHD).~~
4. ~~2.~~ The Center manager is responsible for the implementation of the ~~safety/~~ EOC program per Center EOC standards.

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

1. ~~3.~~ All **workforce** ~~staff~~ members ~~will~~**shall** ~~-~~be knowledgeable of and comply with all applicable **EOC policies and procedures** ~~safety standards~~.
2. ~~4.~~ ~~The safety/~~EOC **plans,** policies and procedures will be readily available to **the workforce**~~all associates~~ and is located with**in** the **TCHD electronic** ~~other~~**policy and procedure manual located on the district's** ~~policies and procedures manuals on the TCHD l~~intranet.
3. ~~The hospital will provide safety/EOC training during the general orientation program each associate receives within the 30 day period from the original date of hire.~~
4. ~~5.~~ ~~A~~ **Department**~~unit specific~~ safety orientation will be presented to ~~the~~ new **workforce members** ~~associate~~ **during orientation.**~~within the orientation period~~.
5. ~~6.~~ All **workforce members**~~associates~~ will complete the annual **EOC** competency requirements ~~of the safety/EOC program~~ as required by TCHD.
6. ~~6.~~ Safety-related incidents will be reported immediately **in** ~~per~~ TCHD ~~incident reporting~~ **electronic reporting program i.e., RL**~~policy.~~
7. ~~Topics/issues/plans to be addressed in unit safety/EOC presentations include but are not limited to:~~
   a. ~~Safety management~~
   b. ~~Disaster~~
   c. ~~Emergency preparedness~~
   d. ~~Life safety~~

~~e. Utility management~~
~~f. Bioterrorism preparedness~~
~~g. Bomb threats/Code Silver Active Shooter~~
~~h. OSHA's exposure control plan for bloodborne pathogens~~
~~i. TB control plan~~
~~j. Electrical power safety~~
~~k. Loss of communication~~
~~l. Hazardous materials (includes biohazardous)~~
~~m. Fire safety~~
~~n. Disaster plan~~
~~o. Global Harmonization SDS program~~
~~p. Infection control plan~~
~~q. Emergency codes~~
~~r. Security plan~~
~~a.~~ Medical equipment

C. ~~REFERENCE(S):~~RELATED DOCUMENT (S):

1. Emergency Operations Manual: Emergency Operations Plan
2. Emergency Operations Manual: Evacuation Plan
3. Environment of Care Manual: Safety Management Plan
4. Environment of Care Manual: Life Safety Management Plan
~~s.~~5. Environment of Care Manual: Security Management Plan

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Fire Alarm/Evacuation Plan**

REVISION DATE: 03/13

Department Approval ~~Date(s)~~:	~~06/16~~02/20~
Division of Oncology Approval ~~Date(s)~~:	n/a
Environmental Health & Safety Committee Approval:	09/22
Pharmacy and Therapeutics Approval ~~Date(s)~~:	n/a
Medical Executive Committee Approval ~~Date(s)~~:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~06/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	06/17

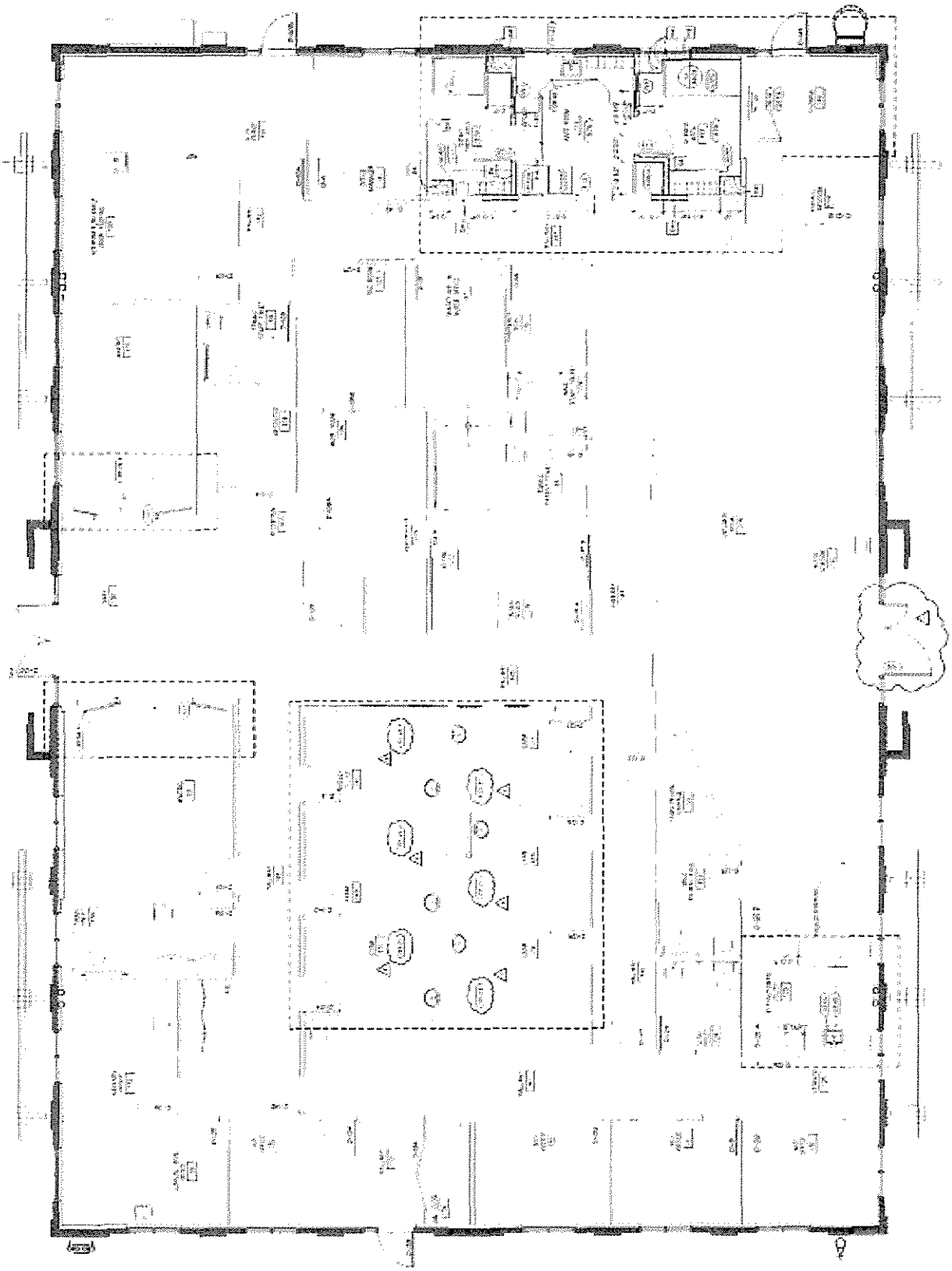
A. **PURPOSE:**
1. To safely remove patients and others from Center in the event of a fire or fire alarm.

B. **POLICY:**
1. When a fire occurs in the center the procedure outlined in the policy will be followed.

C. **PROCEDURE:**
1. Should evacuation of the patients be necessary, Center personnel will:
   a. Reassure patients/others to maintain a calm atmosphere
   b. Prepare patient(s) for transport to the designated safe location per policy
   c. Follow department evacuation procedures and routes according to TCHD Code Red procedure – Rescue, Alarm, Contain, and Extinguish (R.A.C.E.)
      i. Refer to Evacuation Map posted in department.
   d. Perform system emergency shut-down as indicated
   e. Upon completion of evacuation of all patients to the designated safe area, the Center Clinical Manager or RN Supervisor will contact the hospital Safety Officer or command center for appropriate head count of patients.

D. **RELATED DOCUMENT(S):**
1. Evacuation Map - Sample

Evacuation Map



Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13	**SUBJECT: History and Physical**
REVISION DATE:	
Department Approval:	~~06/16~~03/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Familiarity with the patient's medical history and current health status is essential to the plan of care developed for each patient seen at the Outpatient Infusion Center (Center). The initial process in the program consists of a thorough documentation of the patients' medical history and a physical (H&P) examination. Factors to the chief complaint are the main emphasis of this process.

B. **POLICY:**

1. As part of the initial evaluation, the physician will complete a history and physical documenting on the physician's notes and dictate a report incorporating the elements of the history and physical dictation outline as designated below:
   a. Chief Complaint
   b. History of Present Illness
   c. Review of Systems
   d. Physical Examination
   e. Assessment and Plan
2. As part of the preparation for infusion, a pre-operative history and physical will be done that meets the following conditions:
   a. The H&P must be done prior to the procedure/admission, per hospital policy
   b. Patients receiving chemotherapy infusions must have a pre-chemo visit within 30 days of date of service, or prior to day 1 of each cycle. This visit includes review of symptoms, diagnosis and treatment plan.
   c. Patients receiving "maintenance" non-chemotherapy infusions must have a pre-treatment visit every 6 months. This visit includes review of symptoms, diagnosis and treatment plan.
   d. The patient must have medical clearance prior to any procedure.

C. **PROCEDURE:**

1. The physician will perform the initial exam and medical history review.
2. Any staff physician, primary physician, or designee may do the pre-operative H&P and clear the patient medically for surgery.
3. The findings will be documented on the appropriate forms and dictated according to hospital policy/procedure.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Medical Emergencies**

REVISION DATE:

Department Approval ~~Date(s)~~:	**~~06/16~~03/20**
Division of Oncology Approval ~~Date(s)~~:	**~~03/17~~05/20**
Pharmacy and Therapeutics Approval ~~Date(s)~~:	**n/a**
Medical Executive Committee Approval ~~Date(s)~~:	**~~06/17~~09/22**
Administration Appoval:	**11/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~09/17~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**09/17**

A. **PURPOSE:**

1. Sudden and unexpected medical events may occur at any time. To minimize an adverse/detrimental effect to the patient, prompt/immediate response form a competent and qualified staff **member** is required. This policy outlines the process by which the clinic remains current to respond effectively to medical emergencies.

B. **POLICY:**

1. The provision for emergent care in the Outpatient Infusion Center (Center) will remain current through the appropriate certification and practice of its staff members.
2. All clinical staff will maintain current Cardiopulmonary Resuscitation (CPR) certification and be competent in:
   a. Identifying emergency situations
   b. The proper notification/communication process
   c. Palpating pulses
   d. Maintaining an adequate airway
   e. The use of oxygen therapy
   f. Performing adequate chest compression **and resuscitation**
3. Response to an emergency by the clinical staff will be limited to CPR.
4. Basic emergency response equipment will be readily available in the clinic at all times and in good working order.
5. Emergency equipment will be checked, per hospital policy, and replaced as necessary.

C. **PROCEDURE:**

1. Once a valid emergency situation has been identified:
   a. The support staff (or any available staff member) will dial 911.
   b. Basic CPR will be administered until the advanced emergency team has arrived.
   c. The support staff, with the assistance and direction from the clinical staff, will be responsible for coordinating the patient/visitor traffic flow, as well as the advanced emergency responder traffic.
   d. The support staff will also maintain order in the clinic and be available for questions from patient's/families, etc. while adhering to all applicable privacy and confidentiality policies and regulations.
   e. The Registered Nurse (RN) will coordinate the clinic's emergency response activity and remain with the patient at all times.

f. The RN or designee will notify family/friends/caregiver of the emergency and provide a private waiting area. If family member or patient representative is not present, every effort to contact the appropriate party **will be made**.

2. ~~The nurse manger, program director, or medical director will conduct mock emergency scenarios periodically to assess staff readiness.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Patient Discharge**

REVISION DATE: 03/13

Department Approval:	~~06/16~~03/20
Division of Oncology Approval:	~~03/17~~05/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~10/17~~ n/a
Board of Directors Approval:	10/17

A. **PURPOSE:**

1. To establish the requirements for patient discharge from the Outpatient Infusion Center (Center).

B. **POLICY:**

1. All Center patients will be assessed prior to discharge and results documented in the patient's medical record.

C. **GENERAL GUIDELINES:**

1. Patients will be discharged from the Center when the following criteria are met:
   a. Stable vital signs.
   b. Free from signs and symptoms of adverse reactions including severe nausea/vomiting.
2. Patients should have adequate muscular strength, endurance, functional capacity and body composition for activities of daily living and occupational needs, or have assistance for these activities at home.
3. Patients should have satisfactory understanding of the following:
   a. Basic pathophysiology of their disease and treatment.
   b. Medication information including possible adverse effects.
   c. Contact information for the Center and for treating physician/Allied Health Professional (AHP).
4. Patients will be given printed discharge instructions.
5. A discharge summary will be sent to the referring physician/AHP upon completion of treatment.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Patient Instructions**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Patient Instructions provide the patient and family/caregivers with a clear guide to understanding the physician's/Allied Health Professional's (AHP) instructions for care after the Outpatient Infusion Center (Center) visit.

B. **POLICY:**

1. All patients receiving treatment at the Center will receive clear verbal and written instructions for aftercare/homecare.

C. **PROCEDURE:**

1. The licensed staff will transcribe orders for patient use on the approved instruction form.
2. The Center for staff will also provide verbal instructions for clarity and to assess patient understanding.
3. The next appointment date and time will be included on the instruction sheet.
4. A copy of the instructions will be given to the patient.
5. The patient will sign the form indicating receipt and understanding of instructions.
6. The patient's compliance with instructions and understanding of instructions will be assessed with each visit.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Patient Record Content**

REVISION DATE:

Department Approval:	~~01/17~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**
1. A systematic approach to patient record keeping is necessary:
   a. To provide consistency and orderliness
   b. For ease of use for all staff members

B. **POLICY:**
1. A medical record will be maintained in Cerner on all patients treated at the Outpatient Infusion Center (Center).

C. **PROCEDURE:**
1. The order and the contents of the patient record will include, but will not be limited to:
   a. Patient Demographics and Information:
      i. Admission face sheet located in Cerner patient record.
   b. Consents:
      i. Conditions of Admission located in Cerner
   c. History and Physical:
      i. Documented on the physicians notes and dictated in a medical report located in Cerner.
   d. Labs or Radiology:
      i. Accessed in Cerner under "Labs" or "Radiology"
   e. Physicians Orders:
   f. Documented on the physician's/Allied Health Professional's (AHP's) notes and dictated in a medical report located in Cerner
   g. Fax:
      i. Confirmation of faxes sent and received pertaining to patient are retained by Medical Records

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTE

DELETE – follow Patient Care Services Physician/Allied Health Professionals (AHP) Inpatient Orders

ISSUE DATE: 03/13

SUBJECT: Physician/AHP Orders And Request For Services Orders

REVISION DATE: 03/13

Outpatient Infusion Center~~Department~~ Approval:	~~06/16~~03/20
Division of Oncology Approval:	~~03/17~~05/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	09/17

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

~~1. This policy defines the circumstances in which a physician/Allied Health Professional orders or requests for services to the Outpatient Infusion Center (Center).~~

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

~~1. Only physicians/AHPs granted hospital medical staff privileges may provide written, telephone or verbal orders for patients being seen at the Center.~~
~~2. The clinical staff will take orders only from the Center physician/AHP.~~
~~3. Any treatment/procedure may not be performed without the physician's/AHP's written, verbal or telephone instruction unless defined by policy and/or falls within the scope of nursing practice, as mandated by the State of California.~~
~~4. Orders for patients not being seen by the physicians/AHPs at the Center may not be accepted or implemented by the clinical staff.~~
~~5. Hospital policy will be followed when implementing physician's/AHP's orders.~~

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

~~1. When the physician/AHP is on site, orders will be written and signed by the physician/AHP after each clinic visit.~~
~~2. Verbal orders may be taken by the licensed clinical staff at the direction of the Center physician/AHP caring for the patient in an emergent situation only.~~
~~3. All physician/AHP orders will be reviewed by a registered nurse according to Tri-City Healthcare District (TCHD) policy.~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Scope of Services**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. The Outpatient Infusion Center (Center) provides outpatient therapeutic infusions and injections. The primary goal of the Center is to provide vital services to the population in need, which includes patients of multiple and differing socioeconomic and cultural backgrounds. These are patients seeking treatment for a variety of oncologic and hematologic illnesses.
2. The main objective of the program is to provide caring, progressive, state of the art patient care utilizing advanced treatment and modalities.

B. **AGE POPULATIONS:**

1. The program has been designed to meet specific medical needs of the adult population. Under special circumstances and on a case-by-case basis, needs of other patient populations may be considered.

C. **TYPES OF PATIENTS:**

1. The patients seen in the Center are the outpatient population with orders for treatment from their medical oncology practitioner or other physician/Allied Health Professional (AHP).
2. Injections.

D. **CARE AND SERVICES PROVIDED:**

1. The services provided by the Center include, but are not limited to treatment including:
   a. Intravenous infusion of chemotherapeutic and other therapeutic agents.
   b. Intramuscular and subcutaneous injections of chemotherapeutic and other therapeutic agents.
   c. Intravenous hydration.
   d. Accessing and de-clotting of implanted ports.

E. **HOURS OF SERVICE:**

1. The Center is open 5 days per week, Monday through Friday, 8:00 a.m. to 5:00 p.m.

F. **STAFFING PLAN:**

1. The Center is staffed with:
   a. Medical Director.
   b. Center staff members include ~~a~~ full-time qualified clinical manager**ment**, an office manager, nursing/clinical personnel and clerical support staff. The type and number are selected based on qualifications, experience and Center needs. Center needs are determined by the number of active patients in the program, the type of service required

by the patients and the overall requirements of the Center. The members of the staff may include registered nurses, medical assistants, and clerical staff.

G. **PLAN FOR IMPROVING QUALITY OF CARE:**

1. The Center results are compared to national and/or system-wide benchmarks, when available, or the Center's own historical data. Unmet goals are perceived as opportunities for improvement. Corrective actions are relevant to improving the services rendered.
2. The quality management program is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the Center. The key elements of the program are:
   a. Collection of meaningful data.
   b. Selection of ~~measureable~~**measurable** indicators.
   c. A valid method of data collection, management and storage.
   d. Analysis of the data by qualified persons.
   e. Reporting to pertinent hospital personnel and committees/teams.

H. **STANDARD AND PRACTICE GUIDELINES:**

1. The policies, procedures, and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include professional practice guidelines and standards such as the Oncology Nursing Society and Nursing Intervention Research Center, and American Nurses Association.

I. **COMPETENCY/EDUCATION:**

1. Qualifications for the clinical staff of the program include:
   a. Clinical competency as determined by the level of care provided.
   b. Current State license, where applicable.
   c. Current BCLS, where applicable.
   d. Credentialing by the medical staff, where appropriate.
   e. Successful completion of ONS chemotherapy and biotherapy provider course.
2. Competence of the staff is based on:
   a. Education and training (licensing, certification and credentialing as appropriate).
   b. Ability to demonstrate the necessary skills to perform assigned duties.
   c. Years of experience.
   d. Ability to communicate effectively with the medical staff, patients, and their families.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Staffing Plan**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE:**

1. Appropriate and adequate staffing is vital to the success of the multi-service Outpatient Infusion Center (Center). A well-planned approach must be taken to accomplish this goal, and several factors for a good staffing plan must be considered. They are:
   a. Acuity of the patients treated
   b. Level of expertise/competency of the staff
   c. Time allotted for each visit
   d. Continuous planning and assessment (daily, weekly, monthly and yearly)
   e. Frequent review and evaluation to seek opportunities to enhance the system to benefit patient care and for good stewardship of financial resources that impact Center operations.

B. **POLICY:**

1. Acuity Classification: An Acuity Classification has been developed to provide for and validate adequate/appropriate resources for the plan of care for each patient who presents to the Center for treatment and to support the requirements for the continuum of care activities.
2. Staffing: In general, the type and number of staff members are selected based on qualifications, experience and Center needs. Center needs are determined daily and weekly by the number of scheduled patients, the type and acuity of patients, and the type of service required by the patients. Members of the staff may include:
   a. Register Nurse (RN) is empowered to run the day-to-day operations of the Center. They also participate in the decision-making processes related to the selection of the Center model and the services provided. He/she is accountable for ensuring that the Center is adequately staffed and makes certain that patient visits are appropriate and timely.
   b. Medical Assistant (MA), under the supervision of the RN and the direction of the RN/Case Manager performs tasks as assigned. The MA assists other members of the healthcare team while providing direct patient care. As a patient advocate, the MA reports observations and patient responses to care to the RN/MD and assists with maintaining patient privacy/ confidentiality and reports patient complaints of pain to the RN/MD.
   c. Receptionist requires the coordination of the clinical, clerical and general secretarial/office duties, as well as realistic patient scheduling. The receptionist must demonstrate excellent interpersonal skills.
   d. Other staff members may include a nurse practitioner/physician assistant/medical assistants, and additional clerical support staff. Competency of Center staff is based upon:
      i. Education and training
      ii. Years of experience

iii. Ability to demonstrate the necessary skills to perform the defined duties
iv. Ability to communicate effectively with the medical staff and patients and their families.

3. Patient Scheduling: Allowing adequate time for each patient visit is necessary for patient satisfaction, convenience, and care needs and is an essential component of an efficient and smooth-running clinic. To determine the time required for/between each visit, the following general rules apply:
   a. Increased time is allowed for a new patient visit or for complex cases
   b. Less time is required for follow-up and/or less-complex cases
4. Assignments: Assignments are planned by the ~~clinical manager/case manager~~ **Office Manager in collaboration with the RN's** on a weekly basis and are based upon the number of patients scheduled, assessment of clinical needs of the patient, the complexity of the patient's condition, and the clinical care requirements. Staffing levels may be adjusted to correspond with the anticipated care requirements. In addition, the Center manager/coordinator reviews the changes in the daily Center schedule and makes necessary adjustments to staffing levels.
5. Evaluation of Staffing Plan: The staffing plan is periodically reviewed and evaluated by the Center Manager. Opportunities for improvement/enhancement are identified, and changes are made consistent with the needs of the patients and the staff members.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13 **SUBJECT: Standards of Care**

REVISION DATE:

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/17~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/17~~ n/a
Board of Directors Approval:	07/17

A. **PURPOSE**

1. Standards of care and practice must be delineated with the following objectives in mind:
   a. Provide patients and their families with an understanding of the services provided by the Outpatient Patient Infusion Center (Center).
   b. Meet patient/family expectation, which is to have competent care providers when being treated at the Center.
   c. Define the standards of care and practice as required by governing and oversight bodies such as the Department of Health Services (DHS), Centers for Medicare and Medicaid (CMS) and The Joint Commission (JC).

B. **POLICY**

1. All clinical staff will follow the Nurse Practice Act and Standards of Care and Practice, Consensus Standards from the Oncology Nursing Society (ONS) and American Society of Clinical Oncology (ASCO) in the delivery of patient care.
2. The Center will operate according to the established standards, which addresses all aspects of care.
3. The standards of care and practice will be consistent with care and practice standards and mission of Tri-City Healthcare District (TCHD) but will be specifically designed for the services provided at the Center.
4. Standards will be developed collaboratively with other relevant disciplines to maintain constancy in the level of care provided throughout the institution.
5. All activities including treatment plans, policies and procedures, documentation and performance improvement measures will correlate with the approved standards of care and practice.

C. **PROCEDURE**

1. The clinical manager/medical director and the clinical staff of the Center are responsible for developing the standards of care and practice.
2. The hospital format is utilized and defines the:
   a. Standard of care as the expected outcome
   b. Standard of practice as the scope of service, the person responsible, and the timeframe for completion
3. The standards will be reviewed and approved by Patient Care Services prior to implementation.
4. All policies and procedures will be developed/revised utilizing the established standards.
5. The performance improvement (PI) efforts will incorporate the standards in the PI activities.
6. The designated infusion center team will review the standards biannually.
7. The Standards of Care and Practice are delineated on the following pages.

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

1. Outpatient Infusion Center: Standards of Care

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	1. The patient will have a competent and qualified registered nurse responsible for planning, directing and evaluating his/her care.	RN	Ongoing	1. The clinician systematically evaluates the quality and efficacy of nursing practice. Participates in performance improvement (PI) activities as appropriate to the individual's position, education and training, and practice environment. • Identifies key functions important for monitoring • Identifies measures used to monitor quality and efficacy of patient care • Collects data to monitor quality and efficacy of patient care • Analyzes data to identify opportunities for improving care • Make recommendations to improve nursing practice • Participates with team efforts to evaluate clinical practice or health services • Assists with the development of policies and procedures to improve performance. b. Use PI information to initiate change in practice c. Use PI information to initiate change in healthcare delivery 2. The clinician evaluates his/her own nursing practice in relation to professional practice standards and relevant statutes and regulations. a. Engages in performance self-appraisal on a regular basis, identifying areas of strength, as well as areas for professional practice development b. Seeks constructive feedback regarding his/her own performance c. Takes appropriate action to achieve identified goals d. Participates in peer review, as appropriate 3. The clinician maintains proficiency in current professional activities. a. Maintains current state licensure b. Meets the current mandatory educational requirements for employees of the hospital including completion of the orientation and annual reorientation processes c. Has knowledge of and uses established hospital and Center policies and procedures in accomplishing patient care d. Meets or exceeds performance standards as indicated on the annual performance appraisal e. Participates in ongoing educational activities relevant to current practice f. Seeks experience to maintain skills g. Participates in and seeks knowledge about the activities associated with the continuum of care 4. The clinician contributes to the professional development of peers as well as the other levels of caregivers

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	(continued)	RN	Ongoing	a. Shares knowledge and skills with colleagues and others b. Provides the Center's staff with constructive feedback regarding practice c. Contributes to an environment favorable to ongoing clinical education 5. The clinician collaborates with the patient/family/caregiver and healthcare providers in providing consistent care. a. The clinician communicates with the patient/family/caregiver regarding patient care and nurse's role in the provision of care b. The clinician consults with healthcare providers including pharmacist for patient care as needed c. The clinician makes appropriate referrals to agents/agencies for continuity of care d. The clinician collaborates with interdisciplinary staff as appropriate to coordinate all aspects of care 6. The plan of care and the provision for care is conducted in a manner that protects and advocates on behalf of the patient. a. The State's Nurse Practice Act guides the nurse's practice b. The clinician ensures the confidentiality of the patient/family c. The clinician acts as the patient/family advocate d. The clinician delivers care in a non-judgmental and nondiscriminatory manner that is sensitive to the diversity of individual patient needs e. The clinician delivers care in a manner that preserves and protects patient autonomy, dignity and rights f. The clinician seeks appropriate resources to help formulate ethical decisions 7. The clinician uses research findings in practice. a. The clinician uses interventions substantiated by research, which are approved as appropriate to the individual's scope of practice, position, education and practice environment b. The clinician participates in research activities as appropriate to the individual's scope of practice, position, education and practice environment
Aspects of Care	2. The patient will have care and interventions directed toward the support and maintenance of normal and improved physiological status and not experience avoidable complications	RN	Ongoing	The clinician will: 1. Assess the patient's current health status and pertinent information of present and past history. 2. Collaborate with physician and other healthcare providers in planning care. 3. Observe and report signs and symptoms of complications. 4. Provide nursing interventions as appropriate. 5. Document all findings of assessments, interventions and changes of the plan of care.

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	3. The patient will have care and interventions directed toward support of emotional, psychological and spiritual needs.	RN	Ongoing	The clinician will: 1. Assess patient needs, identify desired outcomes, and design specific nursing interventions to achieve goals involving: a. Emotional needs • Observes behavior that reflects patient's emotional needs • Assesses possible contributing factors for behaviors • Determines needs related to behaviors • Identifies resources for meeting the emotional needs b. Psychological needs • Supports the patient during tests/procedures • Encourages questions and expression of feelings • Makes appropriate professional referrals for counseling, as appropriate • Provides for patient privacy c. Spiritual • Acknowledges and supports the patient's religious prohibitions/ restrictions, etc. 2. Evaluate effectiveness of intervention and documents in the patient's record
Aspects of Care	(continued)	RN	Ongoing	
Aspects of Care	4. Before initiation of a chemotherapy regimen, each patient is given written documentation, including, at minimum:	RN	Ongoing	a. Information regarding his/her diagnosis b. Goals of therapy c. Planned duration of chemotherapy, drugs, and schedule d. Confirm with the patient his/her planned treatment prior to each cycle; e. f. Information on possible short- and long-term adverse effects g. Regimen- or drug-specific risks or symptoms that require notification and emergency contact information, including: • How to contact the practice or organization; • Symptoms that should trigger a call; • Who should be called in specific circumstances (oncologist or other provider) h. Plan for monitoring and follow-up i. Patient education materials should be appropriate for the patient's reading level/literacy and patient/caregiver understanding.

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	5. On each clinical visit or day of treatment during chemotherapy administration, staff:	RN	Ongoing	A. Assess and document clinical status and/or performance status B. Document vital signs and weight C. Verify allergies, previous reactions, and treatment-related toxicities D. Assess and document psychosocial concerns and need for support; taking action when indicated. E. At each clinical visit or day of treatment during chemotherapy administration, staff will review the patient's current medications including over the counter medications and complementary and alternative therapies. Any changes in the patient's medications are reviewed and documented by a practitioner during the same visit.
Environ-ment	The patient can expect to be treated in a safe, sanitary, comfortable and therapeutic environment.	All staff	Ongoing	1. The staff will: a. Assure that equipment and supplies will: • Be maintained in good/safe working order • Be readily available • Be kept clean b. Dispose of waste properly by following hospital waste policies including • chemotherapy safety and handling policies • biohazardous waste policy & procedure • Sharps use & disposal policy & procedure c. Take measures that prevent cross-infection and transmission of potentially infectious/communicable microorganisms by: • Following hospital transmission-based precautions as it relates to the practice in the clinic • Handwashing/hand antisepsis (1) Before and after patient contact (2) Before and after contact with patient wounds (3) Before performing or assisting with clinic procedures (4) After contact with contaminated surfaces/equipment (5) After contact with body substances or mucous membranes • Maintain aseptic and clean technique, as appropriate • Maintain a clean and sanitary environment d. Provide for patient's safety by: • Locking wheels of chairs, wheelchairs when transferring or assisting patients from one area to another

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				• Never leaving disoriented/confused patients unattended • Assisting patients with visual deficit when ambulating • Assisting patients with unsteady gait when navigating around the clinic • Placing call bells at every patient chair • Placing personal belongings as close as possible to patient • Using appropriate equipment based on age and size e. Providing assistance and protection in life-threatening events by: • Following hospital's emergency procedures, e.g., fire, disaster, security, etc. • Following emergency cardiac event protocol
Assessment	The patient will be assessed for his/her biophysical, psychological, social, nutritional, functional, comfort and educational needs to determine the course for the plan of care.	RN/PT	Initial visit	1. During the initial visit the clinician will: a. Complete or assist patient with completing the general information requirements and include information, as appropriate, from family members, friends, caregivers and care providers. b. Review available medical history records c. Record relevant medical data including: • Laboratory findings • Allergies • Current medication • Activities of daily living • Nutritional status • Mobility • Social habits such as consumption of tobacco, caffeine, alcohol, and recreational drugs • Past and present medical history • Past hospitalizations, surgeries, invasive procedures • Review of systems • Vital signs - TPR & BP • Pain assessment • Evidence of, or suspicion of, abuse d. Assess pain e. Assess barriers to learning functional assessment f. Evaluate home environment g. Assess transportation needs j. Complete an appropriate age-specific assessment for the adolescent, adult and geriatric patient that includes consideration for: • Growth & development • Emotional needs • Cognitive status

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Assessment	(continued)	RN	Initial visit	• Educational needs • Social needs • Daily activity needs
Reassess-ment	The patient will be reassessed for compliance and response to treatment at each visit.	RN	Ongoing	The patient is reassessed at each visit for: 1. Compliance with the plan of care a. Response to treatment b. Understanding of home instructions c. Changes in care, medication, new illness, hospital visits d. Wound condition e. Supply/equipment needs f. Signs and symptoms of complications g. Continuing care needs h. Pain level i. Mobility status j. Mental status k. Educational needs l. Acuity
Patient/ Family Education Patient/ Family Education	The patient/family/ caregiver will be knowledgeable about the nature of the patient's illness and will be included in the plan of care and the treatment procedures necessary to restore the patient back to optimal health. (continued)	RN RN	Ongoing Ongoing	Nursing will: 1. Assess and document the level of understanding that the patient/family caregiver demonstrates about the patient's illness and healthcare needs. 2. Assess and document the patient's ability and readiness to learn. 3. Develop individualized teaching/learning plans. 4. Collaborate with the clinic physician and other team members to provide continuity of the teaching plan. 5. Provide support and information to patient/family to include: a. Orientation to the Center program b. Explanation of tests and procedures c. Safe and effective use of medications and expected responses and side effects d. Safe and effective use of equipment and supplies e. Patient care techniques f. When to call and how to reach the center

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				g. Access to available community services h. Obtaining assistance from other health disciplines 6. Utilize appropriate teaching methods and tools 7. Evaluate the effectiveness of the teaching 8. Document learning assessments and interventions and patient/family response to educational efforts
Patient Rights	The patient will have a sense of acceptance as a person and of value as a human being and will maintain a sense of personal identity	All clinic staff	Ongoing	The staff will: 1. Protect, to the extent possible, all patient information according to all applicable regulatory and hospital requirements. 2. Approach the patient with a respectful and compassionate attitude by: a. Conveying a sense of concern and warmth b. Identifying themselves at each encounter c. Responding appropriately to patient needs 3. Assist patient to maintain a sense of personal identity by: a. Communicating what the patient can routinely expect, as well as the tests, procedures and treatments performed b. Respecting the patient's right to inquiry and information regarding their illness, the plan of care and associated procedures/treatments c. Making patients/family aware of their rights and the procedure to follow when they have complaints or concerns d. Encouraging patient/family participation in planning care e. Acting as patient advocate f. Use patient's proper name or the stated preference

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

ISSUE DATE: **SUBJECT: Utilization Review~~Management~~ Plan**

REVISION DATE~~(S)~~: 03/12, 02/16, 11/18, 09/19, 09/22

Patient Care Management Department Approval:	**05/20**
Utilization Review Committee Approval:	**06/20**
Medical Executive Committee Approval:	**~~06/20~~10/22**
Administration Approval:	**~~07/20~~11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/20**

A. **INTRODUCTION:**

1. In accordance with the requirements of the Health and Human Services Conditions of Participation, ~~State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, Centers for Medicare and Medicaid Service (CMS) guidelines and Standards of the Joint Commission,~~ Tri-City Medical Center Governing Board delineate this Utilization ~~Management~~ **Review** Plan **(URP)**. This Plan reflects the actual process of reviewing patient care. The Utilization **Review** ~~Management~~ Plan has been developed to be approved by the Quality Assurance Performance Improvement (QAPI), the Medical Executive Committee, and the Board of Directors.
2. The Utilization ~~Management~~ **Review** Program applies to all patients regardless of payment source. The program does not include utilization review conducted by members of the medical staff under control with, or via others means of delegation by a third party payer. The Medical Center maintains the authority of decisions regarding review, including appropriate services, at the local level.
3. **This policy provides a uniform structure for appropriate provision of hospital resources; to**
to achieve the highest quality of care possible in a cost-effective manner; compliant with State
and Federal regulatory requirements; facilitating appropriate reimbursement for services rendered to our patients.

B. **AUTHORITY:**

1. The Board of Directors has the ultimate responsibility for review of the quality, appropriateness, and medical necessity of admissions, continued stays, and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive Utilization **Review** ~~Management~~ Plan. The authority and responsibility for providing personnel, resources, and equipment has been delegated to the Chief Executive Officer or Designee of Tri-City Medical Center.
2. The Utilization **Review**~~Management~~ Plan is under the direction of the Utilization **Review** Committee, and following approval of this Utilization **Review** ~~Management~~ Plan, the Utilization **Review** Committee shall review and approve the **URP**~~Plan~~ annually for scope and objectives.

C. **GOALS/OBJECTIVES:**

1. All patients, regardless of type of insurance or source of payment, are monitored for over-utilization, under-utilization, and inefficient scheduling of resources. The primary objectives of utilization review are the following:

a. Assure **c**~~C~~are at a **l**~~L~~evel **a**~~A~~ppropriate to **p**~~P~~atient **n**~~N~~eeds.
b. Utilization review monitors the level of care on an ongoing basis to ensure that patients receive care in a facility appropriate for their needs.
c. A patient in an acute care facility requires the continuous availability of physicians, skilled nursing services, surgical services and/or ancillary services found only in the acute hospital setting.

2. Provide Professional Accountability
   a. Utilization review provides professional accountability for the utilization of health care resources to the patient and the person or organization paying for his/her care. It addresses issues of quality and cost controls to ensure the highest quality patient care at the lowest cost.
3. Educate the Medical Staff and Other Health Care Professionals
   a. The ongoing utilization review activity and the identification of problem areas provide continuous education on quality of care and utilization issues to the Medical Staff and other health care professionals.

D. **UTILIZATION REVIEW~~MANAGEMENT~~ COMMITTEE**

1. Organization
   a. The Committee shall be a medical staff committee of the hospital **to meet the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation (CoP) requirement.**
   ~~a.~~**b.** **The Committee**~~,~~ will be composed of five (5) physicians, no less than two (2) physicians who must be either medical doctors or doctors of osteopathy and members of the Medical Staff, representing the admitting services of the medical staff, and assisted by other professional personnel.
   ~~b.~~**c.** The other members may be any of the other types of practitioners as specified in **CMS CoP**~~State Operations Manual~~ §482.12(c)(1).
   ~~c.~~**d.** The Physician Advisor will be a member of the Committee.
   ~~d.~~**e.** No person with a direct financial interest in Tri-City Medical Center may –participate in reviews conducted by the Committee. No person who is, or has been, professionally involved in the care of the patient whose case is being reviewed may participate in the review.
   ~~e.~~**f.** All members of the Committee must follow the conflict of interest and confidentiality policies of Tri-City Medical Center.
   ~~f.~~**g.** All medical staff committee members shall be appointed by the Chief of Staff. Appointment shall be for one year.
   ~~g.~~**h.** The Director of Case Management will appoint non-medical staff representatives to the Committee annually.
   ~~h.~~**i.** Committee Representatives may include, but are not limited to:
      i. Director **and/or Supervisor** of Case Management
      ii. **Chief of Patient Care Services**~~Nursing Administrator or representative~~
      iii. Chief Medical Officer
      iv. Chief Financial Officer
      v. Physician Advisor
      vi. Director/Manager of Medical Records
      ~~iii.~~**vii. Director/Manager of Patient Financial Services**~~Medical Records Director or representative as needed~~
      viii. Director of Quality Improvement
      ix. Nursing Directors/Managers (Emergency Department. Surgery)
      x. Compliance Officer
      xi. Hospitalist~~Case Management / Social Services' representative(s)~~
      ~~iv.~~**xii. Director of Pharmacy**~~as needed and may include:~~
         ~~1) CDI Specialist, and Social Services representative(s) as needed~~

~~i.~~**j.** As per Medical Staff Bylaws, for a quorum, no less than two (2) physician committee members shall attend the Utilization Committee Meetings.

~~j.~~**k.** The Committee must meet as often as necessary to accomplish its function, but no fewer than quarterly (4) times per year.

2. Authority
   a. Physician Advisor and Review Personnel
      i. A designated Physician Advisor will be available per contractual agreement, Monday through Friday, to communicate with the Case Managers regarding questionable admissions, quality of care issues, **length of stay (LOS)**~~day~~ or cost outliers and continued stay cases. This communication will be in person, via telephone, or via email, as necessary.
      ii. The Physician Advisor has authority to initiate **a** denial of an admission or **an** extension of length of stay (pending QIO review and concurrence when required).
      iii. The **RN** Case Managers will seek specific assistance and advice from the Physician Advisor in the following situations:
         1) **When the admission or continued stay is not medically necessary based on the criteria.**~~When the Case Manager has reason to believe that an admission, continued stay, is not medically necessary based on criteria.~~
         2) ~~When the Case Manager is unable to make a decision as to whether there is a medical necessity for acute care, even when the guidelines are met.~~
         3) When there is a question of quality of care being rendered.
         4) When the implementation of discharge planning is delayed by either the patient, family and/or **A**~~a~~ttending **P**~~p~~hysician.
         5) When under/over utilization and quality concerns are identified, as well as delays in services with the Attending Physician **or consultants** and intervention is necessary.
      iv. In most instances, the Physician Advisor shall render a decision within twenty-four (24) hours as to the approval or denial of an admission or continued stay. The Director of Case Management shall oversee review activities. Case Management review shall be conducted by personnel qualified to follow directive of the Utilization **Review**~~Management~~ Committee and to apply clinical guidelines and regulations. Sufficient qualified reviewers will be assigned to meet the requirements of reviews.
   b. The Committee has the authority to give notice of non-coverage in accordance with federal and state law and other ~~third party~~**third-party** payer requirements.
   c. The Committee has the responsibility to:
      i. Implement procedures for reviewing all stages of hospital admissions, including but not limited to:
         1) Medical necessity for admission, over~~-~~ and under-utilization of ancillary services, delays in services, quality of care indicators.
         2) Adequacy of medical record documentation, lengths of stay~~, and~~ timeliness of discharges**, drugs and biologics, and assure that the findings and recommendations are implemented.**~~.~~
      ii. Report review findings and recommendations to the appropriate Medical Center and/or Medical Staff persons or entities.
      iii. Review third-party payer denials, make recommendations and/or take appropriate actions.
      iv. Collect and analyze data necessary to carry out its responsibilities.

v. Analyze issues, problems, or individual cases identified through utilization review activities, make recommendations for resolution and/or refer to appropriate entities for resolution.

vi. **Assure coordination between utilization review, quality management, risk management, compliance, and patient financial services.**

3. Upon invitation from the Chairperson, other representatives of the Hospital or medical staff may attend meetings. The Chairperson and other designated members of the committee shall serve as Physician Advisor if there is not an appointed advisor available.
4. Chairpersons of all standing committees shall have an open invitation to attend meetings of the Committee; other Medical Center personnel may attend upon invitation from the Committee.

E. **UTILIZATION REVIEW ACTIVITIES:**

1. Utilization Review Staff
   a. The Utilization Review staff consists of qualified non-physician Medical Center personnel including, but not limited to, nurse case managers, social workers, and assistants who function under the direction of Department Director as staff to the Utilization Review Committee.
   b. **Physician Advisor**
2. Criteria~~:~~
   a. The **RN** Case Managers shall use the prescribed and authorized criteria designated by medical staff while reviewing the severity of illness, intensity of service, and discharge screens.
   ~~a.~~**b.** InterQual Criteria is utilized at Tri-City Medical Center.
3. Admission Review
   a. All designated admissions shall have an initial InterQual® review performed not later than 24 business hours following admission to TCMC.
   b. If during the admission review process the patient does not meet criteria for the ordered level of care, the Attending Physician is contacted for additional information. If there continues to be insufficient evidence to justify the admission the RN Case Manager will contact the Physician Advisor for review and action.
   c. The Physician Advisor reviews the available information and discusses the admission rationale or treatment approach with the Attending Physician if medical necessity for the level of care is not apparent. The Physician Advisor uses his or her medical knowledge to determine appropriate patient status and notifies the Attending Physician of the determination.
   ~~a.~~**d. If the Attending Physician fails to present their views or disagrees with the determination, the final determination must be made by at least two members of the UR Committee.**
4. **Continued Stay Review**~~Concurrent Review~~
   a. **The RN Case Manager performs Continued Stay reviews to determine ongoing medical necessity and per payer request.** ~~The concurrent review process will follow the admission review and will continue throughout the patient's hospital stay.~~
   b. **If during the continued stay review process, the RN Case Manager finds that the review does not meet criteria for appropriateness or medical necessity, the Attending Physician is contacted for additional information. If there continues to be insufficient evidence to justify continued stay, the RN Case Manager will contact the physician Advisor for review and action.**
   c. **The Physician Advisor reviews the available information and discusses the rationale or treatment approach with the Attending Physician if medical necessity for the level of care is not apparent. The Physician Advisor uses his or her**

medical knowledge to determine appropriate patient status and notifies the Attending Physician of the determination.

d. **If the Attending Physician fails to present their views or disagrees with the determination, the final determination must be made by at least two members of UR committee.**

e. **The RN Case Manager performs a retrospective review on cases per payer request.**

~~f. Concurrent reviews shall be provided to payers as requested.~~

~~g. Concurrent reviews for Medicare & Medicaid patients should be performed as per department standards throughout the patient's hospital stay.~~

~~i. For duration of stays, review only cases that they (hospital) reasonably assume to be outlier cases based on extended length of stay, as specified in State Operations Manual §412.80 (a)(1)(i); and~~

~~ii. For professional services furnished, including drugs, biologicals, and medical devices, the hospital needs to review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as specified in State Operations Manual §412.80 (a)(1)(ii)~~

~~h. In keeping with the "Ten (10) Bed Call List" protocol as determined by the San Diego County office for Medi-Cal, those Medi-Cal or Medi-Cal Pending; CMS or CMS Pending patients who no longer meet an acute hospital level of care and are "awaiting placement" shall be identified as being on the "Ten (10) Bed Call List".~~

~~i. The Case Manager shall discuss case with the treating physician and work to obtain a physician order for the patient to be placed on "Ten (10) Bed Call status".~~

~~ii. The Ten (10) Bed Call List will be maintained by the Case Management department's appropriate support staff member.~~

~~iii. Case Manager shall document "Ten (10) Bed Call" status in the patient's EMR.~~

~~5. Outlier Review~~

~~a. The Director of Case Management and Social Work Manager conduct frequent outlier review to ensure the ongoing medical necessity of any patient with an extended stay or high dollar amount of services. Physician Advisor may attend as needed.~~

~~b. Specific outlier cases are discussed in the Hospitalists Stop Light Rounds, and Intensive Care Rounds, outlining clinical condition, discharge barriers, and action plan.~~

~~c. The target indicators for outlier review are:~~

~~i. Length of stay of 10 or more days or~~

~~ii. Total hospital charges of $75,000 or greater~~

~~6. Discharge Planning~~

~~a. Discharge planning is a collaborative effort of a multidisciplinary team of individuals performed as an integral component of the direct patient care process.~~

~~b. The concurrent utilization review process is one of several mechanisms designed to identify and refer patients needing discharge Care Coordination.~~

~~7. Relationship to Third Party Payers~~

~~f. The Hospital is responsible through the Case Management function for the process of reviewing patients' (beneficiaries') clinical information for the purpose of presenting claims to third parties, including the fiscal intermediary, the basis upon which payment is allowed by the intermediary, the condition under which the intermediary denies claims, and the claims appeal data about a case shall be open to review by fiscal intermediaries, state agencies, and the Quality Improvement Organizations (QIO). Information and data shall be protected to ensure confidentiality.~~

~~F. COLLABORATION WITH THE QUALITY ASSURANCE/PERFORMANCE IMPROVEMENT COMMITTEE (QAPI) AND/OR THE MEDICAL STAFF:~~

1. Case Management is one of the components of a hospital Quality Improvement Program, during the course of concurrent and retrospective review, the Case Managers will screen patient records for quality concerns, including those specific events designated by the Quality Management and Regulatory Compliance Specialist. If concerns are identified through Case Management reviews, they will be documented within Allscripts. Case Management and Quality Improvement functions will be integrated as follows:
   a. Quality And Utilization concerns are referred to the appropriate Medical Staff Review Committee:
      i. If a potential quality issue is identified during the review process and is considered to be of immediate need for correction, it will be immediately referred to the Physician Advisor. If the attending physician or Hospital Department Manager is unwilling to correct the problem to the satisfaction of the Physician Advisor, the Chairperson of the attending physician's department, Chief of Staff, or Administration will be immediately notified; the Risk Manager may also be notified.
      ii. If a potential quality issue is identified, however, and correction has already occurred, the case will be referred to the appropriate Medical Staff Committee or Department Manager.
      iii. Problem Diagnosis Related Groups (DRGs) will have Quality Improvement Teams assigned to evaluate the problem, determine the cause, and recommend corrective action.

G. **STANDARD REPORTS TO COMMITTEE:**

1. Standard reports presented at Committee meetings may include at least the following information:
   a. Monthly UR Committee Dashboard: Case Mix Index, Length of Stay, Readmission Reduction
   b. Condition Code 44s per month
   c. Discharge Appeals per quarter
   d. PEPPER Report Analysis quarterly
   e. HSAG Readmission report & HSAG High Risk Medication report (HRM) reported quarterly
   f. Analysis of Observation rates: Observations verses Inpatients & Conversion rates every 6 months
   g. Review of Medicare Specific Inpatient Stays: Chest pain, TIA, Syncope monthly
   h. Physical Advisor Denial Outcomes monthly
   i. Managed Resources Report/Post Appeal Outcomes quarterly

E.F. **HOSPITAL ADMINISTRATION**

1. The Hospital Administration shall provide the necessary resources to ensure the proper functioning of the Case Management Program. This includes acting as a liaison with all departments, ensuring information is properly assembled, and by providing necessary forms, secretarial assistance, and meeting space. Administration shall be responsible for considering and acting upon decisions and recommendations stemming from the Case Management function with respect to Hospital policy, procedures, and staffing.

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

1. **Medicare Conditions of Participation Title 42, volume 2**
2. State Operations Manual, Appendix A – Survey Protocol, §482.30(b) Standard: Composition of Utilization Review Committee
3. State Operations Manual, Appendix A – Survey Protocol, §482.30(c) Standard: Scope and Frequency of Review

~~4. State Operations Manual, Appendix A – Survey Protocol, §482.12(c) Standard: Care of Patients~~
~~5. State Operations Manual, Subpart F – Payment for Outlier Cases, §412.80(a)(1) Basic Rule: Discharges occurring on or after October 1, 1994 and before October 1, 1997~~

Tri-City Medical Center	Progressive Care Unit (PCU)
PROCEDURE:	**ADMISSION PROCESS FOR PROGRESSIVE CARE UNIT (PCU)**
Purpose:	To ensure proper processing of admissions for Justice Involved Individual (JII) patients referred by a County, State or Federal Law Enforcement Agency

A. **DEFINITION**

1. All Justice Involved Individual (JII) requests for direct admission or interfacility transfer to the Progressive Care Unit (PCU) will be processed by the PCU Manager, ANM or Relief Charge RN in close collaboration with the Hospitalist Quarterback or attending physician(s). This will occur 24/7.
2. JII are in custody of the San Diego County Sheriff **Department** (SD**SD~~C~~**), the California Department of Corrections and Rehabilitation (CDCR), or a Federal Law Enforcement Agency (FED)

B. **DEPARTMENTAL PROCESS:**

1. Referrals may be received from CDCR, SD**SD~~C~~** or FED facilities or as interfacility transfers from other hospitals.
2. Facilities requesting a JII patient transfer to Tri-City Medical Center (TCMC) will contact the PCU at (760) 940-7231.
3. Requestor will provide the JII CDCR identification number or Booking number.
4. Requestor (Case Manager, Registered Nurse or Physician) will provide information regarding reason for admission including medical diagnosis, level of care (ICU,Telemetry, Acute Rehab, etc.) and any other necessary information needed to facilitate transfer and proper bed placement. Contact numbers will be obtained for the hospitalist to facilitate a physician to physician report.
5. The PCU Manager, Assistant Nurse Manager (ANM) or Relief Charge Nurse will contact the hospitalist to inform them of request for transfer, reason for request, level of care requested, TCMC bed availability, and contact number of transferring facility.
6. Certain criteria will require a consulting physician to be contacted prior to the Hospitalist acceptance of a patient. These criteria include but are not limited to:
   a. Acute Rehab – **the Director or Supervisor of Acute Rehab**~~Brandon Peer ext. 7144 or Priya Joshi ext. 7868~~ must review records prior to acceptance and approve that patient may be transferred to a medical bed at TCMC for further medical evaluation prior to acceptance in the ARU level of care.
   b. Ortho ~~– on call Orthopedics~~
   c. Cardiology – ~~on call Cardiologist~~
   d. Cardiothoracic – ~~Dr. Daniel Gramins~~
   e. Ophthalmology – ~~Dr. Arvind Saini~~
   f. OMFS – ~~Dr. Brian Mudd~~
   g. Plastics – ~~Dr. Geehan D'Souza~~
   h. General Surgery ~~– on call General Surgeon~~

   Neuro Surgery ~~– Dr.Frank Yoo, Dr.Howard Tung or Dr. Mark Stern~~

   ~~7.~~ The PCU Manager, ANM or Relief Charge in collaboration with the CDCR or SD**SD~~C~~** will assign a bed for the patient, communicate this to the House Supervisor and place information in Aionex.
7. ~~8.~~ The PCU Manager, ANM or Relief Charge will confirm acceptance with the requestor providing both room number and accepting physicians' name.
8. Upon patient arrival, PCU Unit Secretary will send a Cerner Communication Notice to Access Management to inform them of the patient arrival so patient can be admitted in Cerner

~~Department~~Progressive Care Unit Review	Medical Staff Department/Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/20	n/a	n/a	09/22	11/22	n/a	

~~Reference~~RELATED DOCUMENT:
~~TCMC Policy:~~ Patient Care Services; Admission Criteria Policy; ~~Policy VI.A~~

Tri-City Medical Center
Oceanside, California

PROGRESSIVE CARE UNIT (PCU)

ISSUE DATE: ~~NEW~~04/18 **SUBJECT: Hunger Strike: Justice Involved Patients**

REVISION DATE~~(S)~~:

~~Department~~Progressive Care Unit Approval:	**~~12/17~~03/20**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/18~~09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**~~03/18~~ n/a**
Board of Directors Approval:	**04/18**

A. **PURPOSE:**

1. To delineate the roles of Tri-City Healthcare District (TCHD) ~~and department of correction~~ when a justice involved (JI) patient participates in a hunger strike.
2. To ensure JI patients receive care to maintain their nutritional status as ordered by TCHD physician.

B. **DEFINITION(S):**

1. JI Patient – patients held involuntarily through operation of law enforcement authorities.
2. Hunger Strike – refusal of necessary food and or fluids for political, mental health or other grievance-rated reasons.
3. Baseline – date and time that initial medical assessment and documentation occur for monitoring purposes.
4. Nutrition support – nutritional therapy such as food delivered by a tube to the stomach, central venous line, or by an intravenous line when usual diet is insufficient.
   a. Requires a physician order and must be administered in a licensed health facility.
5. Forced treatment – forced treatment that shall occur only in an emergency or with a court order for a mentally incompetent JI patient as provided in California Penal Code Section 3200.
6. Medical Emergencies as defined in the California Code of Regulation (CCR), Title 15, § 3355 (A) and California Correctional Health Care Services (CCHCS):
   a. Any medical, mental health, or dental condition for which evaluation and treatment are necessary to prevent ~~death,~~**severe** ~~severe~~ or permanent disability**, or death**.
   b. A medical emergency exists when there is a sudden marked change in a JI patient condition so that action is immediately necessary for the preservation of life or the prevention of serious bodily harm to the JI patient or others.
   ~~b.~~**c. Custody staff – peace officer assigned to monitor the security of the patient.**

C. **POLICY:**

1. ~~California Department of Corrections and Rehabilitation (CDCR)~~ **JI** patients participating in a hunger strike shall be provided a medical ~~and mental health~~ assessment, monitoring, and necessary treatment, regardless of the reason for the hunger strike.
2. The identification of patient participating in a hunger strike will be performed by ~~CDCR~~ **appropriate custody** staff.
3. Registered Nurses (RN) assigned to a patient refusing to consume meals or stating they are participating in a hunger strike will notify the Progressive Care Unit (PCU)~~,~~ Clinical Manager (CM) or designee immediately and follow the ~~CDCR~~ Division of Correctional Health Care Services (DCHCS) guidelines outlined within this policy.

a. The PCU **RN**, CM, or designee will notify the ~~CDCR Correctional Officer (CO)~~ **Custody Officer** assigned to the patient.

4. Prior to administering a course of medical treatment, medical staff must first obtain the patient's informed consent. To exercise this right, **patient** must:
   a. Receive information about his/her medical condition
   b. **Be educated about** ~~T~~the proposed course of treatment (including nutrition support)
   c. Prospect for recovery
5. Forced feeding (enteral or parenteral nutrition support) shall not take place except in a licensed health care facility by licensed clinical staff.
6. TCHD employees shall grant JI patients autonomy in health care decisions related to nutrition and shall not force feed the JI patient unless one of the following criteria are met:
   a. JI patient's condition meets the definition of emergency status.
   b. JI patient is deemed unable to give informed consent as defined as outlined in CCR Title 15, Article 8, § 3353.1 and the institution obtains an appropriate court order per CCR, Title 15, Article 8, § 3351(a) to treat a mentally incompetent inmate-patient.

D. **PROCEDURE:**

1. RN Responsibilities: ~~Initial~~
   a. After a JI patient is identified as participating in a hunger strike.
      i. Complete all nursing interventions and assessments as outlined in the **TCMC** Standards of Care.
      ~~ii. Review the patient's medical history for medical diagnosis, conditions, or diseases that are an immediate risk to the patient.~~
         ~~1) Examples include but are not limited to the following; diabetes, end-stage renal disease, dialysis.~~
      ~~iii.~~**ii.** Notify the physician of the intended hunger strike and the following:
         1) immediate medical risk
         2) current nutritional intake
         3) output
         4) admission weight
         5) current weight
      ~~iv.~~**iii.** Notify the PCU Manager, Case Manager (CM) and on duty leadership (Assistant Nurse Manager [ANM] or Relief Charge RN).
         1) The CM or on duty leadership will notify the patient's facility Physician or RN on duty and provide the following information:

            ~~a) Most recent documented weight~~
            ~~b)~~**a)** Current measured weight
            ~~c) Physician condition and appearance~~
            ~~d) Emotion and /or psychological condition~~
            ~~e)~~ Vital signs i.e., heart rate (HR), temperature, respirations, orthostatic blood pressure
            ~~f)~~**b)** ~~Relevant medical history including allergies to food and~~ **Current** medications
            ~~g)~~**c)** What the patient is refusing i.e., food or liquids
            ~~h) Current mental health status and history of mental disorders~~
            ~~i) Suicide risk assessment~~

E. ~~**INFORMED CONSENT AND STAFF INTERVENTIONS:**~~ **RIGHT TO REFUSE TREATMENT:**

1. ~~Prior to administering a course of medical treatment, medical staff must first obtain the JI patient's informed consent. To exercise this right, a patient shall receive information about his/her medical conditions, the proposed course of treatment (including nutrition support and his/her prospects for recovery).~~
2. Patient has the right to refuse all medical treatment and care at TCHD provided patient has the capacity and competency to do so. After discussion with the on duty Physician at the custodial

institution, patient may be discharged against medical advice (AMA) back to the institution once accepted by the on duty Physician.

F. **REFERENCE(S):**

1. California Correctional Health Care Services (CCHCS). (2013, July). ~~Cchcs~~ **CCHCS** hunger strike, fasting, & refeeding care guide. Retrieved from http://www.cphcs.ca.gov/careguides/MassHungerStrikeCareGuide.pdf
2. CCHCS. (2012, July). Emergency medical response system policy. 12*(4),* Medical Services. Retrieved from http://www.cphcs.ca.gov/docs
3. San Diego County Sheriff's Department Medical Services Division (2015). Hunger Strikes, MSD.H.12, CCR Title 15, Section 1206

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION

ISSUE DATE: 06/08 **SUBJECT: Emergency Response System**

REVISION DATE: 12/12, 09/18

Department Approval:	**09/18**
Division of Pulmonary Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/12**

A. **PURPOSE:**

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

B. **POLICY:**

1. In the event of a cardiopulmonary emergency, the participant shall be placed in a safe position. The TCMC emergency response system shall be activated by dialing 66 on the hospital phone. The remaining participants in the gym shall be instructed to cease exercising and asked to clear the immediate area. BLS shall be initiated until the code team arrives.

C. **GUIDELINES:**

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

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION

ISSUE DATE: 09/08 **SUBJECT: Patient Enrollment Protocol**

REVISION DATE: 12/12~~-~~, 09/18

Department Approval:	09/20
Division of Pulmonary Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/12

A. **PURPOSE:**
1. To establish guidelines for enrolling new patients into a Pulmonary Rehabilitation Program.

B. **POLICY:**
1. Patient must meet criteria for patient selection.
2. Patient's physician will sign referral stating there are no known contraindications to patient exercising at the time of admission.
3. Patient shall sign exercise consent allowing staff to set guidelines for gradually progressive graded exercise.

C. **GENERAL GUIDELINES:**
1. ~~All P~~patients seen ~~by the pulmonary rehab staff~~ during their inpatient stay shall be contacted ~~by staff after an appropriate interval of recuperation at home, to find out how the patient is doing and~~ **to** determine interest in ~~our~~ **the** Outpatient Pulmonary Rehabilitation program.
2. Patient's **primary** physician **or patient's Pulmonologist** shall be contacted and admission to Pulmonary Rehabilitation requested. Physician approval shall be accompanied by signed referral.
3. Insurance authorization shall be obtained by staff members and patient shall agree to be responsible for any difference between amount billed and amount paid by insurance company, as well as any co-payment necessary under their insurance contracted benefits.
4. Patient shall come to Pulmonary Rehabilitation for intake and a patient history shall be obtained.
   a. Physical, emotional and psychosocial limitations shall be assessed and documented, to ensure maximum benefit and safety of each participant
   b. Relevant medical records shall be obtained and kept as a part of patient's record. These shall include but not be limited to, a discharge summary and recent PFT.

Tri-City Medical Center
Oceanside, California

PULMONARY REHABILITATION

ISSUE DATE: 09/08 **SUBJECT:** Patient Referral

REVISION DATE: 12/12

Department Approval:	**02/20**
Division of Pulmonary Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/12**

A. **PURPOSE:**
1. To establish guidelines for patient referral for Pulmonary Rehabilitation Program.

B. **POLICY:**
1. All patients must be referred to the Pulmonary Rehabilitation Program by a physician order after the patient meets the "Criteria for Patient Selection."

C. **GENERAL GUIDELINES:**
1. The physician shall sign the referral, and, if possible, provide recent laboratory results.
2. If the patient's primary physician or cardiologist does not feel an exercise stress test is necessary or appropriate at this time, target heart rate shall be determined and monitored by the Pulmonary Rehabilitation staff using age determined target heart rate ranges and/or rest plus 30 beats The patient's perceived exertion shall not exceed the Borg Scale of 5.

Tri-City Medical Center
Oceanside, California

RADIOLOGY

ISSUE DATE: NEW

SUBJECT: Screening for Pregnancy in Patients Scheduled for Diagnostic Radiology Procedures

REVISION DATE~~(S)~~:

Department Approval:	**02/20**
Department of Radiology Approval:	**08/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval Date:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Based on American College of Radiology (ACR) guidelines, a screening of pregnant or potentially pregnant patients prior to diagnostic radiologic exams should be performed for patients of menstrual age (typically ages 12 through 50 years).
2. The purpose of screening patients for the possibility of pregnancy is to reasonably minimize the number of unexpected exposures of pregnant patients who have entered a potentially vulnerable stage of gestation. For pregnancies that are more than 4 weeks and less than 15 weeks post- conception, the dose to the conceptus becomes an especially important factor.

B. **POLICY:**

1. All patients of menstrual age (typically ages 12 through 50 years) should be questioned about pregnancy status. If the patient is not positive about her pregnancy, it is radiologic technologist's responsibility to contact patient's nurse (for inpatients), or ordering physician (for outpatients) and request a pregnancy test.
2. If the result of a pregnancy test is positive, it indicates the need to follow up protocols for patients known to be pregnant, and the information must be brought to the attention of ordering physician. Physician can request limited studies such as one view chest, limited ribs, skull, or extremities studies. An informed consent must be obtained to proceed with the radiologic examination.
3. The radiologic technologist will verify the patient has been given informed consent and complete the consent (verbal or written).
4. Special considerations:
   a. For higher radiation dose such as lumbar spine, thoracic spine, abdomen/ pelvic studies, ordering physician needs to inform the patient in regard of the risk and potential effects of ionizing radiation on fetus. Physician may be requesting limited radiologic studies as well as consulting with a radiologist to exposing the patient as low as reasonably possible.
   b. Patients who are minors (in most states, a minor is a child under the age of 18), a parent or guardian is usually responsible for consenting to a minor's health care including radiologic exams. Generally, a minor is considered emancipated if married, on active duty in the armed forces, or otherwise living apart from her parents and managing her own finances. Per California hospital association law, a parent or guardian is responsible for consenting to a minor's health care if minor is unmarried; otherwise minor's consent is sufficient without parental consent.

c. In the event where the ordering physician determines that the procedure must be done without the benefit of a pregnancy test, the technologist will document in the medical record that he/she has been directed to proceed without this information.

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

1. Consent to Diagnostic Radiology Procedure on a Pregnant Patient 7633-1011

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	**11/09**	**SUBJECT:**	**Behavior Management/Supervision Technique**
REVISION DATE~~(S)~~:	**03/10, 03/12, 05/12**		
Rehabilitation Department Approval:		**~~10/15~~08/22**	
Department of Medicine Approval:		**~~06/17~~, 08/22**	
Pharmacy and Therapeutics Approval:		**n/a**	
Medical Executive Committee Approval:		**~~07/17~~09/22**	
Administration Approval:		**11/22**	
Professional Affairs Committee Approval:		**~~01/18~~ n/a**	
Board of Directors Approval:		**01/18**	

A. **POLICY:**
1. All potentially violent and/or suspicious behavior will be dealt with immediately to prevent any harm to patients and staff.

B. **PROCEDURE:**
1. Responsibility/who may perform:
   a. The individuals responsible for performing behavior management/supervision during transport to the Rehabilitation Gym are the following:
      i. Physical Therapists and Physical Therapy Assistants who have active licenses to practice in the State of California.
      ii. Occupational Therapists and Occupational Therapist Assistants who have active licenses to practice in the State of California.
      iii. Speech Language Pathologists who have active licenses to practice in the State of California.
      iv. Assistants will be directly supervised by a therapist within the respective discipline.
   b. To maintain safety during patient transport to/from Rehabilitation Services Gym area, move the patient to another area or remove the other patients from the area and call for staff assistance when violent or suspicious behavior is observed.
   c. Should an event occur, the staff member will gather all information regarding behavior and assess the patient's mental status.
   d. Implement the most appropriate response, which may be a time-out or verbal de-escalation techniques.
   e. Physical restraint is not used as a clinical intervention. If a patient becomes violent, a "Dr. Strong" code must be called immediately by dialing 66 in the hospital. If the patient becomes violent at an offsite location, 911 should be called immediately.
   f. The Director or designee will meet with all staff involved to process the incident. The team will discuss the effectiveness of actions taken and ways to improve future responses to similar occurrences.
   g. Submit required documentation when necessary and forward to the Risk Management Department.
   h. Document the incident and staff response in the patient's medical record.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 04/95	**SUBJECT:** Community Out-Reach Groups
REVISION DATE~~(S)~~: 09/97, 01/00, 01/03, 01/06, 01/09, 05/12	**POLICY NUMBER:** 800

Department Approval:	~~09/15~~08/22
Department of Medicine Approval:	~~06/17~~08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~08/17~~ n/a
Board of Directors Approval:	08/17

A. **POLICY:**

1. Community Out-Reach Groups are provided in a social/group setting to emphasize sustaining or returning to the highest level of functioning within the individual's home and in the community.

B. **PROCEDURE:**

1. Requests for Service:
   a. Participants will be self-referred or referred by a healthcare professional to attend group treatment, per the following guidelines, the patient should display the following:
      i. Appropriate level of motivation to participate and benefit from group treatment.
   b. Appropriate comprehension necessary to understand simple directions and be able to attend for one hour.
   c. Have a realistic expectation of group therapy goals.
2. Hours of Service
   a. One session weekly for one hour, subject to change due to community needs.
3. Responsibilities
   a. Group therapy will involve utilization of multi-modal communication skills. Groups and group goals will be selected pertinent to participants' wants and needs.
   b. Groups may include, but will not be limited to:
      i. Aphasia Group
         1) This group is for individuals who have difficulty with speech and/or language skills and whose personal therapy may have been completed or discharge from therapy is forthcoming. This is language therapy in a group setting, emphasizing social communication skills solving communication problems within the community and promoting multimodal communication skills.
      ii. Parkinson's Group
         1) This exercise program is designs to improve the quality of life for those with Parkinson's disease. The purpose is to help maintain maximum function. The Class begins with a warm-up, followed by upper extremity, lower extremity and trunk strengthening, then a fun activity to increase coordination, balance or mobility. The session ends with a cool-=down activity. Participants are also given written exercises to perform at home and are encouraged to ask questions relating to their disease process.
      iii. Stroke Exercise Group

1) This group is geared toward clients who have been discharged from therapy services and are looking for a continued exercise program for maintenance, learning new techniques, friendships, or just getting out. We begin with a stretching warm-up, upper extremity exercises, lower extremity exercises, balance activities and then a few fun activities.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 07/91

SUBJECT: Job Site Assessment

POLICY NUMBER: 06/09

REVISION DATE~~(S)~~: 11/94, 01/06, 01/09
REVIEW DATE~~(S)~~: 05/00, 01/03, 04/12

Department Approval:	09/15
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **POLICY:**

1. Provide Tri-City employees and outside companies with a Job Site Assessment upon request and written agreement with Tri-City Medical Center.

B. **PROCEDURE:**

1. **For TCMC employee work-related injuries, employee health will refer the employee to Concentra for evaluation and treatment. Once doctor recommends ergonomic evaluation, a referral request will be submitted by Concentra to the WC carrier for authorization. Once authorized, the referral will be forwarded to the Rehab Director or Manager via email (if internal) or electronic/paper referral (if external).** ~~Upon request, the Physical or Occupational Therapist will contact the company and schedule an evaluation of the specific workstation to be done during company working hours.~~

2. **For TCMC employee non work-related injuries, but need for ergo assessment, employee will talk to their supervisor and their supervisor will submit a request for an ergonomic evaluation through Employee Health. There will be no charges for in-house, non-injury related ergonomic assessments.**

~~2.~~3. **A physical or occupational therapist will be designated to provide the evaluation, and they will work out a time with the employee to schedule the evaluation.** The onsite evaluation will include a thorough assessment of the workstation. The evaluation will focus on specified workstation setup relative to tasks, positions, repetitive motions, lifting, and proper body mechanics. A video camera may be used for assessment of findings and interpretation of data.

~~3.~~4. A written report of findings will be ~~provided to the company~~ **completed** upon conclusion of the analysis. Included in the report will be recommendations regarding workstation design, tools, equipment modification, and education programs to help increase worker safety and efficiency.

~~4.~~5. A copy of all reports, and videotapes if applicable, will be maintained in the Rehabilitation Services area. One copy of each final report will be forwarded to the **appointed designee** ~~Occupational Health Program Manager~~ for placement in the company master file or saved on the network-shared drive.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 02/18	**SUBJECT:** Occupational Therapy Assistant Supervision
REVISION DATE~~(S)~~:	~~**POLICY NUMBER: 707**~~
Rehabilitation Department Approval:	~~10/15~~08/22
Department of Medicine Approval:	08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/18~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~02/18~~ n/a
Board of Directors Approval:	02/18

A. **POLICY:**

1. The Occupational Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the occupational therapy assistant does not function autonomously.

B. **PROCEDURE:**

1. Appropriate supervision of an occupational therapy assistant includes, at a minimum:
   a. The weekly review of the occupational therapy plan and implementation and periodic onsite review by the supervising occupational therapist. The weekly review shall encompass all aspects of occupational therapy services and be completed by telecommunication or onsite.
   b. Documentation of the supervision, which shall include either documentation of direct client care by the supervising occupational therapist, documentation of review of the client's medical and/or treatment record and the occupational therapy services provided by the occupational therapy assistant, or co-signature of the occupational therapy assistant's documentation.
   c. The supervising occupational therapist shall be readily available in person or by telecommunication to the occupational therapy assistant at all times while the occupational therapy assistant is providing occupational therapy services.
   d. The supervising occupational therapist shall provide periodic on-site supervision and observation of client care rendered by the occupational therapy assistant.
   e. The supervising occupational therapist shall at all times be responsible for all occupational therapy services provided by an occupational therapy assistant, a limited permit holder, a student or an aide. The supervising occupational therapist has continuing responsibility to follow the progress of each client, provide direct care to the client, and assure that the occupational therapy assistant, limited permit holder, student or aide do not function autonomously.
   f. The level of supervision for all personnel is determined by the supervising occupational therapist whose responsibility it is to ensure that the amount, degree, and pattern of supervision are consistent with the knowledge, skill and ability of the person being supervised.
   g. Occupational therapy assistants may supervise:
      i. Level I occupational therapy students;
      ii. Level I and Level II occupational therapy assistant students; and
      iii. Aides providing non-client related tasks.

h. The supervising occupational therapist shall determine that the occupational therapy practitioner possesses a current license or permit to practice occupational therapy prior to allowing the person to provide occupational therapy services.

C. **REFERENCE(S):**

1. California Board Of Occupational Therapy Regulations. (2015). *Title 16, Division 39*
2. California Code of Regulations

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 09/91	**SUBJECT: Occupational Therapy**
REVISION DATE~~(S)~~: 01/94, 09/97, 03/00, 01/03, 01/06, 01/09, 03/10, 04/12, 03/16	~~**POLICY NUMBER: 702**~~

Rehabilitation Department Approval:	~~03/18~~08/22
Department of Medicine Chiefs Approval:	01/1908/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~04/19~~11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. **POLICY:**

1. Occupational Therapy is accountable through the Leadership Structure of Rehabilitation Services and the referring physician for maintaining a competent level of practice. The department is also accountable through the appropriate Administrative Executive for carrying out the policies and procedures as approved by the Governing Board.
2. Occupational Therapy Staff reports to the Leadership Structure in fulfilling duties and responsibilities.

B. **PROCEDURE:**

1. Requests For Service
   a. All requests for occupational therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP).
   b. Verbal requests for occupational therapy services will be accepted, but must be followed by a written order.
   c. A new order is required for any change in medical status or treatment ordered.
2. Hours Of Service
   a. Inpatient care: Monday through Sunday, 0800 to 1630 for inpatient care.
   b. Outpatient: Monday through Friday, 0700 to 1630.
   c. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities
   a. Provides occupational therapy evaluations and treatment as prescribed by a licensed physician or AHP.
   b. Administers an assessment of Occupational Performance.
   c. Develops an Intervention Plan for each individual with designated goals based upon the individual's medical condition, assessment and personal goals.
   d. Develops Outcomes and Measures to assess the individual's progress or regression.
   e. Implements the Intervention Plan, utilizing specific activities or methods to develop or restore function, compensate for dysfunction or minimize debilitation.
   f. Engages in Intervention Plan Review, modifying treatment based on established Outcomes and Measures, as clinically indicated and medically necessary.
   g. Treatment may include but is not limited to:
      i. Use of therapeutic tasks and purposeful activities to promote psychological, cognitive, physical, sensory integrative and developmental functioning.
      ii. Facilitate and educate in graded self-care and daily-living tasks, socialization skills, pre-vocation skills, vocational roles, and community reintegration with

regard to patients' privacy and dignity. This may involve instructing in the use of compensatory techniques; selecting, constructing and instructing in the use of adaptive devices, orthoses, and prostheses; ordering appropriate equipment and recommending adaptation of the individual's physical environment to enable optimal function.

iii. Use of exercises and other specific techniques such as those to promote relaxation, restore movement, strength and posture in preparation for functional training.

h. Documents patient treatment and treatment outcomes in patient's legal record per American Occupational Therapy Association/Centers for Medicare and Medicaid Services Guidelines for Documentation of Occupational Therapy.

i. Maintains ongoing reporting and consultative role with appropriate health care professionals regarding patient's current status.

j. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.

k. Demonstrates fiscally responsible decision making including the prudent use of therapy equipment and supplies, and conservation of time and resources in a manner that maintains desired income and expense ratios.

l. Maintains appropriate operational and administrative records, may include but not limited to licensure, certifications, timecards, training records, and billing sheets as per department guidelines.

C. **REFERENCE(S):**

1. American Occupational Therapy Association (2014).Occupational therapy practice framework: Domain and process (3rd ed.).*American Journal of Occupational Therapy, 68*(Suppl.1), S1–S48.http://dx.doi.org/10.5014/ajot.2014.682006
2. Gloria Frolek Clark, M. J. (2013). Guidelines for Documentation of Occupational Therapy. (T. C. 2012, Ed.) *American Journal of Occupational Therapy, 67*(November/December), 32-38.
3. Centers for Medicare & Medicaid Services. (2015, May). *Therapy Services.* Retrieved from www.cms.gov: www.cms.gov/Outpatient_Rehabilitation_Fact_Sheet.ICN905365.pdf
4. Centers for Medicare & Medicaid Services. (2015, May). *Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.* Retrieved from www.cms.gov:

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 05/18	**SUBJECT: Supervision of Patients - Outpatient**
REVISION DATE~~(S)~~:	**~~POLICY NUMBER: 1106~~**
Department Approval:	**~~09/15~~08/22**
Department of Medicine Approval:	**~~n/a~~08/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/18~~09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**~~05/18~~ n/a**
Board of Directors Approval:	**05/18**

A. **POLICY:**
1. All physical, occupational and speech and language pathology evaluations and treatments will be directed and supervised by discipline specific licensed clinical staff.

B. **PROCEDURE:**
1. Licensed clinical staff includes: Physical Therapists (PT), Occupational Therapist, Speech and Language Pathologists and Physical/Occupational Therapy Assistants.
2. Support Staff may include PT Aides and Rehabilitation Aides.
3. Support staff may carry out tasks under the guidance of the Licensed Physical/Occupational Therapists in supporting patient therapy sessions as per the guidelines established by the state and discipline specific regulatory body.

C. **REFERENCE(S):**

1. California Physical Therapy State Practice Act. (n.d.). Physical Therapy Board of California. Retrieved July 7, 2015, from Physical Therapy Board of California Website: http://leginfo.ca.gov/cgi-bin/displaycode?section=bpc&group=02001-03000&file=2620-2634
2. California Board Of Occupational Therapy Regulations. (2015). *Title 16, Division 39 California Code of Regulations.*

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: ~~February 19, 19~~02/92

SUBJECT: Code Adam – Security Department Response Plan for an Infant Abduction

REVIEW DATE~~(S)~~: 04/94, 10/97, 05/03, 11/06, 03/09, 06/11

POLICY NUMBER: 503

REVISION DATE~~(S)~~: 07/03

Department Approval ~~Date(s)~~:	~~08/15~~05/20
Environmental Health and Safety Committee Approval ~~Date(s)~~:	~~09/15~~09/22
Administrative Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~11/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	12/15

A. **PURPOSE:**

1. To establish the protection of infants from unauthorized or illegal removal from the Medical Center by any unauthorized person(s).

B. **POLICY:**

1. It is the policy of the Security Department to immediately implement the following procedures in the event that an infant is illegally removed from the Medical Center by any unauthorized person(s). Reference Administrative Policy #369 Code Adam (Infant Abduction).

C. **PROCEDURE:**

1. In the event of a suspected infant abduction all Security Department personnel will respond and implement the following:
   a. Obtain a complete description of the missing infant.
   b. Obtain a time frame for the abduction
   c. Obtain a complete description of the Abductor(s) and their direction or egress.
   d. Notify the Oceanside Police Department of the abduction and relay all information regarding the abduction.
   e. Offer any requested assistance from the responding Law Enforcement agency.
   f. Follow the Administrative Policy regarding an Infant Abduction.
2. All On-Duty Security Department personnel will report to the following locations to inspect any property or persons that may be the Abductor.
   a. The Security Supervisor, Designee, or Shift Lead Officer will assume the Security Incident Commander position and report to the location of the abduction ensuring that sections C.1. a-f are completed.
   b. A perimeter will be set up to observe all property exits and record the following information:
      i. Vehicle descriptions
      ii. License plate number
      iii. Vehicle occupant descriptions
   c. Security Officers will be available to respond to staff requests of suspicious persons or packages.

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

1. Administrative Policy #369: Code Adam (Infant Abduction)

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE:	~~May 27, 1991~~05/91	**SUBJECT: Code Red – Security Department Fire Response Plan**
REVIEW DATE~~(S)~~:	10/97, 03/00, 08/01, 05/03, 11/06, 03/09, 06/11	**POLICY NUMBER: 504**
REVISION DATE~~(S)~~:	10/97, 08/01, 07/03, 12/15, ~~5/2020~~05/20	
Department Approval ~~Date(s)~~:		~~08/15~~10/20
Environmental Health and Safety Committee Approval ~~Date (s)~~:		~~09/15~~09/22
Administration Approval:		11/22
Professional Affairs Committee Approval ~~Date(s)~~:		~~11/15~~ n/a
Board of Directors Approval ~~Date(s)~~:		12/15

A. **PURPOSE:**
1. To set fourth guidelines for Security Department personnel to utilize when responding to a Medical Center "Code Red" alert

B. **POLICY:**
1. All Security Department personnel will be responsible for the knowledge and proper performance of all Administrative and Security Department mandated duties, activities, and assignments associated with ~~a~~**the** Medical Center "Code Red" activation. Reference Environment of Care Policy #3005 Fire Plan-Code Red.

C. **PROCEDURE:**
1. When notified of a "Code Red" activation, all On-Duty Security Officers will immediately implement the following priority response protocol.
   - a. **The Lead Security Officer is to communicate with all on-duty security officers what their responsibilities and expectations are at the time of notification via two-way radio transmission; the Lead Officer will be in charge of radio transmissions until the situation is clear.**
   - b. **All on-duty security officers, with the exception of the scanner post officer who will receive instructions from the Lead Officer, will respond to the emergency call regardless if posted or on a break and will make certain to bring a fire extinguisher to the reported location.**
   - c. **Upon arrival at the scene, the Lead Officer will assess if a security officer needs to go get a golf cart and await the local Fire Department [responsibility of Plant Enginner to inform F.D.] at the Y intersection at Vista Way. The mobile patrol officer will then escort the F.D. to the specific location of the "Code Red" on property.**
   - d. **The Security Department will assist the "Code Red" response team [Plant / Maintenance Dept. as well as the Environmental Services Dept.] until cleared by the Plant / Maintenance Dept. employee.**
   - ~~a.~~e. **All security officers who respond will notate in their daily reports the details of the "Code Red" regardless if it was a drill or actual.** ~~If there are three or more On-Duty Security Officers, the Security Department will respond in the following manner~~.

~~i. The 1-Post Officer will obtain a fire extinguisher and respond to the location of the reported "Code Red" and assist as needed.~~

~~ii. The 2-Post will respond to the Medical Center entrance at the "Y" and await the arrival of the Fire Department and direct them to the appropriate Medical Center building entrance.~~

~~iii. The 3-Post will respond to the appropriate Medical Center building entrance and await the arrival of the Fire Department and direct them to the location of the "Code Red".~~

~~iv. All additional Security Department personnel will respond to the location of the "Code Red" with a Fire Extinguisher and assist as needed.~~

~~v.~~**i.**

D. **REFERENCE(S):**

1. Environment of Care Policy #3005: Fire Plan-Code Red.

Tri-City Medical Center
Oceanside, California

SECURITY
SAFETY

ISSUE DATE: 06/95

SUBJECT: High-Risk Patient or Visitor

REVIEW DATE~~(S)~~: 07/97, 05/03, 11/06, 03/09, 06/11, 07/15

POLICY NUMBER: 509

REVISION DATE~~(S)~~: 07/97, 07/03, 09/15

Department Approval ~~Date(s)~~:	**07/15**
Environmental Health and Safety Committee Approval ~~Date(s)~~:	**~~08/15~~09/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval ~~Date(s)~~:	**~~09/15~~ n/a**
Board of Directors Approval ~~Date(s)~~:	**09/15**

A. PURPOSE:

1. To identify Patients or Visitors which, due to circumstances, may be a high-risk to the Safety, Security, and Welfare of Medical Center Patients, Visitors, and Staff Members.

B. POLICY:

1. It is the policy of the Tri-City Medical Center Security Department to **immediately** identify any Patient or Visitor, which may place the Safety, Security, and Welfare of Medical Center Patients, Visitors, or Staff Members in jeopardy and to take the appropriate level of intervention.

C. PROCEDURE:

1. When any Tri-City Medical Center Security Officer observes, detects, or is otherwise notified of any Patient or Visitor who has arrived at the Medical Center and who due to certain factors would place Patients, Visitors, or Staff Members at a risk for the potential of harm, the Officer will immediately evaluate the situation.
   a. Examples of high-risk behaviors include but are not limited to anger, aggression, verbal or physical threats or inappropriate response to situation
2. The Security Officer will be responsible for notifying all other Officers of the situation and request the necessary level of assistance to effectively and efficiently control the individual. In addition, the Officer will immediately notify the Security Supervisor and/or Shift Lead Officer.
3. The Security Supervisor or Shift Lead Officer will then notify the appropriate Administrator, Manager, or Administrative Coordinator of the situation and any action taken if necessary.
4. High Risk Patients
   a. To ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members, the primary responding Security Officer will ensure that all Clinical Staff responsible for the patient's care are informed of all available information pertaining to this patient. Any Security Officer who interacts with a high-risk patient will follow the guidelines of Security Department policies pertaining to conflict resolution.
      i. The Security Supervisor or Lead Security Officer will assume the responsibility of Primary Officer if they feel it necessary to intervene.
   b. The primary Security Officer will be responsible for ensuring that the high-risk patient is continually monitored and, if necessary, escorted within the Medical Center.

c. Unless otherwise directed, patient visitation privileges will be restricted to two immediate family members only as per the direction of a Charge Nurse and / or an Administrator.

d. In the event that the high-risk patient is involved in an incident that would adversely jeopardize the Safety, Security, and Welfare of the Patients, Visitors, or Staff Members at Tri-City Medical Center, the patients will be registered into the patient tracking system with a no-information/confidential status.

e. In the event that a large crowd, ten or more individuals, associated with the high-risk patient who is in the Emergency Department, and there is a strong possibility of a disruption of normal operating procedures, the Primary Security Officer will immediately implement the following.

   i. Notify the Oceanside Police Department of the situation and need for assistance if necessary.

   ii. Remove the crowd to the outside triage patio area.

   iii. If necessary, close down the Emergency Department registration area and restrict all access into the patient care area.

      1) Use the North/East Ancillary entrance for access into the Emergency Department via the Registration Hallway.

   iv. Position the CCTV system to record all crowd and parking locations adjacent to the Emergency Department and other areas if necessary.

   v. If Necessary, the primary Officer will utilize the Security Department "Emergency Situation Officer Recall"

5. High Risk Visitor

a. To ensure the Safety, Security, and Welfare of all Patients, Visitors, and Staff Members the primary Security Officer will be responsible for ensuring that any high-risk visitors are continually monitored and evaluated for signs of escalating or disruptive behavior.

b. All Security Officers who interact with high-risk visitors will follow Security Department policies pertaining to conflict resolution. In addition, the Officer will utilize all available Medical Center resources to assist in the successful resolution of the incident.

c. If all proactive efforts are unsuccessful, the high-risk visitor will be advised to exit the Medical Center and advised that if they refuse to comply the Oceanside Police Department will be called for assistance in the removal of the high-risk visitor.

d. The Primary Security Officer will be responsible for ensuring that all departmental documentation is completed and submitted in accordance with Medical Center and Security Department policies.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE: 05/00 **SUBJECT: Psychiatric Patient Escorts**

REVIEW DATE~~(S)~~: 08/01, 07/03, 11/06, 03/09, 6/11, 07/15 **POLICY NUMBER: 216**

REVISION DATE~~(S)~~: 08/01, 06/11, 09/15

Department Approval ~~Date(s)~~:	~~07/15~~10/20
Environmental Health and Safety Committee Approval ~~Date(s)~~:	~~08/15~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~09/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	09/15

A. **PURPOSE:**
1. To establish guidelines for Security Department personnel when conducting escorts for psychiatric patients.

B. **POLICY:**
1. It is the policy of the Security Department to ensure the safety, security, and welfare of all involved parties when conducting an escort of any psychiatric patients upon the Medical Center campus.

C. **PROCEDURE:**
1. Prior to any escorts involving a Psychiatric Patient regardless of voluntary/involuntary status, the Officer must complete a safety search of the patient's belongings to assure no weapons or dangerous items are brought with the patient.
   a. If an item is identified as dangerous, the Officer will take custody of the item and secure it for safe keeping in the locked cabinet in the Emergency Department Security Office.
   b. The item will be inventoried and a receipt will be given to the patient.
   c. Upon the patient's discharge, the item will be returned to the patient.
2. All Security Department escorts involving psychiatric patients shall be conducted with the accompaniment of at least one of the following Medical Center personnel.
   a. Registered Nurse (RN)
   b. Licensed Vocational Nurse (LVN)
   c. Emergency Medical Technician (EMT)
   d. Psychiatric Liaison
   e. Acute Care Technician (ACT)/Nursing Assistant
3. Security Department escorts involving psychiatric patients on a Psychiatric/5150 Hold will be conducted by a minimum of two (2) Security Officers if the escort meets at least one of the following criteria:
   a. Family members or a visitor are present at the time of escort.
   b. The patient has demonstrated or verbalized the desire to elope during his or her contact with Medical Center personnel.
   c. The patient is a danger to self or others.
   d. The Security Officer involved has made the determination that the patient may be a flight risk, or may pose a physical threat

4. Security Department escorts involving psychiatric patients on a Psychiatric /5150 Hold will be conducted by a minimum of one (1) Security Officer if the escort meets at least one of the following criteria.
   a. No family members or visitors are present at the time of escort.
   b. The patient has not demonstrated of verbalized the desire to elope during his or her contact with Medical Center personnel.
   c. The patient is gravely disabled and unable to elope during the escort.
5. Security Department escorts involving psychiatric patients not on a Psychiatric /5150 Hold will require the presence of one (1) Security Officer unless the escort meets one of the following criteria.
   a. The patient is not on a Psychiatric /5150 Hold at the time of the escort, but if the patient attempts to elope he/she may be placed on a Psychiatric /5150 Hold.
   b. The patient has demonstrated or verbalized the desire to elope and at the time of the escort if the patient attempts to elope he/she will be placed on a Psychiatric /5150 Hold.
   c. Medical Center personnel due to the patients' potential of becoming violent or a danger to self or others during the escort request security.
6. Security Department personnel shall be able to react in a quick and professional manner in the event that it is necessary to control a situation that may arise during an escort. To ensure that Security Officer's may safely and quickly react in the event of a situation the following will be followed by all Security Department personnel.
   a. No Security Officer shall be required to push a wheelchair during an escort.
   b. No Security Officer shall be required to carry any large objects that may inhibit him/her from a quick reaction.
   c. If the patient has multiple bags of belongings, the Security Officer shall ask for assistance from another Officer, or another member of Medical Staff.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

~~TRI-CITY MEDICAL CENTER~~	POLICIES AND PROCEDURES
~~Formulation: April 17, 1991~~ ~~Reviewed: 5/94, 1/97, 12/99, 5/03, 11/06, 3/09, 5/13~~ ~~Revision: 1/00, 7/03, 6/11~~ ~~Approvals: Director of Security~~	~~Subject: Security Department Reports~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 111~~

ISSUE DATE: ~~April 17, 1991~~04/91

SUBJECT: Security Department Reports, Documentation, and Information

REVIEW DATE~~(S)~~: 05/94, 01/97, 12/99, 05/03, 11/06, 03/09, 05/13

REVISION DATE~~(S)~~: 01/00, 07/03, 06/11, 02/20~~20~~

Department Approval ~~Date(s)~~: 02/20
Environmental Health and Safety Committee Approval ~~Date (s)~~: 09/22
Administration Approval: 11/22
Professional Affairs Committee Approval ~~Date(s)~~: n/a
Board of Directors Approval ~~Date(s)~~:

A. **PURPOSE:**
1. To set guidelines **and expectations** for the proper completion of all Security Department reports, **documentation, and information**~~.~~

B. **POLICY:**
1. A formal departmental reporting system ~~had been~~ **to** establish~~ed for~~ an internal means of documenting duties and actions by Security Officers~~.~~

C. **PROCEDURE:**
1. **D.S.R. [daily security report]**
   a. ~~Each Shift Officer will initiate a Daily Security Report (DSR) at the beginning of their assigned shift~~**The officer's DSR will be completed by the end of shift unless authorized by the department's leadership [Manager / Director, Supervisor, or Lead] to complete on the next scheduled shift.** This DSR will itemize in chronological order each ~~activity~~**duty**, ~~function, or action~~ **location, duration of the duty, and remarks** which the Officer ~~is~~**was** involved in. **The following notations must be provided in the D.S.R. with details for documentation standards: room numbers or locations, persons involved and their titles / contact numbers, patient interaction [verbal and physical], use of force, contraband, belongings, valuables, and crime / incident report criteria. If the security officer is assisting another officer / not the first on scene, they must still include all details in their own DSR as if they were the primary security officer involved.** Each DSR entry will be clear **and legibly written in capital letters and black ink.**~~, concise, and complete and will include the duty number, location, time initiated, and total time~~

~~involved. It is important to keep in mind that the DSR will be written in a running log format.~~ **DSRs are not to be used in lieu of a crime / incident report unless authorized by the Manager / Director or Supervisor.**

2. **Crime / Incident Reports**
   a. **C.I. reports will be completed within 24 hours of the incident occurring and the final copy within 48 hours unless directed-otherwise by the department's leadership. All fields / boxes must be completely filled-in with applicable information. All known and investigated information will be included in the narrative section utilizing the basic questions [who,what, when, where, why, and how] with full attention to accuracy, consistency, detail, and format. All appropriate attachments are to be included in the report such as photographs, witness statements, maps, copies of personal information [D.L. / insurance], and report-gathering templates. A report will be generated / completed, if deemed necessary, regardless of the level of cooperation from complaintants, involved-persons, and witnesses. Physical descriptions are to be included of all combative persons, injured persons, and suspicious subjects identified.**
3. **Field Notes**
   a. **Field notes are utilized to document pass-down information from shift to shift / person to person as well as the security officer's daily activity before transferring the information to their DSR, C.I. Report, or any other Security Department document. Field notes are to be destroyed at the end of the security officer's shift and after the applicable information is transferred to a S.D. document.**
4. **Enforcement Reports**
   a. **Enforcement reports will be completed with attention to filling out all the boxes and details: patient information, room numbers, 5150 initiation / discontinuation, patient's status, checklist, applicable personnel, and narrative. The narrative will include but is not limited to patient interaction, use of force, belongings' whereabouts, and a synopsis for each major intervention or event.**
5. **Detail or Equipment Logbooks and Daily Lead Checklist**

~~1.~~**6.** **All such logbooks will be updated and completed by the end of the officer's shift. The logbooks include but are not limited to: valuables, lost and found, property custody, weapons scanner, and patients' belongings. Other logbooks could include golf cart maintenance, fire / safety / floor check. The daily leads' checklist will be completed by the end of the lead's shift and is initiated to have the shift goal-oriented. The checklist ensures that the off-going shift has completed basic safety checks and responsibilities to assist the on-coming shift with their operations.**

~~2. All departmental reports, including but not limited to:~~
~~a. Daily Security Report (DSR)~~
~~b. Crime/Incident Report (Cover Page)~~
~~c. Crime/Incident Report (Investigation Page)~~
~~d. Enforcement Report~~
~~e. PTO Request~~
~~f. Unscheduled Absence/Tardy~~
~~g. Witness Statement~~
~~h. Photo Attachment~~
~~i. Video Attachment~~
~~j. All Reports will be completed in the proper format containing all related information to the incident.~~

~~1.~~**7.** All Security Department reports, **documentation, and information** will be treated as privileged **and confidential** information, and no information from any ~~report or a copy of any report~~**category** will be given to anyone **[employee, patient, involved-person, or law enforcement] inquiring.** ~~unless the expressed permission of t~~The Security **Department's Leadership [Manager / Director or** Supervisor**]** ~~or Designee has been given~~ **is only**

authorized to release the information to the Risk Management, Legal, and Human Resources Departments. See all of the attachments / documents of the Security Department notated below, and all non-mentioned reports, documentation, information, or templates' will have their contents protected as well.

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

~~Approved format of Crime/Incident report writing process.~~
~~Attached Report forms.~~

1. **Accident Report Map**
2. **Accident Report Synopsis Page**
3. ~~k.~~ Crime/Incident Report ~~(Cover Page)~~
   a. **Slip/Fall/Injury Information-Gathering Template**~~Crime/Incident Report (Investigation Page)~~
   b. **Theft Information-Gathering Template**
      ~~Traffic Accident (Incident Report)~~
      ~~Traffic Accident Page 2 (Map)~~
   c. **Vehicle Collision Information-Gathering Template**
4. ~~l.~~ Daily Security Report (~~DSR~~**Documentation**)
5. ~~m.~~ Daily Security Report (Map)
   ~~Crime/Incident Report Approved Format.~~
6. ~~n.~~ Enforcement Report
7. **Lead Security Officer's' Shift Checklist**
8. **Lost and Found Logbook**
9. **Passdown Shift Information**
10. **Property Custody**
11. **Valuables Logbook**
12. ~~o.~~ Witness Statement**s**

~~p. Report Continuation Sheet~~
~~Photo Attachment~~
~~Video Attachment~~
~~PTO Request~~
~~Unscheduled Time Off (Absence / Tardiness)~~
~~Continuation Report~~
~~**Weapons Scanner**~~
~~**Patients' Belongings**~~
~~**Consent to Photograph**~~

E. **NON-COMPLIANCE:**

1. Non-Compliance of any part of this policy will lead to disciplinary action up to and or including termination of employment.

Tri-City Medical Center	Distribution: Women and Newborn Services
PROCEDURE:	**CORD GAS COLLECTON**
Purpose:	To outline the process for **umbilical** ~~assisting the physician/ Allied Health Professional (AHP) with~~ cord gas collection at delivery.
Supportive Data:	**Umbilical cord blood acid-base analysis is a quantitative method of determining fetal acid-base balance and oxygenation at the time of cord clamping when umbilical circulation has ceased. A finding of normal umbilical blood gas measurements precludes the presence of acidemia at or immediately before birth and is a more objective measurement, especially in the preterm fetus.** ~~Obtaining a cord gas specimen provides useful information regarding blood pH levels of the neonate at delivery. The intrapartum acid-base status of the fetus is an important component in establishing the link between intrapartum events and neonatal condition. The analysis of cord blood gases from the umbilical artery is believed to be the best representation of the fetal acid-base status immediately before birth.~~
Equipment:	1. Personal protective equipment 2. Disposable umbilical cord clamps, 2 3. Plastic specimen bags, 2 (One must be a Biohazard labeled bag for transport) 4. Newborn's Identification label

A. **PROCEDURE:**

1. Don personal protective equipment.
2. Obtain a section of the umbilical cord from the **delivery provider**~~physician/ AHP~~.
3. If the **provider**~~physician/AHP~~ has not placed a disposable cord clamp at each end of the umbilical cord specimen, then do so at this time.
   ~~a. Remove the surgical clamps from each end of the umbilical cord specimen and replace with the disposable clamps,.~~
4. Place the umbilical cord specimen in first plastic bag with ice, close the bag, and label the outside of the bag with the newborn's identification label.
   a. Write delivery date and time of birth on the label.
      i. Date and time of birth is essential to processing the test within the **recommended** ~~defined 30~~-60 -minute window.
5. Next, put the specimen bag in the second biohazardous ~~labeled plastic~~ bag, in preparation for transport.
6. Call the Neonatal Intensive Care Unit (NICU) Respiratory Care Provider and indicate there is cord gas specimen sample that needs to be retrieved and processed.

~~6. For the process information see the Pulmonary procedure_Umbilical Cord Gas Sampling.~~ **The provider will place an order in the patient's electronic health record (EHR), in the postpartum order set, for the umbilical cord gas (arterial/venous).**

B. RELATED DOCUMENTS:

1. **Pulmonary Procedure: Umbilical Cord Gas Sampling**

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

1. Lyndon, A., **Wisner, K.**~~Usher-Ali, L.~~ (**2021**~~2015~~). *Fetal* ***H****~~h~~eart* ***R****~~r~~ate* ***M****~~m~~onitoring* ***P****~~p~~rinciples and Practice (*6~~5~~th Ed.). **Association of Women's Health, Obstetric and Neonatal Nurses:** ~~Dubuque, IA:~~ Kendall Hunt.
2. Blickstein, Isaac, MD., Clinics in Perinatology, vol 34, Issue 3, 09/2007, *Umbilical Cord Gases*, W.B. Saunders and Company.

Review Revision Date	Division of Neonatology	Department of Pediatrics	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Administration	Board of Directors Approval
03/97, 05/03, 07/09, 01/16, **05/22**	08/16	11/16	01/13, 02/17, **08/22**	n/a	05/13, 03/17, **10/22**	06/13, 04/17, **n/a**	**11/22**	06/13, 04/17

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	**GROUP BETA STREPTOCOCCAL (GBS) PREVENTION AND TREATMENT IN LABOR AND NEWBORN FOLLOW-UP**
Purpose:	To prevent the ~~intrapartal~~ transmission o~~ff early onset~~ GBS disease to newborns, women shall receive universal screening for GBS during their prenatal period. For those found at risk, ~~chemo~~prophylaxis treatment with antibiotic administration when in labor should be initiated on admission and received by the patient greater than or equal to 4 hours prior to delivery. ~~For those with an unknown GBS status (no GBS results documented, culture is incomplete or results are not available) chemoprophylaxis shall be initiated at the onset of labor AND if any of the following intrapartum risk factors are present: Estimated Gestational Age (EGA) is less 37 completed weeks, rupture of membrane history is greater than 18 hours or maternal intrapartum temperature is greater than or equal to 38 C (100.4 F).~~
Supportive Data:	Administration of Intrapartum antibiotics which includes (Penicillin, Ampicillin or Cefazolin) greater than or equal to 4 hours prior to delivery in at risk laboring patients has reduced the rate of perinatal transmission of early onset GBS and other infections among newborns.
Equipment:	Main Intravenous Line Intravenous antibiotic piggy back source and secondary line Infusion pump with medication guardrails

A. **POLICY:**

1. Intrapartum antibiotic prophylaxis (IAP) administration to prevent perinatal transmission is initiated based on these findings:
   a. Positive GBS culture results collected **in** ~~at 35-37 weeks~~ **~~Estimated Gestational Age (EGA) during~~ current**~~this~~ pregnancy
   b. Positive maternal history of an infant born with early onset GBS disease
   c. GBS bacteriuria finding during **current**~~this~~ pregnancy
   d. If culture status is unknown (culture not done, incomplete or results not available) at the onset of labor AND if any of the following risk factors are present:
      i. Premature delivery is anticipated at less than 37 **0/7** weeks EGA
      ii. Rupture of ~~membranes~~**membranes** (ROM) history is greater than 18 hours
      iii. ~~**Isolated** Maternal **oral** intrapartum temperature: is greater than or equal to 38° C (100.4° F) **two times or 39° C (102.2°F) on any one occasion.**~~**Known GBS positive status in a previous pregnancy at provider digression.**
      ~~**Suspected Intrauterine Inflammation, Infection or Both (Suspected Triple I): A fever without a clear source plus any of the following:**~~
         ~~**Baseline fetal tachycardia (greater than 160 bpm for 10 minutes or longer, excluding accelerations, decelerations and periods of marked variability)**~~
         ~~**Maternal White Blood Cell (WBC) count greater than 15,000 per MM^3 in absence of corticosteroids**~~
         ~~**Definite purulent fluid from the cervical os**~~
      ~~**Confirmed Intrauterine Inflammation, Infection or Both (Isolated Maternal oral temperature, Suspected Triple I plus the following) is Confirmed Triple I:**~~
         ~~**Amniocentesis-proven infection through a positive gram stain**~~
         ~~**Low glucose or positive amniotic fluid culture**~~
      ~~iii. **Placental pathology revealing diagnostic features of infections**~~

2. Intrapartum ~~chemo~~prophylaxis is NOT indicated when:

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Admini stration	Board of Directors
05/15	12/15, 12/21	04/22	07/15, 07/22	01/16, 09/22	02/16, n/a	11/22	02/16

a. The patient had a positive GBS during a previous pregnancy (unless colonization status in current pregnancy is unknown at onset of labor at term)
b. A negative GBS culture is obtained within the last five weeks during the current pregnancy.
c. Cesarean birth performed before onset of labor on a woman with intact amniotic membranes, regardless of GBS colonization status or gestational age.
~~2.~~**d. Unknown GBS status at onset of labor and no intrapartum risk factors present (i.e., less than 37 0/7 weeks of gestation, amniotic membrane rupture 18 hours or more, or maternal temperature 100.4°F (38°C) or higher)**
~~a. There is a positive maternal GBS screening culture in a previous pregnancy but no neonatal GBS infection AND a NEGATIVE GBS culture result in the current pregnancy~~
~~b. A planned Cesarean Section is performed in the absence of labor or ROM~~
~~c. NEGATIVE GBS culture in late gestation during the current pregnancy, regardless of intrapartum risk factors.~~

B. **PROCEDURE FOR 37 0/7 WEEKS OR GREATER EGA ADMITTED FOR LABOR/INDUCTION:~~/ ACTIVE LABOR (POSITIVE GBS HISTORY OR UNKNOWN STATUS):~~**

1. Upon admission to Labor and Delivery (L&D), nurse shall verify the patient's GBS status and assess for risk factors as indicated.
   a. If status is unknown, efforts will be made to retrieve results from patient's prenatal record, laboratory service and/or clinic
2. For patient's meeting IAP criteria, the nurse will administer intrapartum antibiotics per provider order.
   a. The goal for prophylaxis is for patient to receive at least one dose of antibiotics greater than or equal to 4 hours prior to her delivery.
   b. Obstetric interventions, when necessary, should not be delayed solely to provide 4 hours of antibiotic administration before birth.
      ~~a.~~**i. Such interventions include but are not limited to administration of oxytocin, artificial rupture of membranes, or planned cesarean birth, with or without pre-cesarean rupture of membranes.**

C. **PROCEDURE FOR THREATENED OR IMMINENT PRETERM DELIVERY LESS THAN 37 0/7 WEEKS EGA WITH~~OUT~~ UNKNOWN GBS STATUS:**

1. Upon admission, obtain a GBS culture per provider order. Usually this is obtained if it appears the patient is unlikely to deliver for 48 hours or more
2. IAP should be initiated until patient delivers or GBS culture results are received. Negative results may indicate IAP discontinuation per provider order.

D. **MONITORING CONSIDERATIONS FOR THE NEWBORN POST DELIVERY:**

1. The nurse caring for the newborn will review the maternal GBS status and whether or not IAP was received **greater**~~more~~ than **or equal to** 4 hours prior to the delivery, if indicated.
2. If IAP was received at or greater than the ~~4 hour~~**4-hour** time period prior to delivery:
   a. Newborn shall receive normal transition care with routine assessment and monitoring.
   b. No lab work is required, unless newborn becomes symptomatic
3. If IAP was NOT received and the newborn is greater than **or equal to 36 0/7 weeks**~~37 weeks~~ EGA with a maternal:
   a. **Rupture of Membranes** (ROM) of less than 18 hours:
      i. Newborn shall have normal transition care and nurse shall initiate Newborn Care Standardized Procedure (SP)
      ii. Newborn may remain with mother for couplet care if asymptomatic
      iii. No lab work is required, unless **the** newborn becomes symptomatic
      iv. Newborn shall remain in the hospital a minimum of **36**~~48~~ hours for close observation **offor** sepsis

b. ROM of greater than 18 hours, **or maternal temperature greater than or equal to 38°C (100.4°F) not meeting criteria for Triple I, or other risk factors for GBS disease:** ~~:~~
   i. Newborn shall have normal transition care and nurse shall initiate Newborn Care SP
   ii. **Laboratory shall** ~~Nurse shall collect a~~**collect** neonatal complete blood count (CBC) with manual differential, **C-Reactive Protein** (CRP) and isolator blood cultures within 6 to 12 hours of age per SP and notify the provider of results
   iii. Newborn may remain with mother for couplet care if asymptomatic and the lab results are reviewed by the provider to be normal values
   iv. Newborn shall remain in the hospital for greater than or equal to 48 hours for observation ~~offer~~ sepsis**, pending negative culture**.

~~4. If IAP was not received and newborn is less than or equal to 37 weeks EGA:~~
   ~~a. Newborn shall have normal transition care and nurse shall initiate **Care of the** Newborn Care SP~~
   ~~b. **Laboratory**Nurse shall collect a neonatal complete blood count (CBC) with manual differential, CRP and isolator blood cultures within 6 to12 hours of age per SP and notify the provider of results~~
   ~~c. Newborn may remain with mother for couplet care if asymptomatic and the lab results are reviewed by the provider to be normal values~~
   ~~d. Newborn **should** shall remain in the hospital for greater than or equal to 48 hours for observation for sepsis.~~

4. If the patient has a **Penicillin (**PCN) allergy and the IAP **received** ~~used~~ was not ~~(~~Penicillin G, Ampicillin or Cefazolin **treatment should be considered not fully adequate in the neonate.** ~~), the newborn is considered UNTREATED because the sensitivity of alternate antibiotics have not been established.~~ Newborn may remain with mother for couplet care if asymptomatic. ~~and the lab results are reviewed by the provider to be normal values.~~ Newborn **should** ~~shall~~ remain in the hospital for **a minimum of** ~~greater than or equal to~~ **36**48 hours for observation ~~offer~~ sepsis.

5. With the diagnosis of Confirmed Triple I the newborn usually requires admission to the Neonatal Intensive Care Unit (NICU) for observation, lab draws, and antibiotic administration.
   ~~5.~~**a. The nurse caring for the newborn shall notify the newborn provider and prepare the newborn for transport to NICU.**

~~E. **MONITORING CONSIDERATIONS FOR NEWBORN WITH MATERNAL CHORIOAMNIONITIS DIAGNOSIS REGARDLESS OF MATERNAL GBS STAUS:**~~
~~1. If a patient is diagnosed with Chorioamnionitis by the Obstetrics (OB) provider, the nurse caring for the newborn must be notified as soon as possible.~~
~~2. Criteria used to diagnosis Chorioamnionitis can present in labor and/or during the post-partum period and includes:~~
   ~~a. Maternal temperature greater than 38 C (100.4F) AND 2 other signs or symptoms:~~
      ~~i. Fetal tachycardia~~
      ~~ii. Maternal tachycardia~~
      ~~iii. Maternal white blood cell (WBC) count greater than 15,000~~
      ~~iv. Uterine tenderness~~
      ~~v. Foul smelling amniotic fluid history~~
~~3. The diagnosis of maternal chorioamnionitis requires the newborn to be admitted to the Neonatal Intensive Care Unit (NICU) for observation, lab draws, and antibiotic administration.~~
   ~~a. The nurse caring for the newborn shall notify the newborn provider and prepare the newborn for transport to the NICU.~~

~~F. **FORMS:**~~
~~1. Intrapartum GBS Prevention and Newborn Follow-up Algorithm~~

~~G.~~E. RELATED DOCUMENT(S)

1. Patient Care Services Care of the Newborn Standardized Procedure
2. WNS Newborn Sepsis Care Guidelines Procedure
3. **Proposed Neonatal Management for Isolated Maternal Fever, Suspected Triple I or Confirmed Triple I**
~~2.~~4. **Features of Isolated Maternal Fever and Triple I with Classification**

~~H.~~F. REFERENCE(S): ~~LIST~~

1. American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). 2017~~2~~. Guidelines for Perinatal Care. **8th Ed.** Washington D.C.
~~1.~~2. **ACOG (2020) Committee Opinion: Number 797. Preventions of Group B Streptococcal Early-Onset Disease in Newborns.**
~~2. AAP Committee Policy Statement (2011). Recommendations for the Prevention of Perinatal Group B Streptococcal (GBS) Disease. Pediatrics (ISSN Numbers: Print 0031-4005)~~
~~3. ACOG (April 2011) Committee Opinion: Number 485. Prevention of Early-Onset Group B Streptococcal Disease in Newborns~~
3. **Baker, C.J. (2018) Up to Date. Neonatal group B streptococcal disease: Prevention**
4. **Puopolo KM, Lynfield R, Cummings JJ, AAP COMMITTEE ON FETUS AND NEWBORN, AAP COMMITTEE ON INFECTIOUS DISEASES. Management of Infants at Risk for Group B Streptococcal Disease. *Pediatrics.* 2019;144(2): e20191881**
~~4.~~5. Schrage. S. et al: Prevention of Perinatal Group B Streptococcal Disease: Revised Guidelines from CDC. MMWR, 2010; 59 (No RR 10): November 19, 2010.
~~5.~~6. ~~Tita, A. T. N. & Andrews, W. W. (2010) Management of Clinical Chorioamnionitis. Clinical Perinatology, 37: 339-354.~~

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE: 02/03	**SUBJECT: Hearing Screening Program: Newborn and Infants**
REVISION DATE: 06/03, 02/07, 02/08, 05/09, 07/09, 04/09, 06/11, 10/13, 6/13, 06/14, 02/18	**POLICY NUMBER: 6385-100**

Department Approval:	~~02/18~~06/22
Department of OB/GYN Approval:	n/a
Perinatal Collaborative Practice Approval:	n/a
Department of Pediatrics Approval	~~05/18~~08/22
Pharmacy & Therapeutics Committee Approval:	n/a
Administration Approval:	11/22
Medical Executive Committee Approval	~~06/18~~09/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. PURPOSE:

1. To identify infants with possible hearing loss, Tri-City Medical Center (TCMC) will provide Newborn Hearing Screening Program services (NHSP) in accordance with:
   a. California Children's Services (CCS) NHSP.
   b. Health & Safety Code 123975.
   c. Article 6.5 (commencing with Section 124115) of Chapter 3, Part 2 of Division 106 of the Health & Safety Code.
2. All newborns and infants who are admitted to Women's and Newborn Services (WNS) at Tri-City Medical Center (TCMC) will have a hearing screen done prior to discharge unless a newborn hearing screening waiver is signed by the parent or guardian. Parents of infants admitted to the Neonatal Intensive Care Unit (NICU) may only waive ~~NHS~~ **screening** for religious reasons.
3. Newborn Hearing Screening **(NHS)** will be available, as needed ~~via pager~~ 24 hours a day/ seven days a week/365 days a year.
4. NHS may be provided by a contract agency.
5. The Department of Health Care Services (DHCS) and NHSP or its designee will be notified
   a. Of any changes in the use of a contract agency.
   b. Of any other changes to the program, including but not limited to the director.
   c. **A hospital designee** ~~The hearing screen coordinator~~ will inform the ~~South Eastern~~ Hearing Coordination Center **(HCC)** regarding **a** change ~~in~~ **to** the program director.

B. STAFF AND PROGRAM:

1. The director for the hearing screen program will be the ~~director~~ **Director** of WNS or ~~the~~ **a** designee, who is a registered nurse employed by Tri-City Medical Center. The director is responsible for the following:
   a. Oversight for the operation and management of the program.
   b. Coordination of all services related to the program.
   c. Staff training and supervision of the individuals performing the screening.
      i. Staff will be selected in accordance with state and regulatory standards.
      ii. Records of staff annual competency validation and training will be maintained ~~in WNS at Tri-City Medical Center.~~ **& accessible through Human Resources.**
   d. ~~Providing weekly, monthly, and annual~~**Ensure** ~~reports~~ **requested by DHCS** ~~regarding the number of infants screened and the number of infants who pass or do not pass the exam~~**are provided timely** ~~.~~

e. **Oversight of** ~~S~~staff, parent, & physician education.
f. ~~Ensure~~ **Ensuring** follow-up for infants requiring referral **is completed**.
g. ~~Ensure~~ **P**participati~~one~~ in**, or send a designee to,** hearing coordination center semi-annual meetings.

2. The medical director of the Neonatal Intensive Care Unit (who is a CCS--paneled Neonatologist) provides medical direction and oversight of the program in collaboration with the director.
3. A CCS-paneled consulting audiologist is available to:
   a. Review and approve, in collaboration with the medical director, the hearing screening program for newborns and infants at TCMC.
   b. Provide ongoing assessment and evaluation of the program at least annually.
   c. Inspect and approve newborn hearing screen equipment.
   d. Review and sign (per an addendum) all policies and procedures.

~~4. The Hearing Screen Coordinator:~~
~~a. Is accountable to the director/designated RN.~~
~~b. Is responsible for the daily operations of the program.~~
~~c. Is the data manager.~~
~~d. Provides screener training and maintains documentation of training at TCMC.~~
~~e. Ensures staff is available to perform testing 24 hours a day, 7 days per week, 365 days per year.~~
~~f. Monitors and orders supplies.~~
~~g. Provides data reports to the director and Infant Data Management Services (IDMS)/designee, monthly, quarterly, and annually as required by the DHCS/NHSP.~~
~~h. Maintains hearing screening logs, checks, reconciles/updates DMS birth log for both the newborn and NICU units.~~

~~5.~~**4.** The hearing screen technicians will:
~~a. Maintain screening log with patient information, correct and legible.~~
~~b.~~**a.** Have had documented training and competency validation in the use of the hearing screening equipment and rationale for the program.
~~c.~~**b.** Provide hearing screening for ~~all screen~~ eligible newborns and infants at ~~Tri-City Medical Center.~~**TCMC.**
~~d.~~**c.** Contact all families of newborns and infants discharged prior to screening and schedule an appointment within four weeks following discharge ~~(if not completed by the coordinator).~~
~~e.~~**d.** Complete all ~~associated paperwork~~**necessary documentation in the electronic health record (EHR); including:** ~~and refer to RN to provide educational materials to parents or provide educational information to parents.~~
   ~~f. Note the following in the patient record:~~
      i. Test type
      ii. Results
      iii. Date
      ~~iv.~~ The Primary Care Provider (PCP) shall obtain written hearing screen results in the infant's medical record.
      ~~v.~~**iv.** ~~Technician's signature.~~
e. Inform RN **of screening results & any questions parents/guardians may have.**
~~g. or physician of any questions parents may have.~~
f. Document all required information on **Infant Data Management Services** (IDMS) website or fax when the website system is down **or per DHCS' specifications**.
g. Provide data reports to the director and IDMS/designee, monthly, quarterly, and/or annually as required by the DHCS/NHSP.
h. Reconciles/updates data entered into IDMS with birth logs for both the newborn and NICU units.
~~h.~~**i. Monitor and order supplies.**

C. STAFF COMPETENCY VALIDATION:

1. The hearing screen ~~coordinator and~~ technician will have documented training and competency validation in:
   a. The use of the hearing screening equipment.
   b. Rationale for the program.
2. Competency shall meet criteria as established by the NHSP and will be conducted annually.
   ~~2.~~**a. Employee's annual competency shall be documented in the employee file and maintained by Tri-City Medical Center.**

~~3. Training will include watching a video, taking an exam, observing a hearing screen and doing a return demonstration successfully in the presence of the instructor.~~

~~4. Additionally, the coordinator will document periodic random checking of technicians performing the test.~~

~~a. Employee's annual competency shall be documented in the employee file and maintained by Tri-City Medical Center.~~

3. Education:
   ~~5.~~**a. Hearing screening technicians may attend semi-annual meeting.**

~~a. Participation in semi-annual meetings with Hearing Coordination Center.~~

~~i. Hearing screening coordinator or designee will attend one semi-annual meeting.~~

~~ii. Hearing screening technicians may attend semi-annual meeting.~~

D. EQUIPMENT:

1. ~~Tri-City Medical Center's~~**TCMC's** newborn hearing screening program is performed using FDA-approved evoked potential testing, ~~(~~screening automated auditory brainstem response (AABR) that detects a mild (30-40 dB) hearing loss in infants and newborns.
2. Use of screening equipment shall be in accordance with the manufacturer's operating literature and stated norms.
3. The equipment performs a probe calibration in each ear prior to each AABR test.
4. The ~~Coordinator/T~~technician will validate calibration prior to each screening. If self-calibration is not complete, testing will not be performed.
5. TCMC**'s** biomedical department will do an initial and annual calibration on all equipment (preventative equipment maintenance) used for the screening.
6. Records regarding validation of preventative equipment maintenance will be maintained in the biomedical department.
7. The director will be notified of completion of the annual validation.
8. The manufacturer of the equipment will also do testing once per year. Tri-City Medical Center's biomedical department will coordinate this equipment calibration and maintain the equipment records.
9. In the event of primary equipment failure, the hearing screen ~~coordinator~~ **technician** will arrange back up equipment from the manufacturer. If the backup/loaner equipment is not available within 24-hours the HCC will be notified of the equipment failure.

~~10. The equipment will be stored in the maternal child health services unit when not in use.~~

E. SUPPLIES:

1. The ~~IDMS~~ **Department of Health Care services** or its designee will approve all brochures and equivalent materials.
2. The Hearing Screen ~~Coordinator~~ **technicians are**~~is~~ responsible for maintaining supplies and for ensuring that all disposables **supplies** are not reused.

F. MEDICAL AND NURSING STAFF EDUCATION:

1. Physician information will be disseminated by the NICU Medical Director to the medical staff by committee meetings and written correspondence.
2. Women's and Newborn Services (WNS) clinical and medical staff providing care for pregnant women and infants shall be in-serviced at a minimum of annually, regarding the newborn hearing screen program.
3. The program director/ designee will maintain minutes of all educational offerings in the WNS department ~~to be provided annually as a minimum~~.

G. PATIENT EDUCATION:

1. The hearing screen program is reviewed during maternity tours and during the admission process.
2. Informational literature specific to the program is placed in admission packets. **The RN will review the information with the parent/guardian and document the education in the EHR.**
3. RN**s** will review "ages and stages" with parents prior to discharge.
4. The hearing screen technician shall inform each parent of the opportunity to have a hearing screen~~,~~ **and** the methodology of administration of the exam.
5. Following the exam the hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen.
6. The hearing screen technician will notify the RN of **all screening results,** ~~any~~ waive**s**~~r~~ or refer**s** and the ~~registered nurse~~**RN** will discuss these with infant's parents. Written material will also be provided.

~~5.~~**7.** The Department of Health**care** Services or it's designee will approve all brochures and equivalent materials.

~~6. Participation in semi-annual meetings with Hearing Coordination Center.~~
~~a. Hearing screening coordinator or designee will attend one semi-annual meeting.~~
~~b. Hearing screening technicians may attend semi-annual meeting~~

H. NEWBORN HEARING SCREENING:

1. Identification of Infants:
   ~~a.~~ Hearing screen staff will review the daily census to identify new infants who have not been screened.
   ~~b. For the infant in NICU, the neonatologist will order the hearing screening when the infant is medically stable and/or age appropriate.~~
   ~~c. Infants transferred out of NICU to another facility will receive a hearing screen prior to transfer, if medically stable.~~
   ~~d.~~**a.** Any transfers to other facilities must be entered into DMS website within 24 hours or faxed when the website system is down.
2. Consent:
   ~~a. The information packets given to parents on the postpartum and NICU contain information about the hearing screening process and is given to the parent/guardian by the registered nurse.~~
   ~~b.~~**a. Parent/guardians c**~~C~~onsent for the hearing test ~~is achieved through~~**when** ~~the~~ signing ~~of~~**the** Conditions of Admission. ~~followed by Admission Orders for Newborn Nursery.~~
   ~~c.~~**b. If the parent/guardian wishes to refuse screening they must sign a waiver form.** ~~Waiver form for refusing screening will be obtained from the parent or guardian of the infant.~~
   ~~d.~~**c.** ~~The waiver needs to be signed by the parent or guardian and then witnessed by RN and screening technician.~~
      i. ~~If the parent/guardian refuses testing, the~~**The RN** ~~registered nurse~~**will provide additional education if the parent/guardian wishes to refuse testing and provide the appropriate brochure from the NHSP.** ~~should further educate the family, and if screening is still refused, the waiver shall be signed.~~
      ii. The RN will notify the pediatrician/neonatologist of the refusal.
      ~~c.~~**iii. The RN will document the refusal in the EHR.**
   ~~f. The waiver form will be documented as part of the infant's medical records.~~
3. Performing the screen:
   ~~3.~~**a. Well newborn hearing screening(s) will take place at the mother's bedside.**
      ~~a. Maternal-child health services:~~
   ~~i. Newborn hearing screening(s) will take place at the mothers bedside if conditions allow or in the newborn hearing screening room.~~
   ~~b. Neonatal intensive care unit:~~

~~i.~~ **NICU** ~~N~~newborn screening(s) will be performed in a quiet environment. ~~and as close to discharge as possible.~~

~~c. A log of all screens performed will be maintained for the newborn nursery and in NICU.~~

~~d.~~**b.** ~~Infants with unilateral atresia and/or microtia shall have test done on the developed ear, then shall be referred to Children's Audiology Clinic for a diagnostic evaluation.~~ Infants with unilateral or bilateral atresia, and/or microtia **will be screened on the developed ear and then** shall be:

i. Referred to Diagnostic services **at a CCS-approved Type C Communication Disorder Center (CDC) location or insurance equivalent** as soon as possible.
ii. Assisted in completing the CCS application form.
iii. Referred to Early start ~~(fax# 1-916-445-4550)~~ utilizing the early start referral form– atresia infants only.

~~e.~~**c.** Infants who do not pass the hearing screen in each ear shall be retested in both ears prior to discharge.

i. The discharge RN will ensure the rescreen is completed prior to discharge. The need for the rescreen will be handed off in report to ensure it is done prior to discharge.

4. Notification of ~~results~~**Results, Documentation & Follow-up**:

a. The hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen.

b. The hearing screen technician will notify the RN of any waivers or refers.

c. ~~A registered nurse~~**An RN** will notify, document and educate the parents of hearing screen results. The ages and stages will be reviewed with parents by RN and **education** documented. The hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen. ~~The registered nurse will be notified by the hearing screen technician of any waiver or refer.~~

d. Appropriate NHSP brochures (pass, refer, waive, or refer to diagnostic) will be given to parent/guardian.

e. If the parent/guardian has additional questions the physician will be notified.

f. All hearing screen result printouts will be maintained in the medical record.

g. If the infant refers, an appointment will be made prior to discharge with an outpatient provider, (i.e. TCMC) to take place within two weeks of discharge and no later than four weeks after discharge.

i. The parent/guardian will be provided the date, time, location and contact number for the follow-up appointment in writing.

~~a. If the infant refers, an appointment will be made with an outpatient provider, (i.e. TCMC) to take place within two weeks of discharge.~~

ii. ~~The registered nurse will notify the infant's parents of the date, time, location, contact number~~ **The RN will educate them regarding the**~~and the~~ importance ~~for~~ **of** follow-up screening.

iii. The follow-up appointment information will be documented in the medical record.

~~b.~~**h.** The following will be obtained on all infants with a "refer" result:

i. Primary contact information – verification of parent/legal guardian address and phone number).
ii. Secondary contact information – obtain name/address/phone number for an additional person not living with the family if possible.
iii. PCP
~~iii.~~**iv.** The parent/legal guardian shall be provided with a contact number for the newborn hearing screen program, and shall be instructed to inform the hearing screen coordinator/technician for:
1) Changes in contact phone number and/or address
~~1)~~**2) The need to reschedule appointment**
~~2) The need to reschedule appointment~~

~~c. Appropriate NHSP brochures (pass, refer, waive, or refer to diagnostic) will be given to parent.~~

~~d. The registered nurse will forward any questions they cannot answer to the physician.~~

~~e. All hearing screen result printouts will be maintained in the medical record.~~

i. The newborn's primary care provider **(PCP)** will **have access to the electronic medical record to review results. The PCP will** ~~be~~ **also be** informed of screening waivers, missed ~~tests~~**screenings**, ~~passes~~ or refers by mail. **The PCP will be informed of necessary follow-up at the time of results notification.**

i. Notification of refers, a missed screening, or waive of screening will be included in the newborn record.

~~f. Notification of pass, refer, or waiver of hearing tests is included in the newborn record.~~

~~g. The hearing screen technician will write the date, time, and location of the follow-up screen appointments (if needed). Notification will be sent to the primary care provider from the coordinator within one week of any infants that REFER, including any required follow-up.~~

~~h. Infants who do not pass the hearing screen in each ear shall be retested in both ears prior to discharge.~~

~~i. The discharge RN will ensure the rescreen is completed prior to discharge. The need for the rescreen will be handed off in report to ensure it is done prior to discharge.~~

~~i. Infants with unilateral or bilateral atresia, and/or microtia shall be:~~

~~i. Referred to Diagnostic services as soon as possible.~~

~~ii. Assisted in completing the CCS application form.~~

~~iii. Referred to Early start (fax# 1-916-445-4550) utilizing the early start referral form– atresia infants only.~~

~~j. If the infant refers, an appointment will be made with an outpatient provider, (i.e. TCMC) to take place within two weeks of discharge.~~

~~k. The hearing screen technician will schedule the referral appointment prior to the infant's discharge. The appointment will be within two weeks of discharge if possible and no later than four weeks after discharge. Parents will be given written information regarding appointment date/time/location/contact number. Document parent's receipt of appointment information in the medical record.~~

~~l. The following will be obtained on all infants with a "refer" result:~~

~~i. Primary contact information – verification of parent/legal guardian address and phone number).~~

~~ii. Secondary contact information – obtain name/address/phone number for an additional person not living with the family if possible.~~

~~iii. The parent/legal guardian shall be provided with a contact number for the newborn hearing screen program, and shall be instructed to inform the hearing screen coordinator/technician for:~~

~~1) Changes in contact phone number and/or address~~

~~2) The need to reschedule appointment~~

~~m. The primary care provider will be notified of the re-screening provider and appointment time. Information will be documented in the medical record for missed screens.~~

j. If a screen is missed:

i. It should be documented in the EHR.

ii. An outpatient appointment should be scheduled to be completed within four weeks of discharge. The appointment date and time should be documented in the medical record.

~~n.~~**iii.** ~~Scheduling a hearing screen for infants who are missed is done by the~~**The** hearing screen ~~coordinator/ technician~~**technician will make** ~~by~~ at least three good faith attempts via the following **to schedule missed screenings** and recorded **the attempted contacts** in the medical records:

~~i.~~**1)** Telephone call

~~ii.~~**2)** Registered letter written to the family of missed event

~~iii.~~**3)** Letter to the Primary Care Physician about the missed event and follow up information.

~~e. Outpatient Provider (i.e. TCMC) or Type C CDC Provider will be notified of inpatient results and special needs (i.e. monolingual).~~

I. **Special Considerations – NICU Patients~~NEONATAL INTENSIVE CARE UNIT~~:**

1. All infants admitted or transferred into the NICU shall have an Automated Auditory Brainstem Response (AABR) hearing screen when the infant's medical condition warrants and as close to discharge as possible.
2. Infants transferred from mother baby unit to the NICU shall be screened in the NICU prior to discharge- whether or not they have been previously screened.
3. If the infant does not pass the initial screening in each ear, the infant shall be re-screened in both ears prior to discharge.
4. Validity of hearing screening results is limited to 7 days. The infant needs to be re-screened prior to discharge if hospitalization continues greater than 7 days after the most recent screen.
5. Any infants six months corrected age or older at time of discharge shall be scheduled for a ~~C Communicative Disorders Center (C CDC)~~ diagnostic evaluation at a type C CDC.
6. Infants transferred from the NICU to another facility will receive a hearing screen prior to transfer, if medically stable. If the infant/newborn is transferred before being medically stable (screenable), newborn hearing screening shall be included in the plan of care on the transfer record.
   a. **Any infants transferred to another facility must be entered into the DMS website within 24 hours (or faxed if the system is down).**
   ~~6. Any transfers to other facilities must be entered into DMS website within 24 hours or faxed when the website system is down.~~
7. Infants transferred back to TCMC NICU from another the facility will have ~~the~~ **a** hearing screen ~~as close to discharge as possible.~~**prior to discharge.**
8. If a NICU infant refers, the hearing screen ~~coordinator or~~ technician will:

~~9. Schedule an appointment with an outpatient provider (i.e. TCMC) within 2-4 weeks of discharge or:~~

   a. ~~According to the Neonatologist orders: schedule~~ **Schedule** an outpatient re-screen~~,~~ or schedule a diagnostic evaluation with a CCS-approved Type C Communication Disorders Center **based on neonatologist's orders**~~.~~
   ~~b. Schedule the appointment as soon as possible after discharge.~~
   ~~c. The follow up appointment date, time, and location shall be documented in the patient's medical record and IDMS website.~~
   b. For infants with orders to follow up with ~~A~~ **a** CCS-approved Type C CDC or equivalent facility approved by the infant's insurance, assist families in completing a CCS application, complete request for services, and a copy of screen results shall be documented in the medical record, sent to the C CDC audiologist and sent to the appropriate CCS office. Family will be provided with written information regarding the referral or an appointment date/time/location if obtained.
   ~~d.~~**c. Communicate any special needs of the family to the Type C CDC provider.**

J. **REPORTING AND DATA MANAGEMENT:**

1. The hospital, as a certified inpatient and outpatient infant hearing screening provider shall report to the IDMS or its designee, data on all infants receiving neonatal services in a format and frequency specified by IDMS.
   a. ~~The hearing screen coordinator shall:~~**The hearing screen technicians shall:**
   ~~a. Oversee program for accuracy, including results for infants receiving newborn hearing screening services in the Mother/Baby Unit and the NICU.~~
   b. ~~All infants screened will be compared to all admissions to the unit. Validation of hearing~~**Validate** ~~screening will be compared to~~**all** TCMC deliveries **and outside admissions are screened and the data entered is complete and accurate.**
   ~~b. for completeness and accuracy of data.~~

c. Review, reconcile and update DMS. Verify~~ication that infant reporting that are entered into DMS for the following infants~~**the following infants are entered into the IDMS**:
   i. Infants who pass screening
   ii. Infants who did not pass screening.
   iii. Infants who did not receive screening.
   iv. Parents who waived screening
   v. Infants transferred to another facility.
   vi. Expired infants.
   vii. Infants with Atresia and/or microtia, Bilateral or Unilateral
   viii. Screening not medically indicated (NMI) determined by a physician.

~~viii.~~**d. Provide the Hearing Coordination Center with the total number of live births by the 10th day of the month.**

~~d. Transmitting a monthly report to the South Eastern Hearing Coordination Center (SECHCC) in the DHCS approved format that includes the following (for both WNS and NICU acuity) no later than the 10th day after the ending month:~~

   ~~i. The total number of infants who left the NICU during the reporting month.~~
   ~~ii. The total number of live births during the reporting month.~~
   ~~iii. The total number of infants screened.~~
   ~~iv. The total number of infants who pass the inpatient screen.~~
   ~~v. The total number of infants who refer.~~
   ~~vi. The total number of infants who expire.~~
   ~~vii. The total number of waives.~~
   ~~viii. The total number of NMI.~~
   ~~ix. The total number of missed.~~

~~e. Data uploads and archival storage~~
   ~~i. Will be managed by medical records Hearing screening results and data will be entered by technician.~~
   ~~ii. Hearing screening backup and archived data will be stored in appropriate manner as determined by Tri-City Healthcare District policy and the director of medical records.~~

~~f. Data purge~~
   ~~i. Data will be purged annually from the Screening device (in accordance with the manufacturer's instructions).~~

K. QUALITY ASSURANCE:

~~1. The hearing screen program director/designee, medical director, and hearing screen program coordinator will meet at least semi-annually.~~
~~2. Director/designee, medical director, or hearing screen program coordinator will participate in semi-annual meetings with the Hearing Coordination Center.~~
~~3. Nursing, hearing screen technicians and medical staff will have newborn hearing education at least once per year.~~
~~4. The coordinator will provide quality assurance, with reports submitted to the director.~~
~~5.~~**1.** The ~~coordinator and~~ director will monitor quarterly screening rates, with target goals being:
   a. A minimum of 98% of newborns born in the hospital are provided hearing screening prior to discharge.
   b. 100% of NICU infants receive a hearing screen prior to discharge.
   c. ~~Expected refer rate less than or equal to5% and greater than and equal to 1%.~~ **There is no greater than a 5% refer rate and no less than a 1% refer rate.**
   d. Corrective measures if targets are not achieved, as evaluated by the director, include the following:
      i. Checking equipment/recalibration.
      ii. Observing screener's ~~-~~**competency**~~by the Coordinator~~.
      iii. Checking compliance with policies and procedures.

L. REFERENCE(S):

1. American Academy of Pediatrics/ACOG. (~~2012~~2017). Guidelines for Perinatal Care, ~~7~~th-8th Edition.
2. California Children's Services Standards Chapter 335, statutes of 2006
3. California Health and Safety Code, Section 123975
4. Joint Committee on Infant Hearing (2007). Year 2007 Position Statement; Principles and Guidelines for Early Detection and Intervention Programs.
5. Department of Health Care Services (2008) AB 2651 amended Section 124116.5.
6. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.1. Revision September 2016

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

ISSUE DATE:	**10/94**	**SUBJECT:**	**Neonatal Delivery Room Attendance**
REVISION DATE~~(S)~~:	**01/00, 06/03, 03/06, 09/09, 04/10, 06/13, 02/17, 06/19**		

Women and Newborn Services Department Approval:	**~~06/18~~07/22**
Department of OB/GYN Approval:	**~~02/19~~08/22**
Perinatal Collaborative Practice Approval:	**~~04/19~~08/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~05/19~~10/22**
Administration Approval:	**~~06/19~~11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**06/19**

A. **DEFINITIONS:**
1. The Neonatal Intensive Care Unit (NICU) resuscitation team consists of:
   a. The Neonatologist ~~or Allied Health Professional (AHP)~~
   b. NICU Registered Nurse (RN)
   c. Respiratory Care Practitioner (RCP)
   d. Additional personnel, including other RNs may be included depending on the maternal/neonatal condition.

B. **PURPOSE:**
1. To provide guidelines for neonatal delivery attendance for both vaginal and cesarean section deliveries.

C. **POLICY:**
1. At every delivery there will be at least one RN whose primary responsibility is the newborn and who is skilled to initiate resuscitation per the Neonatal Resuscitation Program (NRP) guidelines. The RN will initiate the steps of the NRP algorithm, as appropriate until the NICU resuscitation team arrives. In cases of multiple births, one RN is present for each newborn.
2. A multidisciplinary NICU resuscitation team is immediately available at all times to perform a complete resuscitation, including endotracheal intubation, use of medications and intravenous line placement.
3. ~~Verbal Situation, Background, Assessment, Recommendation (SBAR) communication of maternal history and risk factors will be provided by the delivery RN to the attending neonatal team.~~**L& D personnel will communicate the following information to the team.**
   a. Neonatal Resuscitation Program (NRP) 8th Edition "Four pre-birth questions"
      i. Gestational Age
      ii. Amniotic fluid color
      iii. Additional risk factors
      iv. Umbilical cord management plan
   ~~3.~~b. Any other pertinent maternal/neonatal medical history
4. In unforeseen emergencies, the designated NICU team will be notified to respond immediately. This emergency response is triggered by dialing 66 and activating ~~a Code Caleb~~**Team NICU**.
   ~~4.~~i. Refer to Team NICU Response Plan ~~Please refer to the Code Caleb Standardized Procedure.~~

D. **TRANSITION RN ATTENDANCE AT DELIVERIES**

1. Spontaneous Vaginal Delivery
   a. The transition registered nurse (RN) will attend all low-risk, spontaneous vaginal deliveries.
   b. Vaginal deliveries with identified risk factors (as listed below) will require the NICU resuscitation team.
2. Cesarean Section
   a. The transition RN and the RCP will attend the scheduled low-risk cesarean section deliveries.
   b. The transition RN and RCP will attend the unscheduled low risk cesarean section deliveries. Neonatologist will be available as needed.
   c. Cesarean sections with risk factors will be attended by the NICU resuscitation team

E. **NICU RESUSCITATION TEAM ATTENDANCE AT DELIVERIES:**

1. The team will be alerted before delivery for the following risk factors:
   a. Anticipated delivery of less than 36 weeks gestation or ≥ 42 weeks gestation
   b. Fetal heart rate patterns suggesting hypoxia (Category III and some Category II patterns)
   c. Placental abnormalities (e.g. placenta previa, vasa previa, abruption)
   d. Fetal anomalies, if it is suspected that resuscitative measures may be needed (e.g. pulmonary hypoplasia, diaphragmatic hernia)
   e. Multiple gestations
   f. Emergency cesarean delivery or general anesthesia
   g. Operative vaginal delivery (e.g. vacuum assist, forceps)
   h. Prolapse of the umbilical cord
   i. Suspected hydrops
   j. Macrosomic fetus and/or potential for shoulder dystocia
2. The maternal primary care provider/Obstetrician/Anesthesiologist ~~OR~~ **or** delivery RN may request the presence of the NICU resuscitation team at any delivery.

F. **DELIVERY ATTENDANCE RESPONSIBILITIES:**

1. An infant warmer with all supplies for a neonatal resuscitation should be available in the delivery room.
2. The labor and delivery (L&D) RN ~~has the primary~~**is** ~~responsibility~~ **responsible** for **ensuring all** ~~having the~~ neonatal resuscitation supplies **are** available **in the delivery room (including an infant warmer)** and checked for function ~~in the delivery room~~**prior to delivery**. Transition RN additionally verifies supply availability and function if time allows prior to delivery.
3. ~~When the request for neonatal attendance at delivery is made, the following information shall be communicated to the transition and/or NICU RN, as available:~~
   a. ~~Whether the infant(s) already delivered~~
   b. ~~Expected gestational age~~
   c. ~~Color of the amniotic fluid~~
   d. ~~How many babies are expected~~
   e. ~~Any risk factors~~
   f. ~~Location of the delivery~~
4. ~~3.~~ **Prior to delivery,** ~~T~~the appropriate neonatal team is ~~then~~ assembled based on ~~the~~ perinatal risk factors.
5. ~~The L&D RN shall provide sufficient time for the transition RN or NICU RN to arrive and check equipment as possible.~~
6. ~~4.~~ Upon arrival for the delivery, the transition RN or NICU resuscitation team shall identify themselves to the L&D team and patient/family, as the situation allows.
7. ~~5.~~ The RN or MD~~/AHP~~ is responsible for assigning and documenting the newborn's APGAR scores.

~~8.~~**6.** The transition RN or NICU RN shall ~~receive~~ **retrieve** the newborn identification bands ~~from the L&D RN~~ and place them on the baby **per the Newborn Identification Banding & Electronic Alarm Device Procedure.**~~.~~

~~9.~~**7.** ~~The transition RN or~~ NICU RN will report off to the ~~L&D~~**transition** RN **or designee** prior to leaving the birthing area.

~~10.~~**8.** At no time will a newborn be left without an RN designated to provide care for him/her.

~~11. NICU Resuscitation Team:~~

~~a. The NICU resuscitation team shall be identified at the start of each shift.~~

~~b.~~**9.** The L&D charge RN will communicate with the NICU charge RN throughout the shift to ensure the team is alerted to patients that may require the presence of the NICU resuscitation team at delivery.

~~c. Management of the NICU resuscitation team shall belong to the neonatologist/AHP, and includes coordination, performance, and delegation of activities.~~

~~d. In the event of multiple births (i.e. twins, triplets), the neonatologist/AHP should verify that adequate resources are available to provide adequate and complete resuscitation of each infant.~~

~~e. The Neonatologist/AHP will ensure that there is communication with the parents about the infant's condition.~~

~~12.~~**10.** Cesarean section considerations:

a. It is required that the neonatal team (the transition RN or NICU RN and RCP) be present for the surgical time out process to ensure immediate availability for the delivery.

b. The RN/Neonatologist~~/AHP~~ will receive the infant **via sterile technique** from the Obstetrician **and** ~~. This will require the RN/Neonatologist/AHP to don a sterile gown, sterile gloves, and the use of a sterile drape to receive the infant from the surgical field. Once the infant is received, the RN/Neonatologist/AHP will~~ bring the newborn to the infant warmer/high care bed for initial evaluation and stabilization.

c. Maternal newborn skin-to-skin in the operating room may be initiated, providing the neonate and mother are stable.

G. **DOCUMENTATION:**

1. Documentation of all assessments and interventions shall be completed in the Electronic Health Record by the RN ~~and/or licensed professional~~ performing the interventions/assessments.
2. The documentation shall include:
   a. The time the transition RN and/or NICU team arrived.
   b. What interventions were performed.
   c. The condition of the infant and response to interventions.
   d. Use of the Neonatal Resuscitation Record, if indicated.

H. ~~REFERENCE(S)~~**RELATED DOCUMENT(S)**:

1. **Patient Care Services Procedure: Newborn Identification Banding & Electronic Alarm Device**
2. **Patient Care Services Policy: Team NICU Response Plan**

~~H.~~**I.** **REFERENCE(S):**

1. American Heart Association and American Academy of Pediatrics (2016). Neonatal Resuscitation Textbook: 7th Ed. Washington, D.C., Library of Congress.
2. American Academy of Pediatrics (2010). Special Report- Neonatal resuscitation: 2010 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. Pediatrics, 126 (5), 1400-1411.
~~2.~~**3.** **Weiner, G.M. (Ed). (2021). *Textbook of neonatal resuscitation (8th ed.).* American Academy of Pediatrics.**
~~3. Besuner, P. (2007). Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN): Templates for Protocols and Procedures for Maternity Services (2nd Edition). Washington, DC~~

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	~~NEWBORN HEARING SCREENING: INPATIENT AND OUTPATIENT HEARING SCREENING OF NEWBORN AND INFANTS USING BIOLOGIC EQUIPMENT~~
Purpose:	~~To establish a process to offer and provide newborn hearing screenings to all newborns during their birth admission or infants admitted to the Neonatal Intensive Care Unit~~
Supportive Data:	~~Hearing problems are typically not detected until a child normally learns speech, at two or three years of age. Detecting hearing problems at birth may help prevent the occurrence of developmental and social problems later in childhood if the hearing problems are not detected in a timely fashion. Newborn and infa~~ ~~3 per 1,000 births. Fifty percent of infants with~~ ~~Infants can be fitted with hearing aids as early~~
Equipment:	~~Biologic Abaer Screening Unit~~ ~~Disposable ear tips~~ ~~Electrodes for Automated Auditory Brainstem~~

Delete- covered in Hearing Screening Program: Newborn & Infants & Manufacturer's guidelines for equipment use

A. ~~**PRE-PROCEDURE:**~~

1. ~~Select an infant appropriate for screening. Infants sh~~
   a. ~~The hearing screener will review the postpar~~ ~~screened.~~
   b. ~~Infants who are preparing for discharge from~~ ~~will be identified in interdisciplinary rounds. T~~ ~~forwarded by the NICU charge nurse to the hearing screener to be scheduled for a hearing screen when medically stable and prior to discharge.~~

B. ~~**DEFINITIONS:**~~

1. ~~**AABR** = Automated auditory brainstem response.~~

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

1. ~~Plug electrical cord of machine into dedicated outlet.~~
2. ~~Turn system on properly.~~
3. ~~Log onto the system.~~
4. ~~Enter patient information on the SCREENING HOME screen for the patient about to be screened, including type of screen being performed.~~
   a. ~~Enter all required newborn patient information.~~
   b. ~~Note risk factors that may be important to have on the test report.~~
5. ~~Place disposable ear tip on ear probe and insert in infant's ear. This is required for (AABR) screening. Ear muffins may be used for the AABR test.~~
   a. ~~Proper insertion and fitting of the ear probe is required for the acquisition of valid data.~~
   b. ~~Guidelines for placing the ear probe:~~
      i. ~~Check that the disposable tip is completely onto the probe.~~
      ii. ~~The disposable tip should be inserted snugly, but not completely into the ear canal.~~
      iii. ~~The end of the disposable ear tip should not be kinked or pressed against the ear canal wall.~~
      iv. ~~If the disposable tip is too small for the ear canal, select a larger size to ensure a snug fit.~~
   c. ~~Conducting an AABR:~~
      i. ~~Apply electrodes and plug electrodes into electrode yoke:~~

Departme nt Review	Department of OB/GYN	Perinatal Collaborati ve	Department of Pediatrics	Pharmacy & Therapeutic s Committee	Medical Executive Committee	Administra tion	Professional Affairs Committee	Board of Directors Approval
7/03, 10/06, 6/07, 5/08; 6/09, 6/11, 02/18	n/a	n/a	12/13, 05/18	n/a	05/13, 05/14, 06/18, 09/22	11/22	06/13, 06/14, 07/18, n/a	06/13, 06/14, 07/18

1) Ear muffins:
a) Blue (nape of neck)
b) White (forehead)
c) Red (shoulder)

ii. Ear probes:
1) Blue (behind left ear)
2) White (forehead)
3) Red (behind right ear)

6. Press "accept" button and identify which ear is to be screened.
a. The screening will begin when all protocols are in place
b. Click PAUSE to temporarily pause screening. Click PAUSE again to resume screening.
c. Click STOP to discontinue screening if necessary
i. The operator will have the option to print patient reports or letters
7. Repeat steps 4 through 6 on the other ear.
8. If the screening needs to be repeated, follow steps 4 through 6.

D. **POST-PROCEDURE:**
1. Remove ear probe from infant. Discard disposable tip and place probe in designated location .
2. Print hearing screening results.
a. Make additional copies of the hearing screening results and give to:
i. Infant's health care provider – to be mailed out monthly.
ii. Infant's parents
3. Chart placement of results.
a. Inpatients:
i. Place hearing screening results in infant's hospital chart.
b. Outpatients:
i. Place results of screening in the medical record's out box.
4. Turn system off properly.
a. Select EXIT in the top right hand corner of the Abaer program screen.
b. Select START in the lower left hand corner of the Windows main desktop.
c. Select SHUT DOWN from the start menu.
d. Select SHUT DOWN, click OK and wait until the Windows message indicates that it is safe to turn the system off.
e. Turn the power off via the power mains (refer to the operator manual).
5. If the infant receives a PASS:
a. The RN shall inform the parents that the infant passed the screening.
b. The hearing screener may inform the parents that the infant passed the screening using scripted language.
6. If the infant receives a REFER:
a. The hearing screener should re-screen the infant.
i. This should be done within several hours of the original screening.
b. If the infant still received a REFER, the infant will be scheduled to return to Tri-City Medical Center or a certified California Newborn Hearing Screening Outpatient Provider within four weeks of discharge for an outpatient newborn hearing screening.

E. **PARENTAL/CAREGIVER NOTIFICATION OF RESULTS:**
1. Notification of results
a. A registered nurse will notify the parents of hearing screen results. The hearing screen technician may provide scripted information to parents if their infant successfully passes the hearing screen. The hearing screen technician will notify the registered nurse of any waiver or refer and the registered nurse will notify the infant's parents of the date, time, and location or follow up screen and the need for follow up. Written material will also be provided. All brochures and equivalent materials will be approved by the department of health care services or its designee.

F. **DOCUMENTATION, TRI-CITY MEDICAL CENTER: ALL HEARING SCREENING RESULTS WILL BE MAINTAINED IN THE MEDICAL RECORD:**

1. Consent/waiver for declination of hearing screening in the infant's chart.
   a. If the parent(s) decline the screening, they are to be given the waiver of newborn hearing screening brochure, and sign the verification that they have waived the hearing screening.
2. Printed hearing screening results are distributed as follows:
   a. Infant's chart
   b. Infant's parents
   c. Infant's health care provider
3. Infants who PASS
   a. The parents are given a hearing screening pass brochure with the following information entered by the hearing screener:
      i. Infant's name
      ii. Date of screening
      iii. Type of screening (ABR) circled
4. Infants who REFER
   a. Well babies:
      i. The parents are given a hearing screening refer brochure with the following information entered by the hearing screener:
         1) Infant's name
         2) Appointment date and time
         3) Appointment location
         4) Appointment contact phone number
   b. NICU babies:
      i. The parents are given a hearing screening refer brochure or diagnostic hearing evaluation referral brochure (if determined by physician) with the following information entered by the hearing screener:
         1) Infant's name
         2) Appointment date and time
         3) Appointment location
         4) Appointment contact number
5. Scheduling of infants who refer:
   a. The hearing screen coordinator/technician will schedule outpatient refer appointments prior to the infant's discharge or provide follow-up information.

G. **DOCUMENTATION REQUIREMENTS, STATE OF CALIFORNIA:**

1. Completion of the DMS Data Entry (or fax when the website system is down) is required for the following circumstances:
   a. Passed results
   b. Refer results
   c. Transferred in house (e.g. NICU) or intra-facility transfers (e.g. infant is transferred to Children's Hospital)
   d. Discharged missed
   e. Waived
   f. Expired or not medically indicated (NMI) for screening per physician determination.

H. **REFERENCE(S):**

1. California Children's Services Manual of Procedures, Chapter 3 – Provider Standards, Infant Hearing Screening Services, 3.42.1. September 2016.
2. California Children's Services Standards Chapter 335, statues of 2006

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**NEWBORN HEARING SCREENING: STATE OF CALIFORNIA REPORTING**
Purpose:	To outline the procedure required for transmitting Newborn Hearing Screening Program information to the designated State of California Hearing Coordination Center
Supportive Data:	Section 124119 California Health and Safety Code
Equipment:	Newborn Hearing Screening Monthly and Weekly Report Neonatal Intensive Care Unit (NICU) Newborn Hearing Screening Monthly and Weekly Report Infant Reporting Form (IRF) Infant Record Information Form (IRIF) Outpatient Reporting Form (ORF)

Delete- covered in Hearing Screening Program: Newborn & Infants

A. **PROCEDURE:**

1. Newborn Hearing Screening Monthly And Weekly Report
   a. Newborn Hearing Screening data is reported daily to the Department of Health Care Services (DHCS) website according to the b
      system is down.
      i. Include all supportive documentation
         1) Any transfers must be entere
            receiving hospital:
         2) Any outpatient screens:
            a) Completed Infant Outp
         3) Outpatient Diagnostic Refers,
            a) CCS Request for Service Form
            b) CCS Application for Eligibility Form
   b. Weekly Reporting
      i. Check the live births entered into the Infant Data Management Services (IDMS) (or faxed when the website system was down) from the previous week, compare with the labor and delivery log, and ensure entry of all required demographics of live births into the IDMS (or faxed when the website system was down).
   c. Monthly Reporting
      i. Check the IDMS birth log (or the faxes if the website system was down) for the previous month, and ensure matching of live birth count obtained from TCMC Birth Log and the number of infants entered into the IDMS (or faxed when the website system was down). Reconcile/update if necessary.
      ii. The completed Newborn Hearing Screening Monthly Report is to be faxed to the designated Hearing Coordination Center no later than the 10th day of the month following the reporting month.
2. NICU Newborn Hearing Screening Monthly And Weekly Report/Fax Transmittal
   a. NICU Newborn Hearing Screening data is reported daily (or faxed when the website system is down) to the IDMS website, baby's information is entered after screening but prior to discharge.
      i. Include all supportive documentation:
         1) Any transfers must be entered within 24 hours of transfer, noting the receiving hospital:
         2) Any outpatient screens:
            a) Completed Infant Outpatient Reporting Form (ORF)
         3) Outpatient Diagnostic Referrals, Atresia or Microtia:

Review/Revision Date	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
7/03, 10/06, 05/08 6/09, 7/09, 6/11, 02/14, 02/18	n/a	n/a	8/07, 6/09, 12/13, 05/18, **08/22**	n/a	06/18, **09/22**	**11/22**	06/13, 06/14, 07/18, **n/a**	9/07, 6/09, 6/13, 06/14, 07/18

a) CCS Request for Service Form
b) CCS Application for Eligibility Form

b. Weekly Reporting
i. Check the live births entered into the IDMS (or faxed when the website system is down) from the previous week, compare with the labor and delivery log, and ensure entry of all required demographics of live births into the IDMS (or faxed when the website system is down)

c. Monthly Reporting
i. Check the IDMS birth log (or faxed when the website system is down) for the previous month, and ensure matching of live birth count obtained from TCMC Birth Log and the number of infants entered into the IDMS (or faxed when the website system is down). Reconcile/update if necessary.
ii. The completed NICU Newborn Hearing Screening Monthly Report is to be faxed to the designated Hearing Coordination Center no later than the 10th day of the month following the reporting month.
iii.

3. Faxing of these documents will be done according to Tri-City Hospital District Administrative Policy, *Faxing of Protected Health Information*.

B. **REFERENCE(S):**

1. Department of Health Services. September 2016. California Children's Services Manual of Procedures. Sacramento: Author.
2. Department of Health Services. (04/09) NHSP Reporting Requirements Reminder. Sacramento: Luis Rico, Acting Chief
3.1. Tri-City Hospital District Administrative Policy, *Faxing of Protected Health Information*.

Tri-City Medical Center	Distribution: Women's and Newborn's Services
PROCEDURE:	**OXYTOCIN ADMINISTRATION~~PITOCIN ADMINISTRATION FOR INDUCTION/ AUGMENTATION OF LABOR~~**
Purpose:	**To promote safe and effective use of oxytocin for induction and augmentation of labor. Induction refers to the use of methods to begin labor in a woman who is not spontaneously laboring. ~~To achieve a labor pattern that produces progressive cervical dilation, while ensuring fetal and maternal safety.~~ Augmentation refers to use of methods to restart or strengthen labor after it has spontaneously begun. ~~Induction refers to the use of methods to begin labor in a woman who is not spontaneously laboring.~~ ~~To promote safe and effective use of oxytocin, and to outline the nursing management of the patient requiring continuous oxytocin infusion for induction or augmentation of labor. This procedure is to be implemented for all patients undergoing induction/augmentation of labor.~~**
Supportive Data:	**To outline a standardized approach at Tri-City Medical Center for the administration and management of oxytocin for labor induction and augmentation.** ~~Induction is defined as the stimulation of labor by artificial means. Oxytocin is the drug used in the medical induction of labor and is also used to augment existing contraction patterns that may not be adequate for progression of labor to include trial of labor after Cesarean candidates.~~
Equipment:	~~1. Pre-mixed, labeled Normal Saline solution with Oxytocin 20 units, 1000 mL bag (Pyxis)~~ **1) ~~2.~~ Pre-mixed, Oxytocin 30 units/500mL Normal Saline~~Lactated Ringer~~'s, IV solution bag** **2) Intravenous** (IV) administration tubing (~~Portless~~**Port less tubing**~~device~~ is recommended) ~~IV 3. Needleless access device~~ **3)** ~~5. Alaris~~ Infusion pump **4)** ~~6.~~ Color-coded Oxytocin I~~L~~abels for ~~labeling pump and~~ **IV** tubing

A. ~~POLICY STATEMENT:~~

~~The decision to augment or induce labor with oxytocin should be made by a woman and her physician or Certified Nurse Midwife (CNM) after a discussion of risks, benefits, and options.~~

1. **The registered nurse (RN) will verify that the provider has discussed the indications and potential risks and benefits of induction or augmentation of labor with the use of oxytocin with the patient, and that her verbal consent is documented in the medical record.**

~~A signed consent form must be in the medical record.~~

~~Prenatal records should be available.~~

~~1. Responsibility for the decision to use oxytocin requires a provider order.~~

2. **The ~~provider~~physician or CNM will document the followings in the Electronic Health Record (EHR)~~e medical record~~:** ~~Provider or RN must evaluate patient immediately prior to administration of oxytocin:~~
   - ~~2.~~a. **History and Physical (H&P)**
   - b. **Fetal presentation**
     - i. **Cephalic presentation must be determined and documented by vaginal exam, Leopold's Maneuvers, and/or ultrasound on the day of induction.**
   - c. **Pelvis is adequate for vaginal delivery**
     - i. **May be documented on prenatal record**
     - ii. **A previous vaginal delivery indicates a proven pelvis**

Review/Revision Date	Department of OB/GYN	Departemtn of Pediatrics	Pharmacy and Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
06/94; 06/96; 04/00; 03/03; 05/09, 06/13, 05/14, 03/22	06/09, 07/13, 04/14, 06/22	n/a	01/15, 07/22	02/15, 10/22	11/22	03/15, n/a	06/03; 07/09; 03/15

d. Indication for induction~~n or augmentation~~
   i. May be documented on prenatal record
e. Estimated fetal weight is less than 5000 grams (less than 4500 grams in a diabetic woman)
   i. May be determined by Leopold's Maneuvers and/or ultrasound
   ii. May be documented on prenatal record

~~a. Cervical status, including dilation, effacement, station~~
~~b. Fetal presentation~~
~~c. FHR assessment~~
~~d. Uterine activity~~
~~e. Indication for oxytocin use~~

3. Prenatal records are available or requested from the provider/clinic.
   a. Prenatal records must be available for scheduled inductions prior to the start of oxytocin.
4. An order for oxytocin must be in the EHR ~~medical record~~ prior to the start of oxytocin.

~~The provider or RN must perform the following immediately prior to the initiation of an oxytocin infusion:~~
~~Cervical examination, including Bishop score~~
~~Fetal assessment:~~
~~A minimum of 30 minutes of fetal monitoring is required prior to starting oxytocin~~
~~A reassuring tracing is obtained or a BPP of 8/10 is present within the past 4 hours, or moderate variability~~
~~No late decelerations in the last 30 minutes~~
~~No more than 2 variable decelerations exceeding 60 seconds and decreasing greater than 60 bpm within the previous 30 minutes prior to starting Pitocin infusion~~

5. An o~~O~~bstetrician (OB) ~~able to perform an~~with privileges to perform a ~~emergency~~ cesarean section must be readily available.
6. The RN will verify and document in the EHR that all items mentioned above have been completed for a scheduled induction prior to starting oxytocin.
~~3.~~7. The oxytocin infusion is titrated by the RN based on provider orders and the maternal fetal response to the medication as indicated in the procedure below.

B. INDICATIONS AND CONTRAINDICATIONS:

1. A scheduled induction prior to~~before~~ 39 0/7 completed weeks of gestation must have a medical indication, such as: ~~Indications for induction may include the following:~~
   a. Abruptio placentae
   ~~a.~~b. Chorioamnionitis
   ~~b.~~c. Fetal demise
   d. ~~Pregnancy-induced~~Gestational hypertension
   ~~c.~~e. Preeclampsia, eclampsia
   ~~d.~~f. Premature rupture of membranes
   g. Maternal medical conditions (e.g. diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
   h. Fetal compromise (e.g. severe fetal growth restriction, isoimmunization, oligohydramnios)

~~e. Postterm pregnancy~~
~~f. Fetal compromise:~~
~~i. Oligohydramnios~~
~~ii. Severe fetal growth restriction~~
~~iii. Isoimmunization~~
~~iv. APrevious stillbirth~~
~~g. Preeclampsia or eclampsia~~

~~h. Maternal medical condition:~~
~~i. Diabetes mellitus~~
~~ii. Renal disease~~
~~iii. Chronic pulmonary disease~~
~~iv. Chronic hypertension~~
~~i. **NOTE:** Distance from hospital and history of short labor are not considered medical indications.~~ ~~Logistics:~~
~~i. History of rapid labor.~~
~~ii. Distance from the hospital.~~
~~iii.~~**i.** ~~Psychosocial indication~~

~~2. Induction may be considered, but necessitate special precautions, on a case-by-case basis for the following conditions:~~
~~a. One or two previous low transverse cesarean delivery~~
~~b. Maternal heart disease~~
~~c. Multifetal pregnancy~~
~~d. Polyhydramnios~~
~~e. Presenting part above the pelvic inlet~~
~~f. Severe hypertension~~
~~g. Abnormal fetal heart rate patterns not necessitating emergent delivery~~

~~3.~~**2.** Contraindications **to augmentation or induction include, but are not limited to**:
a. Vasa previa
b. Complete placenta previa
c. Non-vertex presentation (viable fetus)
d. Umbilical cord ~~prolapsed~~**presentation**
e. Prior classical uterine incision
f. Active genital herpes infection
~~d.~~**g. Previous myomectomy entering the endometrial cavity**
~~e. Previous invasive transfundal (upper segment) uterine surgery~~
~~f. Known lateral extension of the uterine incision following cesarean delivery~~
~~g. Other maternal or fetal condition for which spontaneous labor and vaginal delivery is contraindicated~~

3. Conditions that are not contraindications to augmentation or induction, but may require special attention include, but are not limited to:
a. Previous cesarean birth, or history of a prior uterine scar
i. Continuous fetal monitoring required
ii. Use the lowest dose of oxytocin required to achieve adequate labor progress
iii. Oxytocin titration cannot exceed 20mU/min
b. Category II fetal heart rate patterns
c. Maternal heart disease
d. Multifetal pregnancy
e. Polyhydramnios
f. Presenting part above the pelvic inlet
g. Severe hypertension

C. **PROCEDURE**:
1. Follow the routine admission procedure to Labor and Delivery (LD) unit. ~~**Patient is admitted to labor and delivery.**~~
~~**Complete Pre-Induction Oxytocin Safety Checklist**~~
2. Explain procedure to patient and support person.
3. The provider or RN must perform and document the following within 30 minutes prior to the initiation of an oxytocin infusion:
a. Cervical examination, including Bishop score
b. Fetal assessment:

i. A minimum of 30 minutes of fetal monitoring meeting the following requirements:
   1) A reassuring tracing is obtained or a BPP of 8/10 is present within the past 4 hours, or moderate variability in the absence of accelerations
   2) No late decelerations in the last 30 minutes
   3) No more than 2 variable decelerations exceeding 60 seconds and decreasing greater than 60 bpm within the previous 30 minutes prior to starting Pitocin infusion

~~Apply fetal monitor and observe the fetal tracing. Patient must have a reactive non-stress test prior to oxytocin administration.~~
~~Perform vaginal exam as indicated.~~
~~Cephalic presentation must be determined and documented by vaginal exam, Leopold's Maneuvers, and/or ultrasound.~~
~~The Bishops score is documented by the RN~~
~~Start mainline IV as ordered.~~
~~Set up IV infusion pump with _____.~~

4. Piggyback oxytocin infusion into mainline IV using the port closest to the injection site.
   a. An infusion pump is used for titration.
   b. Label the oxytocin IV ~~bag, IV~~ tubing as it enters the infusion pump, and the IV tubing site closest to the injection site. Do not place a label on the pump/channel.
5. Begin the oxytocin infusion at 2mU/min. ~~at 1 mU/min~~
6. Titrate~~Increase~~ oxytocin infusion at a rate of 1-2mU/min every 15 or 30 minutes, per provider order~~by 1-2 mU/min no sooner than every 30 minutes~~ until labor is adequate, a max dose of 20mU/min is reached or an indication to decrease or discontinue oxytocin is indicated.
   a. Adequate labor process is defined as:
      i. Uterine contractions every 2-3 minutes and lasting 45-60 seconds
      ii. Montevideo units (MVU) 250-300 mm Hg in a 10-minute window.
      iii. When labor process is adequate, maintain oxytocin infusion at current rate
   b. The RN may administer to a max dose of 30mU/min if the provider has assessed the patient, placed an IUPC, reviewed the FHT/UC pattern and an order has been placed in the EMR.~~.~~
   c. Indications to decrease or discontinue oxytocin include but are not limited to tachysystole, fetal status is indeterminate or fetal status is abnormal.
      i. Provide interventions as described in the Fetal Heart Rate Surveillance/Monitoring procedure whenever warranted.
      ii. Use the tachysystole algorithm (Attachment 1) to guide interventions when oxytocin induced tachysystole occurs.
   d. Resume oxytocin titration per the following:
      i. If oxytocin has been discontinued for less than 30 minutes, the FHR is normal and contraction frequency, intensity and duration are normal resume oxytocin titration at no more than half the rate when discontinued.
      ii. If oxytocin has been discontinued for more than 30 minutes, resume oxytocin at the initial dose ordered when the FHR is normal and contraction frequency, intensity and duration are normal.

~~When labor process is adequate, Mmaintain oxytocin infusion at current rate or decrease rate when Adequate labor process is adequatedefined as.:~~
~~Uterine contractions every 2-3 minutes and lasting 45-60 seconds~~
~~Montevideo units (MVU) 250-300 mm Hg in a 10 minute window.~~
~~Notify physician or CNM when the maximum dosage of 20 mU/min is reached.~~

7. Continuous fetal monitoring is maintained during oxytocin administration.
   a. Assess ~~and document~~ the fetal monitoring tracing when oxytocin dosage is increased or decreased, every ~~30~~15 minutes during the latent and active stage ~~if~~

~~the dose is unchanged~~, and every ~~5-15~~ minutes during the active pushing phase of the second stage of labor.

b. Document the fetal monitoring tracing when oxytocin dosage is increased or decreased, every 30 minutes during the latent and active stage, and every 5-15 minutes during the active pushing phase of the second stage of labor.

~~Provide interventions as described in the Fetal Heart Rate (FHR) Surveillance/Monitoring policy whenever warranted.~~

8. If an intra uterine pressure catheter (IUPC) is in place, MVU must be less than 300 mmHg, and the resting tone must be less than 25 mmHg.

~~Use the Tachysystole algorithm (attached) to guide interventions when Tachysystole occurs.~~

9. The RN may discontinue the oxytocin infusion at any time ~~without a physician order,~~ based on fetal heart tracing or uterine contraction patterns.

a. The~~NOTE: Patient's~~ provider will be notified after interventions to resolve the clinical situation. ~~is notified when oxytocin is discontinued.~~

~~1. The L&D RN shall:~~

~~a. Verify provider order for administration of oxytocin for induction/augmentation of labor.~~

~~b. Assist the patient to a position of comfort, preferably the left or right lateral position,to increase uterine perfusion~~

~~c. Perform Maternal-Fetal assessment:~~

~~i. Maternal Assessment:~~

~~1) Assess baseline maternal temperature, pulse, respirations, and blood pressure.~~

~~2) In the absence of ruptured membranes assess cervical status to include: dilatation, effacement, station, consistency and position of cervix prior to beginning infusion.~~

~~3) Assess uterine activity, including palpation of contraction(s).~~

~~d. Perform Fetal Assessment per Fetal Heart Rate Surveillance Policy:~~

~~i. Review 30 minute reassuring fetal heart rate tracing, Category I.~~

~~ii. Confirmation of vertex presentation and fetal position.~~

~~iii. Notify provider if the fetal heart rate tracing interpretation is a category II or III.~~

~~e. Assemble equipment:~~

~~i. This procedure requires a patent intravenous line.~~

~~ii. Premixed oxytocin solution contains 20 Units in 1000 mL of Normal Saline solution.~~

~~f. Clearly label the following with color-coded labels:~~

~~i. IV Oxytocin/Pitocin bag~~

~~ii. IV tubingat the point as it enters the infusion pump~~

~~iii. IV tubing at the point it enters the IV port.~~

~~2. Induction/Augmentation of labor:~~

~~a. Begin infusion at 0.5 milliunits/min to 2 milliunits/minute per provider order.~~

~~b. Titrate dosage by 1 milliunit/minevery 30 minutes or per provider order until adequate contraction pattern to achieve progress of labor. (Pitocin may not be titrated in less than 15 minute intervals.see titrating medication below in 2d)~~

~~c. Administration of oxytocin exceeding 20 milliunits/min requires provider assessment and a provider order.~~

~~d. Titrating Medication: Adequate progress of labor and/or uterine activity is defined as:~~

~~i. Three to five (3-5) contractions in a 10 minute period with a maximum, not to exceed 5 contractions in a 10 minute period (tachysystole) .~~

~~ii. Contraction duration of 40--90 seconds.~~

~~iii. Moderate to strong contraction intensity by palpation with adequate resting tone by palpation.~~

~~iv. If using an Intrauterine Pressure Catheter (IUPC) an amplitude of at least 50 mm/Hg above the resting tone is desired. The resting tone shall be less than 20 mm/Hg.~~

~~3. Nursing assessment:~~

~~a. Continuous electronic fetal monitoring shall be maintained when oxytocin is used.~~

~~b. The fetal heart rate and uterine contraction pattern should be evaluated and documented at the start of the oxytocin infusion, after any rate increase or decrease and every 30 minutes during maintenance. (See Fetal Heart Rate Surveillance Policy)~~

~~i.~~

~~c. Monitor the patient per intrapartum standards of care and for the following complications:~~

~~i. Uterine Tachysystole~~

~~1) Defined as > 5 contractions in a 10 minute window averaged over 30 minutes~~

~~ii. Uterine Rupture~~

~~iii. Non-Reassuring Fetal Status. Category II, progressing to a Category III or a Category III Tracing.~~

~~iv. Water Intoxication~~

~~v. Cord Prolapse~~

~~vi. Precipitous Labor~~

~~d. Assess for signs of uterine rupture:~~

~~i. Fetal Heart Rate with Category II progressing to III or category III tracing and/or a prolonged deceleration.~~

~~ii. Uterine tachysystole OR complete loss of uterine activity~~

~~1)~~

~~iii. Abdominal pain and rigidity~~

~~iv. Hypotension, tachycardia~~

~~v. Vaginal bleeding~~

~~vi. Loss of fetal station~~

~~vii. Mis-shaped abdominal wall/ increased fundal height~~

~~e. Assess for signs and symptoms of water intoxication:~~

~~i. Headache.~~

~~ii. Nausea and vomiting.~~

~~iii. "Feeling sick".~~

~~iv. Mental confusion.~~

~~v. Decreased urinary output (< 30 cc per hour and/or less than 120 per 4 hour interval)~~

~~vi. Hypotension.~~

~~vii. Tachycardia.~~

~~viii. Heart rate irregularities.~~

~~ix. Abnormal lung sounds:~~

~~x. Rales~~

~~4. Decrease Oxytocin per provider order for:~~

~~a. Uterine Tachysystol~~

~~b. Contractions lasting 2 minutes or more~~

~~c. Contractions of normal duration occurring within 1 minute of each other~~

~~d. Insufficient return of uterine resting tone between contractions via palpation OR if IUPC resting tone pressure is greater than 25 mmHg~~

~~e.~~

~~5. Discontinue oxytocin per provider order and notify provider for any of the following:~~

~~a. Category II progressing to Category III and/or Category III fetal heart rate findings.~~

~~b. Prolonged FHR deceleration~~

~~c. Uterine tachysystole with FHR changes~~

~~d. Suspected uterine rupture.~~

~~e. Suspected water intoxication.~~

~~f. RN is not available to evaluate the effects of oxytocin at least every 30 minutes.~~

~~6. Intervention considerations for oxytocin induced tachysystole per provider orders:~~

~~a. For uterine tachysystole episodes with FHR Category I tracing:~~

~~i. Maternal repositioning~~

~~ii. Give IV fluid bolus of 500 mL of Lactated Ringers Solution~~

~~iii. If uterine activity is not within normal limits after 10 minutes, may decrease oxytocin rate by half~~

~~iv. If uterine activity continues to evidence tachysystole after the rate was halved, discontinue oxytocin until uterine activity is less than 5 contractions in 10 minutes.~~

~~b. For uterine tachysystole episodes with FHR Category II:~~

~~i. Decrease oxytocin rate by half~~

~~ii. Maternal Repositioning~~

~~iii. Give IV fluid bolus of 500 mL of Lactated Ringers Solution~~

~~iv. Consider oxygen at 10L/min via non rebreather mask if the first interventions trialed did not resolve the indeterminate tracing~~

~~v. If uterine activity remains in a tachysystole pattern, discontinue the oxytocin and notify the provider of the actions taken and patient/ FHR response.~~

~~c. For uterine tachysystole with FHR Category III:~~

~~i. Discontinue oxytocin infusion~~

~~ii. Maternal repositioning~~

~~iii. Give IV fluid bolus of 500 mL of Lactated Ringers Solution~~

~~iv. Give oxygen at 10 L/min via non rebreather facemask~~

~~v. If no uterine contraction response, ready 0.25 mg terbutaline for subcutaneous administration per provider order~~

~~d. The oxytocin infusion may be restarted per provider order:~~

~~i. If Pitocin is off less than 30 minutes, restart Pitocin at one half (1/2) the discontinued rate~~

~~ii. If Pitocin is off greater than 30 minutes, restart Pitocin at the original start rate order rate.~~

D. **DOCUMENTATION:**

1. Document initial and subsequent maternal vital signs, and fetal heart rate status in the Electronic ~~Medical~~ **Health** Record (~~EMR~~**EHR**).
2. Document abnormal maternal and fetal assessments, including all interventions in the ~~EMR~~**EHR**
3. Document adverse events associated with ~~this infusion~~**oxytocin in**~~on~~ the ~~patient~~ ~~EMR~~**EHR**
4. Document infusion rate and times of dosage changes **in**~~on~~ the ~~patient~~ ~~EMR~~**EHR**.

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

1. **WNS Procedure: Fetal Heart Rate (FHR) Surveillance/Monitoring**
2. **WNS Procedure: Elective Delivery**
3. ~~4.~~**Standards of Care: Intrapartum**

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

1. AAP & ACOG. (2017~~2~~). Guidelines for Perinatal Care, ~~8~~7thEdition.
2. ~~1.~~**ACOG Practice Bulletin: 107: Induction of Labor. August 2009 (Reaffirmed 2019).**

~~2. American Congress of Obstetrics and Gynecology (ACOG) (2010)). Vaginal Birth after previous Cesarean Delivery, ACOG Practice Bulletin. Number 554. Washington, DC~~

~~3. Besuner, P. AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition (2007)~~

~~4. Gilbert, E.S. and Harmon, J.S. (2008), Manual of High Risk Pregnancy and Delivery (4th Ed.), Mosby.~~

~~5. Kennedy, B.B, Ruth, D.J., Martin, E.J. (2009) Intrapartum Management Modules (3rd Ed.) Lippincott Williams and Wilkins.~~

~~6.~~**3.** Macones, G.A., Hankins, G.D.V., Spong, C.Y., Hauth, J., Moore, T. (2008). The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring: Update on Definitions, Interpretation, and Research Guidelines. JOGNN, Principles & Practice, 37, 510-515. Retrieved from http://jognn.awhonn.org.

4. Simpson, K. R. (20**20**~~08~~). *Cervical Ripening & Induction & Augmentation of Labor*, **5th** ~~3rd~~ Edition.

5. Simpson, K. R., & Creehan, P. A. (20**21**~~08~~). AWHONN's perinatal nursing, ~~.~~**5th Ed.** ~~Philadelphia, PA: Wolters Kluwer / Lippincott Williams & Wilkins.~~

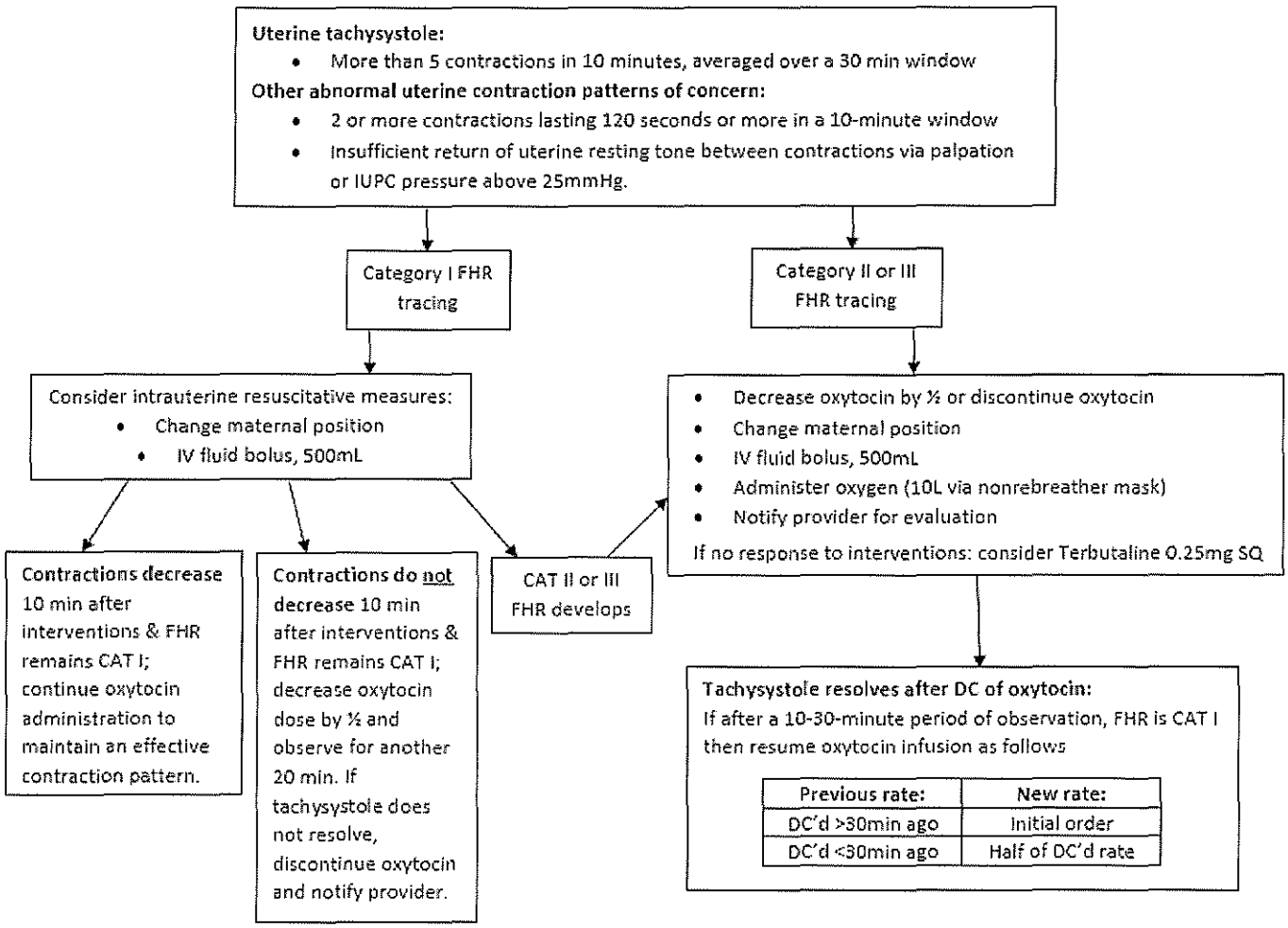
~~7.~~**6. Troiano, N.H, Witcher, P.M, McMurtry Baird, S. (2019). AWHONN's High-Risk & Critical Care Obstetrics, 4th Ed.**

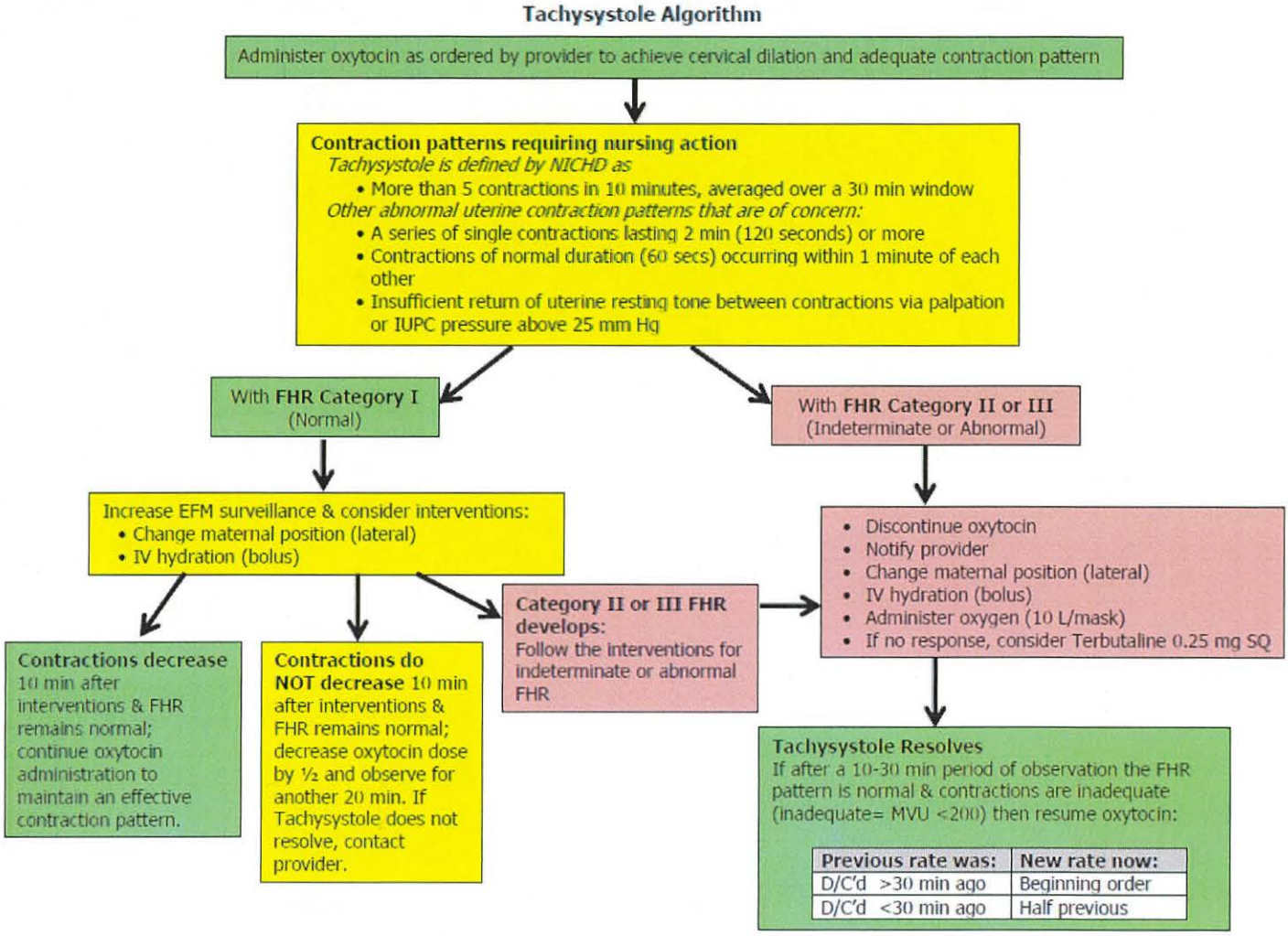
~~8. Wing, D.A. (2008) Induction of labor in women with prior cesarean delivery. Retrieved from www.uptodate.com 4/06/09.~~

~~9. Wing, D.A. (2008) Induction of labor. Retrieved from www.uptodate.com 4/06/09.~~

Attachment 1:~~**Related Document**~~

Oxytocin Induced Tachysystole Algorithm




Tachysystole Algorithm
Administer oxytocin as ordered by provider to achieve cervical dilation and adequate contraction pattern
Contraction patterns requiring nursing action
Tachysystole is defined by NICHD as
• More than 5 contractions in 10 minutes, averaged over a 30 min window
Other abnormal uterine contraction patterns that are of concern:
• A series of single contractions lasting 2 min (120 seconds) or more
• Contractions of normal duration (60 secs) occurring within 1 minute of each other
• Insufficient return of uterine resting tone between contractions via palpation or IUPC pressure above 25 mm Hg
With FHR Category I (Normal)
With FHR Category II or III (Indeterminate or Abnormal)
Increase EFM surveillance & consider interventions:
• Change maternal position (lateral)
• IV hydration (bolus)
• Discontinue oxytocin
• Notify provider
• Change maternal position (lateral)
• IV hydration (bolus)
• Administer oxygen (10 L/mask)
• If no response, consider Terbutaline 0.25 mg SQ
Contractions decrease 10 min after interventions & FHR remains normal; continue oxytocin administration to maintain an effective contraction pattern.
Contractions do NOT decrease 10 min after interventions & FHR remains normal; decrease oxytocin dose by ½ and observe for another 20 min. If Tachysystole does not resolve, contact provider.
Category II or III FHR develops:
Follow the interventions for indeterminate or abnormal FHR
Tachysystole Resolves
If after a 10-30 min period of observation the FHR pattern is normal & contractions are inadequate (inadequate= MVU <200) then resume oxytocin:
Previous rate was: | New rate now:
D/C'd >30 min ago | Beginning order
D/C'd <30 min ago | Half previous

Tri-City Medical Center	Women and Newborn Services
PROCEDURE:	**HYPERTENSION IN PREGNANCY~~PREECLAMPSIA CARE~~ GUIDELINES**
Purpose:	**To outline the nursing management of inpatients who have a hypertensive disorder of pregnancy, including special considerations of patients on antihypertensive medications and those diagnosed with severe preeclampsia or preeclampsia without severe features.** ~~tTo outline the nursing management of inpatients who have preeclampsia including special considerations for the management of patients~~ **~~having a hypertensive emergency~~** ~~requiring~~ **~~urgent~~** ~~antihypertensive medications~~**~~, Magnesium Sulfate for seizure prophylaxis~~**~~, and management of eclampsia~~**~~, utilizing the California Maternal Quality Care Collaborative (CMQCC) order set recommendations.~~**
Supportive Data:	**Hypertensive disorders of pregnancy constitute one of the leading causes of maternal and perinatal mortality worldwide. Preeclampsia is a disorder of pregnancy associated with new-onset hypertension, which occurs most often after 20 weeks of gestation and frequently near term. Postpartum hypertension and preeclampsia are either persistent or exacerbated hypertension in women with previous hypertensive disorders of pregnancy or a new-onset condition.**~~Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage which may impact the cardiovascular, renal, hematological, neurological, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology~~**~~, but multiple theories exist~~** ~~. Preeclampsia is characterized by new onset of hypertension and proteinuria after 20 weeks gestation in a previously normotensive woman~~**~~, and can present as late as 4-6 weeks postpartum and in most cases the blood pressure returns to baseline by 12 weeks postpartum..~~**
~~Issue Date:~~	~~06/14~~

A. **DEFINITION:**

1. **P**~~p~~reeclampsia without severe features ~~(mild)~~:
   - a. **Blood Pressure (BP):**
     - i. **Systolic blood pressure (SBP) of 140mmHg or more or diastolic blood pressure (DBP) of 90mmHg or more on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure. Or**
     - ii. **SBP of 160mmHg or more or DBP of 110mmHg or more.**
   - b. **AND Proteinuria:**
     - i. **300mg or more per 24-hour urine collection or**
     - ii. **Protein/creatinine ratio of 0.3 or more or**
     - iii. **Dipstick reading of 2+ (used only if other quantitative methods not available).**
   - c. **In the absence of proteinuria, new-onset hypertension with the new-onset of any of the following:**
     - i. **Thrombocytopenia: Platelet count less than $100x10^9$ /L**
     - ii. **Renal insufficiency: Serum creatinine concentrations greater than 1.1mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease**
     - iii. **Impaired liver function: Elevated blood concentrations of liver transaminases to twice normal concentration**
     - iv. **Pulmonary edema**

Department Review	Department of OB/GYN	Department of Pediatrics	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/22~~12/14~~	12/14, 04/22, 06/22	n/a	12/15, 07/22	02/16, 10/22	11/22	03/~~16~~1, n/a	03/16

~~1.~~v. **New-onset headache unresponsive to medication and not accounted for by alternative diagnoses or visual symptoms.**

~~Hypertension (HTN): Blood pressure (BP) greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart in a woman with a previously normal BP.~~

~~**May be asymptomatic.**~~

~~a. **In most cases the blood pressure will return to baseline by 12 weeks postpartum.**~~

~~b. Completed a minimum of 20 weeks gestation~~ AND

~~c. Proteinuria:~~

~~i. Greater than 300 mg protein per 24 hr. urine collection~~

~~ii. Protein/Creatinine ratio greater than or equal to 0.3 mg/dl~~

~~iii. Dipstick r~~**R**~~eading of (1+) protein (used only if other quantitative methods unavailable)~~

~~d. In the absence of proteinuria if the patient has new onset HTN~~ and ~~new onset of any of the following:~~

~~i. Platelet count less than 100,000/microliter~~

~~ii. Serum creatinine concentration greater than1.1mg/dl or a doubling of the serum creatinine in the absence of other renal disease.~~

~~iii. Elevated blood concentrations of liver transaminases to twice normal concentration~~

~~iv. Pulmonary edema~~

~~v. Cerebral or visual symptoms~~

2. **Preeclampsia with severe features:**~~SEVERE PREECLAMPSIA:~~
   a. **SBP of 160mmHg or more, or DBP of 110mmHg or more on two occasions at least 4 hours apart (unless antihypertensive therapy is initiated before this time)**
   b. **Thrombocytopenia (platelet count less than 100x10⁹/L)**
   c. **Impaired liver function that is not accounted for by alternative diagnoses and as indicated by abnormally elevated blood concentrations of liver enzymes (to more than twice the upper limit normal concentrations). Or by severe persistent right upper quadrant or epigastric pain unresponsive to medications**
   d. **Renal insufficiency (serum creatinine concentration more than 1.1mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease)**
   e. **Pulmonary edema**
   f. **New-onset headache unresponsive to medication and not accounted for by alternative diagnoses**
   ~~2.~~g. **Visual disturbances**

~~BP of 160 mm Hg systolic or higher or 110 mm Hg diastolic or higher~~ on two occasions at least 4 hours apart while patient is on bed rest. (Hypertension can be confirmed within a short interval (**10-30** minutes) to facilitate timely antihypertensive therapy.

~~**Administer the medication as soon as possible with the goal of 30-60 minutes from the time of confirmed hypertension.**~~

~~**This is considered a hypertensive emergency that needs resolved to prevent central nervous system injury such as cerebral injury or infarction (maternal stroke)**~~

a. The goal is not to normalize BP; but to achieve a range of 140-150/90-100 mm Hg to prevent loss of cerebral vasculature autoregulation

b. Completed a minimum of 20 weeks gestation

c. Proteinuria or **OR** ilf one or more of the following are present:

i. New onset cerebral or visual disturbances

ii. Pulmonary edema or cyanosis

iii. Epigastric or right upper quadrant pain

iv. Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent RUQ or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses or both

v. Thrombocytopenia (platelet count less than 100,000/microliter)

vi. Progressive renal insufficiency (serum creatinine concentration greater than 1.1 mg/dl or a doubling of serum creatinine concentration in the absence of other renal disease)

3. **Eclampsia:**ECLAMPSIA: **new-onset tonic-clonic, focal, or multifocal seizures in the absence of other causative conditions such as epilepsy, cerebral arterial ischemia and infarction, intracranial hemorrhage, or drug use.**

a. Presence of new onset grand mal seizures in a pregnant women with preeclampsia (rule out idiopathic seizure disorder or other central nervous system pathology such as intracranial hemorrhage, bleeding arteriovenous malformation, ruptured aneurysm)

New onset seizures 48-72 hours postpartum (other central nervous system pathology is the likely reason for the seizure after 7 days)

Eclampsia can occur 4-6 weeks postpartum.

b. **In some cases hypertension and/or proteinuria was absent.**

4. **Chronic Hypertension**CHRONIC HYPERTENSION:

a. **SBP greater than or equal to 140mmHg, DBP greater than or equal to 90mmHg, known to predate conception.**

b. **When preconception BP are not known, elevated blood pressure detected before 20 weeks of gestation.**

4.c. **Hypertension that is diagnosed for the first-time during pregnancy and that does not resolve in the typical postpartum period.**

a. A BP of 140mmHg systolic or greater and 90 mmHg diastolic or greater predating conception and/or patient taking hypertensive medications before pregnancy.

Elevated BP detected BEFORE 20 weeks gestation.

b. **Persists greater than 12 weeks post-partum**

5. **G**estational Hypertension**al Hypertension**ESTATIONAL HYPERTENSION:

a. **SBP 140mmHg or more or a DBP of 90mmHg or more, or both, on two occasions at least 4 hours apart, without proteinuria, after 20 weeks of gestation, in women with a previously normal BP.**

i. **Considered severe when the SBP reaches 160mmHg or DBP reaches 110mmHg, or both.**

5.b. **BP level return to normal in the postpartum period.**

a. A BP of 140 mmHg or greater systolic or 90 mmHg or greater diastolic WITHOUT proteinuria occurring AFTER 20 weeks gestation.

b. May evolve to preeclampsia

May be a recurrence of chronic hypertension abated in mid-pregnancy

c. **Normalization of blood pressure by 12 weeks post-partum**

6. **S**uperimposed Preeclampsia**uperimposed Preeclampsia**UPERIMPOSED PREECLAMPSIA/ECLAMPSIA:

a. **Preeclampsia is considered superimposed when it complicates preexisting chronic hypertension.**

~~6.~~

~~**New-onset of hypertension in a woman with hypertension prior to 20 weeks**~~

~~a. Patients with underlying renal or vascular disease and those with chronic hypertension are at risk.~~

~~b. Sudden increase in proteinuria if already present in early gestation~~

~~c. Sudden increase in BP~~

~~Development of headache, scotomata **(a partial loss of vision or blind spot in an otherwise normal visual field,)** or epigastric pain~~

~~d. **Development of HELLP Syndrome: see below**~~

7. HELLP **Syndrome**~~YNDROME~~ (Hemolysis, Elevated Liver enzymes, Low Platelets):
   a. Patients with **preeclampsia with severe features**~~severe preeclampsia~~ ~~that~~ develop hepatic and hematologic manifestations as the predominant clinical picture, and is associated with increased risk of adverse outcomes.
   b. **Can occur without hypertension or proteinuria.**
8. **Severe Hypertension: Two consecutive BPs with SBP of 160mmHg or greater or DBP of 110mmHg or greater within a short interval (15 minutes).**
9. **Hypertensive Emergency:**
   a. **When severe hypertension is persistent**
   b. **Can occur during pregnancy or postpartum**
   c. **Can present as new acute-onset, or in patients with chronic hypertension who are developing superimposed preeclampsia with acutely worsening, difficult to control, severe hypertension.**
   ~~a.~~d. **Either SBP 160mmHg or greater or DBP 110 or greater taken twice 15 minutes apart.**

B. **ADMISSION ~~CONSIDERATIONS~~:**

1. Assess maternal vital signs including: BP, respiratory rate **(RR)**,~~and~~ heart rate **(HR)**, **temperature and oxygen saturation (O2Sat)**
   a. **Refer to section D Nursing Assessment Frequency Guidelines for frequency.**
   b. **One severe-range BP requires the initiation of frequent BP measurements every 15 minutes for at least one hour.**
      i. **If the patient meets the requirement for treatment with antihypertensive medications, frequency of BP will change to treatment recommendations.**
         1) **See Attachment 1: Antihypertensive Treatment Algorithm for Hypertensive Emergencies.**
      ii. **If at one hour the patient does not meet the requirement for treatment with antihypertensive medications, frequency of BP will return to recommendations in section D Nursing Assessment Frequency Guidelines.**
2. **Assess BP using an appropriately sized BP cuff with patient sitting or in the upright position with the patient's arm at the level of the heart~~.~~ and legs/feet uncrossed.**
   a. **The patient needs to sit quietly for 5 minutes prior to measurement.**
   b. **Do not reposition the patient to either side to obtain a lower BP**

~~1.~~

~~2. Obtain BP~~ **~~on the patient arm~~** ~~using an appropriate sized cuff with~~ **~~the~~** ~~patient sitting or in the upright/~~**~~semi-fowlers~~** ~~position with the patient's arm at the level of the heart.~~
~~Do not reposition the patient to her left side and retake the BP, as this can give a false lower reading.~~
~~a.~~ **~~Have patient uncross their legs/feet~~**
3. **Apply external fetal monitor (EFM), or obtain fetal heart tones with a hand held doppler per the Fetal Heart Rate Surveillance/Monitoring Procedure**~~Apply external fetal monitor (if viable gestational age) and perform monitoring and assessment per fetal heart rate (FHR) surveillance policy for antepartum and intrapartum periods~~.
4. Assess for the **absence or** presence of:
   a. Headache
   b. Visual changes
   c. R**ight upper quadrant pain** ~~**ight Upper Quadrant (RUQ)**~~ or epigastric pain ~~**(not heart burn)**~~
   d. Nausea/-vomiting
   e. General malaise
   ~~e.~~**f. Generalized edema and/or significant rapid weight gain**
5. Assess upper/~~-or-~~lower deep tendon reflexes **and clonus**.
6. Auscultate lung sounds, noting any presence of rales, rhonchi, wheezing, etc.
~~6.~~**7. Assess intake and output per section D Nursing Assessment Frequency.**
~~7. Assess for generalized edema and significant, rapid weight gain.~~
8. Obtain intravenous (IV) access as ordered by the provider.
~~9.~~ Prepare to administer medications to lower BP and prevent seizure activity~~. See Administration of Magnesium Sulfate Procedure, Patient Care Services.~~
~~10.~~**9.** ~~Monitor patient's intake and output (I&O)~~ **~~per provider order~~** ~~at a minimum every two hours.~~
10. Maintain activity as ordered by the provider.
   ~~11.~~**a.** If on bed rest, maintain side-lying position as much as possible ~~to increase uteroplacental perfusion if patient antepartum or intrapartum,~~ and change patient position every two hours or more often as needed.
~~12.~~**11.** Obtain lab work as ordered by provider and review results.
~~13.~~**12.** Ensure oxygen and suction equipment are available and functioning.
~~14.~~**13.** Implement ~~**seizure precaution**~~ measures to decrease stress levels, such as maintaining a quiet environment with low lighting~~. per Elsevier Skills~~
~~15. Consider implementing seizure precautions, per Mosby procedure for severe preeclampsia diagnosis.~~
~~16.~~**14.** Provide emotional support and opportunity for patient family to verbalize questions and concerns.
~~17.~~**15.** ~~Reportable conditions; notify the provider for:~~**Notify the provider for any of the following:**
   ~~a.~~ **~~Repeated SBP of 160mm~~** ~~Repeated BP greater and 160 systolic OR greater than 105-110 diastolic (taken at least 15 minutes apart).~~
   a. Hg or greater or DBP of 110mmHg or greater, taken at a short interval (15 minutes).
   b. New or worsening complaint of any of the following:
      i. Headache
      ii. Visual changes
      ~~ii.~~**iii. Change in level of consciousness**
      ~~iii.~~**iv.** Right upper quadrant (RUQ) or epigastric pain
   c. Abnormal lab values

d. Urine output less than 30 mL in an hour or less than 120 mL in 4 hours.

~~C. MEDICATION CONSIDERATIONS FOR HYPERTENSION:~~

~~1. A sustained systolic blood pressure (SBP) greater than or equal to 160 mg Hg or diastolic pressure greater (DBP) than or equal to 110 mm Hg on two consecutive occasions at least 15 minutes apart is considered "severe hypertension" and needs to be treated with IV antihypertensive medication to protect the patient from cerebral vascular accident.~~

~~Oral antihypertensive medication should only be considered if IV access has not been established. and~~

~~a. Immediate release oral Nifedipine is the medication of choice due to the rapid onset. Oral Labetolol should only be utilize if the immediate release Nifedipine is unavailable.~~

~~b. Patients shall receive medication to reduce the blood pressure within 60 minutes of the finding.~~

~~c. A single, elevated "severe range" blood pressure finding requires further monitoring and evaluation.~~

~~2. The goal of treatment is to obtain a SBP of 140-150 and/or diastolic blood pressureDBP of 90-100 mm Hg to maintain fetal perfusion.~~

C. ANTIHYPERTENSIVE MEDICATIONS ~~ADMINISTATION PROCEDURE~~:

1. Treatment is indicated for SBP of 160mmHg or greater or DBP of 110mmHg or greater to protect the patient from cerebral vascular accident.
   a. Initiation of medication should be within 30-60 minutes after confirmation (second BP) of severe range blood pressures.
   b. The goal of treatment is a target BP range of 130-150/80-100mmHg
2. See attachment, Antihypertensive Treatment Algorithm for Hypertensive Emergencies, for medication guidelines.
3. Labetalol is a combined alpha and beta-blocker, resulting in decreased peripheral vascular resistance without altering heart rate or cardiac output. Its use is contraindicated in patients with bronchial asthma, heart block and severe bradycardia.
   a. A patient with tachycardia should receive labetalol as the initial intravenous (IV) therapy.
4. Hydralazine is a vasodilator and results in vasodilation of vascular smooth muscle.
5. Nifedipine is a calcium channel blocker that acts to relax the smooth muscle of the heart and blood vessels.
   a. If acute treatment is needed in a patient without IV access, immediate release nifedipine is recommended.
6. When antihypertensive treatment and magnesium sulfate are ordered simultaneously, and concurrent administration is not possible, antihypertensive treatment should be first priority.
   a. See Magnesium Sulfate, Administration in Obstetric Patients Procedure for administering Magnesium Sulfate.
7. Maintain bedrest during and for 3 hours following medication administration. Assess for postural hypotension prior to ambulation.
8. If BP unstable after completing the medication algorithm, contact provider regarding consideration of other medications and/or transfer to a higher level of care.

a. The provider may consider a consult with maternal-fetal medicine, internal medicine, anesthesia, or critical care subspecialists.

9. Reportable conditions to notify provider:
   a. SBP greater than or equal to 160mmHg. DBP less than 80mmHg or greater than or equal to 110mmHg following medication administration.
   b. Category II or III fetal heart tracing following antihypertensive administration.
   c. Sustained maternal HR less than 50 beats per minute or greater than 120 beats per minute during or within 30 minutes following medication administration.
   d. The patient becomes eclamptic.
      i. For eclamptic management see the standardized procedure: Eclampsia Management in the Antepartum, Intrapartum or Postpartum Period.

D. NURSING ASSESSMENT FREQUENCY GUIDELINES:

1. Preeclampsia without severe features:

Assessment Type	Antepartum *	Intrapartum*	Postpartum*
BP, Pulse, Respirations, SpO2	Every 4 hours	Hourly	Every 4 hours
Lung Sounds	Every 4 hours	Every 4 hours	Every 4 hours
Level of Consciousness, edema, DTRs, clonus, headache, visual disturbances, epigastric pain (RUQ)	Every 4 hours	Every 4 hours	Every 4 hours
Fetal Status and uterine activity	Minimum of every shift, along with presence of fetal movement	Continuous	N/A
Temperature	Per Department Standards of Care		
I& O	Every 4 hours, with total every 24 hours.		
* This is the minimum frequency recommended for the patient not on magnesium sulfate			

2. Preeclampsia with severe features on magnesium sulfate
   a. Refer to the procedure: Magnesium Sulfate, Administration in Obstetric Patients
3. Post eclamptic seizure and magnesium sulfate toxicity
   a. Refer to the standardized procedure: Eclampsia Management in the Antepartum, Intrapartum, or Postpartum Period
4. Acute BP treatment with IV medication:

Assessment Type	Assessment Frequency
BP, pulse and respirations	Once BP is considered stable, then BP every 10 minutes x1hour, every 15 minutes x1hour, every 30minutes x1hour and every one-hour x4hours.
SpO2	Continuous
LOC	Every 5-15 minutes for a minimum of 1 hour
Fetal status and uterine activity	Continuous until delivery

5. **Vital signs and assessments may be more frequent based on patient condition and provider order.**

~~D.~~

~~1. Ensure the patient has a patent IV site~~**~~, or start patient on a first line oral medication such as immediate release oral Nifedipine.~~**

~~2. Monitor FHR continuously, per FHR surveillance policy if antepartum or intrapartum.~~

~~3. Monitor BP, Pulse and Respiratory Rate every 5-15 minutes, per provider order,~~**~~10 minutes~~** ~~for a minimum of one hour,~~ **~~every 15 minutes for one hour, every 30 minutes for one hour and then every four hours~~** ~~following IV medication administration to assess for BP reduction.~~

~~a. Maintain bed rest during and for three hours following medication administration.~~

~~i. Assess for postural hypotension prior to ambulation~~

~~4. If medication does not reduce the blood pressure to~~ **~~the target level of SBP of 140-150 and/or DBP of 90-100 mm Hg~~** ~~a diastolic reading between 90-100 mm Hg, contact the provider to discuss other medication options.~~

~~5. HYDRALAZINE (Apresoline) Aadministration Cconsiderations based on provider orders:~~

~~a. Hydralazine is a vasodilator and results in vasodilation of vascular smooth muscle.~~

~~Administer initial dose IV push (IVP) over 1-2 minutes.~~

~~b. Usual dose range is 5-10 mg.~~ **~~Refer to providers orders.~~**

~~c. May repeat dose at 20 minutes~~ **~~based upon provider orders~~** ~~intervals until desired blood pressure is achieved. Consider giving 10 mg hydralazine IVP if elevated BP continues after initial dose.~~

~~Cumulative dose should not exceed 40mg.~~

~~d.~~ **~~Parental hydralazine may increase the risk of maternal hypotension such as a SBP less than 90 mm Hg or less.~~**

~~After 420 minutes if BP continues to be elevated, consider 20 mg of Labetalol IVP be given.~~

~~e.~~ **~~See OB Magnesium/Hypertension Management Order set for guidelines on when to order OB and Hospitalist consults~~**

~~6. LABETALOL Administration Considerations based on provider orders:~~

~~a. Labetalol is a combined alpha and beta- blocker, resulting in the decreased peripheral vascular resistance without altering heart rate or cardiac output. Its use is contraindicated in patients with bronchial asthma, heart block and severe bradycardia.~~

~~IV PUSH:~~

~~Administer initial dose IVP over 2 minutes. (Usual dose is 20 mg)~~

~~**Subsequent doses may be given at dedicated intervals based upon provider orders**~~

~~**See OB Magnesium/Hypertension Management Order set for guidelines on when to order OB and Hospitalist consults**~~

~~**Cumulative dose should not exceed 220mg**~~

~~**Parental labetalol may cause neonatal bradycardia.**~~

~~b. **Should be avoided in women with bronchial asthma, heart disease or congestive heart failure**~~

~~i. A repeat dose may be given at 10 minute interval.~~

~~ii. After first 10 minutes if BP continues to be elevated consider 40 mg of Labetalol IVP.~~

~~iii. If 40 Mg did not reduce the BP after 10 minutes, consider administering 80 mg labetalol.~~

~~iv. If no reduction in BP after 80 mg of labetalol IVP, consider Hydralazine.~~

~~CONTINUOUS IV:~~ ~~If required, consult~~

~~**Consult** with the **IntensivistHospitalist in the** Intensive Care Unit **to initiate transfer to the Intensive Care Unit to begin IV Drip** shall be done~~

~~c. **and/or PerinatologyConsult Perinatology**~~

~~i. Continuous Cardiac monitoring is required~~

~~ii. Infuse labetalol on an infusion pump at ordered rate by provider until **SBP of 140-140 and/or DBP** diastolic pressure is 90-100 mm Hg.~~

~~iii. Maximum dose is 300 mg in 24 hours.~~

~~An ORAL dose of Labetalol~~ **Labetalol:**~~200 mg~~

~~c**C**an be given if no IV access, and **oral immediate released oral nifedipine is not available.**~~

~~d. is used primarily to control elevated BP's with systolic value less than 160 mm Hg or diastolic value less than 110 mm Hg.~~

~~BP shall be checked in 30 minutes~~

~~i. **It may be utilized as an oral maintainance dose to maintain blood pressure**~~

~~7. **Oral** NIFEDIPINE A**a**dministration C**c**onsiderations based on provider orders:~~

~~a. Nifedipine is a calcium channel blocker and produces vascular and smooth muscle relaxation.~~

~~b. In the event that acute treatment is needed for patients with severe hypertension (systolic BP greater than 160 or diastolic BP greater than 110) in a patient without IV access, ORAL Nifedipine shall be used.~~

~~c. Suggested dose is 10 mg by mouth which can be repeated in 30 minutes if indicated.~~

~~Reportable conditions to notify the provider include:~~

~~d. Diastolic BP less than 80 mm Hg or greater than 105-110 mm Hg following medication administration.~~

~~Category II **tracing progressing to a Category** or III **or a Category III** FHR tracing observed following antihypertensive medication administration~~

~~e. **or if tThe patient does become ecclamptic.**~~

~~f. Sustained maternal heart rate less than 50 or greater than 120 during or within 30 minutes following medication administration.~~

~~E. **SEIZURE PREVENTION MEDICATION ADMINISRATION CONSIDERATIONS:**~~

~~1. Magnesium Sulfate is administered as a first line drug to prevent maternal eclamptic seizures and exerts its effect by depressing the central nervous system.~~

~~2. Use is supported for those patients with severe preeclampsia and eclampsia. (See Magnesium Sulfate Administration procedure in Patient Care Services Manual)~~

~~For patients diagnosed with "preeclampsia without severe features (mild)" the American Congress **College** of Obstetrics and Gynecology (ACOG) suggests that magnesium sulfate not be administered universally for the prevention of preeclampsia. Administration shall be based on provider assessment, **gestational age** and patient symptoms.~~

F. NURSING ASSESSMENT FREQUENCY FOR PATIENTS WITH PRE-ECLAMPSIA

Preeclampsia without Severe Features Guidelines

	Preeclampsia without Severe Features		
	Antepartum *	Intrapartum*	Postpartum*
BP, Pulse, Respirations, SpO2	Every 4 hours	Hourly	Every 4 hours
Lung Sounds	Every 4 hours	Every 4 hours	Every 4 hours
Level of Consciousness, edema, DTRs, clonus, headache, visual disturbances, epigastric pain (RUQ)	Every 4 hours	Every 4 hours	Every 4 hours
Fetal Status and uterine activity	Minimum of every shift, along with presence of fetal movement	Continuous	N/A
Temperature	Per Department Standards of Care		
I& O	Every 2 hours Every 2 hours Every 2 hours		

(*) This is the minimum frequency recommended for the patient NOT on Magnesium Sulfate.

Severe Preeclampsia Nursing Assessment Frequency Guidelines

	Severe Preeclampsia Antepartum, Intrapartum and Postpartum
BP, Pulse, Respirations, SpO2	Every 30 minutes during maintenance Magnesium Sulfate Administration, if patient is Intrapartum, or is an unstable Antepartum or Postpartum. When the patient is stable the blood pressure may be every 4 hours or more frequent dependent on patient condition or providers orders. Continuous SpO2 during Magnesium Sulfate infusion for Intrapartum. For Antepartum and Postpartum patient SpO2 check with Vital Signs. SaO2 Goal when the patient is pregnant is greater than 94%.
Lung Sounds	Every 2 hours for an Unstable Antepartum, Intrapartum or and first 24 hours of Postpartum. (needing multiple IVP medications that cause tachycardia) or eEvery 4 hours if the patient is considered stable and beginning 24 hours after delivery.
Level of Consciousness, Edema, DTRs, clonus, headache, visual disturbances, epigastric pain (RUQ)	Every 4 hours or more frequently dependent on patientt condition. Notify provider of any changes in condition.
Fetal Status and uterine activity	Continuous Fetal Monitoring during a Hypertensive crisis until patient is stable, then per provider orders.
Temperature	Per Department Standards of Care (Antepartum, Intrapartum, or Postpartum)
I& O	Intake: Total hourly intake (IV and PO) when on Magnesium Sulfate should be less than125 mL/hr. NPO with ice chips or as permitted by provider. Output: Consider Foley placement with urometer Hourly- Calculate end of shift total and 24-hour totals

1. Utilize the Magnesium Sulfate Administration Policy, this policy, Eclampsia Policy and provider Oorders to determine if assessment frequency needs to be more frequent than in the charts above.change. Vital signs and assessments may always be more frequent based on the patient condition.

G. ANTEPARTUM ONGOING ASSESSMENT (See Table 1):

1. ~~Assess for signs of severe or worsening preeclampsia symptoms or development of eclampsia~~
2. ~~Prolongation of pregnancy to optimize fetal maturation shall be weighed against risk of pregnancy continuation.~~
3. ~~Preeclampsia without severe features (mild):~~**~~Refer to Related Document: Nursing Assessment Frequency for Patients with Pre-eclampsia~~**
   a. ~~Obtain blood pressure, pulse, respirations every 4 hours. Include oxygen saturation values if patient is receiving magnesium sulfate.~~
   b. ~~Assess lung sounds every 4 hours.~~
   c. ~~Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~
   d. ~~Obtain nonstress test (NST) or monitor fetal heart rate with uterine activity for a minimum of 30 minutes every shift, as condition warrants, and per provider order~~
   e. ~~Assess for fetal movement each shift~~
   f. ~~Monitor intake and output (I&O) at a minimum every 2 hours.~~
4. ~~Severe Preeclampsia:~~**~~Refer to Related Document: Nursing Assessment Frequency for Patients with Pre-Eclampsia~~**
   a. ~~Obtain blood pressure, pulse, respirations and O2 sats hourly.~~
   b. ~~Assess lung sounds every two hours~~
   c. ~~Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~
   d. ~~Monitor FHR and uterine activity continuously~~
   e. ~~Monitor I&O hourly~~

~~H. **INTRAPARTUM ONGOING ASSESSMENT (See Table 1):**~~

1. ~~Preeclampsia without severe features (mild):~~
   a. ~~Obtain blood pressure, pulse and respirations hourly Include oxygen saturation values if patient is receiving magnesium sulfate.~~
   b. ~~Assess lung sounds every 4 hours.~~
   c. ~~Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~
   d. ~~Monitor FHR and uterine activity continuously~~
   e. ~~Monitor I&O at a minimum every 2 hours.~~
2. ~~Severe Preeclampsia:~~
   a. ~~Obtain blood pressure, pulse, respirations and O2 sats every 30 minutes.~~
   b. ~~Assess lung sounds every 2 hours~~
   c. ~~Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~
   d. ~~Monitor FHR and uterine activity continuously.~~
   e. ~~Monitor I&O hourly.~~

~~I. **POSTPARTUM TO DISCHARGE ONGOING ASSESSMENT (See Table 1):**~~

1. ~~Preeclampisa without severe features (mild):~~
   a. ~~Obtain blood pressure, pulse and respirations every four hours. Include oxygen saturation values if patient is receiving magnesium sulfate.~~
   b. ~~Assess lung sounds every four hours~~
   c. ~~Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~
   d. ~~Monitor I&O at a minimum every 2 hours, while on Magnesium Sulfate or every 4 hours, otherwise~~

~~2. Severe Preeclampsia:~~

~~a. Obtain blood pressure, pulse, respirations and O2 sats every hour **during the Intrapartum period** for **approximately** the first 24 hours after delivery then every four hours.~~

~~b. Assess lung sound every 2 hours for the first 24 hours after delivery and then every four hours~~

~~c. Evaluate deep tendon reflexes (DTR's), clonus, level of consciousness (LOC), headache, visual disturbances, epigastric pain every four hours.~~

~~d. Monitor I&O hourly until Magnesium Sulfate discontinued.~~

E. REFERENCES:

1. **Chronic hypertension in pregnancy. ACOG Practice Bulletin No. 203. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133: e26-50.**
2. **Gestational hypertension and preeclampsia, ACOG Practice Bulletin No. 222. American College of Obstetricians and Gynecologists. Obstet Gynecol 2020;135: e237-60.**
3. **Maurice L. Druzin, MD; Laurence E. Shields, MD; Nancy L. Peterson, RNC, PNNP, MSN; Christa Sakowski, MSN, RN, C-ONQS, C-EFM, CLE; Valerie Cape, BSBA; Christine H. Morton, PhD. Improving Health Care Response to Hypertensive Disorders of Pregnancy, a California Maternal Quality Care Collaborative Quality Improvement Toolkit, 2021.**

~~3.~~4. **Simpson, K., Creehan, P., O'Brien-Abel, N., Roth, C., & Rohan, A. (2020). Perinatal Nursing 5th ed. Philadelphia, PA: Wolters Kluwer.**

~~4. Druzin, M, Shields, L, Peterson, N, Cape, V, (2014). Preeclampsia Toolkit: Improving Health Care Response to Preeclampsia (California Maternal Quality Care Collaborative **(CMQCC)** Toolkit to Transform Maternity Care) Developed under contract #11-10006 with the California Department of Public Health; Maternal, Child and Adolescent Health Division, Published by the CMQCC.~~

~~5. ACOG. Diagnosis and Management of Preeclampsia and Eclampsia #33. American C**ollege**ongress of Obstetricians and Gynecologists Practice Bulletin Number 33. 2010**2** (Reaffirmed 201**8**2).~~

~~6. ACOG. Hypertension in Pregnancy: Report of the American College of Obstetricians and Gynecologists' Task Force on Hypertension in Pregnancy. Obstet Gynecol. 2013; 122(5): 1122-1131.~~

~~7. Payne B, Magee L, Cote A, et al. PIERS proteinuria: Relationship with adverse maternal and perinatal outcome. Journal of Obstetrics and Gynaecology Canada. 2011; 33:588-597.~~

~~8. ACOG Committee Opinion no. 514. Emergent therapy for acute-onset, severe hypertension with preeclampsia or eclampsia. Obstet Gynecol. 2011**(Reaffirmed 2019)**; 118: 1465-1468.~~

~~9. Simpson K, Crehan P. Perinatal Nursing 4**5**th ed. Philadelphia: Wolters/Kluwer/Lippincott Williams & Wilkins; 20**20**14.~~

F. RELATED DOCUMENT(S):

1. **Patient Care Services Procedure: Magnesium Sulfate, Administration in Obstetric Patients**
2. **Patient Care Services Standardized Procedure: Eclampsia Management in the Antepartum, intrapartum or Postpartum Period.**
3. **Women and Newborn Services Procedure: Fetal Heart Rate (FHR) Surveillance/Monitoring**

~~J.~~

~~Patient Care Services Procedure: Administration of Magnesium Sulfate in the Obstetrical Patient~~

~~Women and Newborn Services Policy: Fetal Heart Rate Surveillance~~**Surveillance** ~~and Monitoring~~

~~**Standards of Care for the Antepartum, Intrapartum or Postpartum patient**~~

~~1. **Eclampsia Management in the Antepartum, Intrapartum or Post-Partum Period**~~

~~TABLE 1. NURSING ASSESSMENT FREQUENCY~~

~~A. Preeclampsia without Severe Features (Mild)~~

	~~Preeclampsia without Severe Features (mild)~~		
	~~Antepartum *~~	~~Intrapartum*~~	~~Postpartum*~~
~~BP, Pulse, Respirations, SaO2~~	~~Every 4 hours~~	~~Hourly~~	~~Every 4 hours~~
~~Lung Sounds~~	~~Every 4 hours~~	~~Every 4 hours~~	~~Every 4 hours~~
~~Level of Consciousness, Edema, DTRs, clonus, Assessment for headache, visual disturbances, epigastric pain (RUQ)~~	~~Every 4 hours~~	~~Every 4 hours~~	~~Every 4 hours~~
~~Fetal Status and uterine activity~~	~~Every shift~~	~~Continuous~~	~~N/A~~
~~Temperature~~	~~Per Department Standards of Care~~		
~~I& O~~	~~Every 2 hours~~	~~Every 2 hours~~	~~Every 2 hours~~

~~(*) This is the minimum frequency recommended for the patient NOT on Magnesium Sulfate.~~

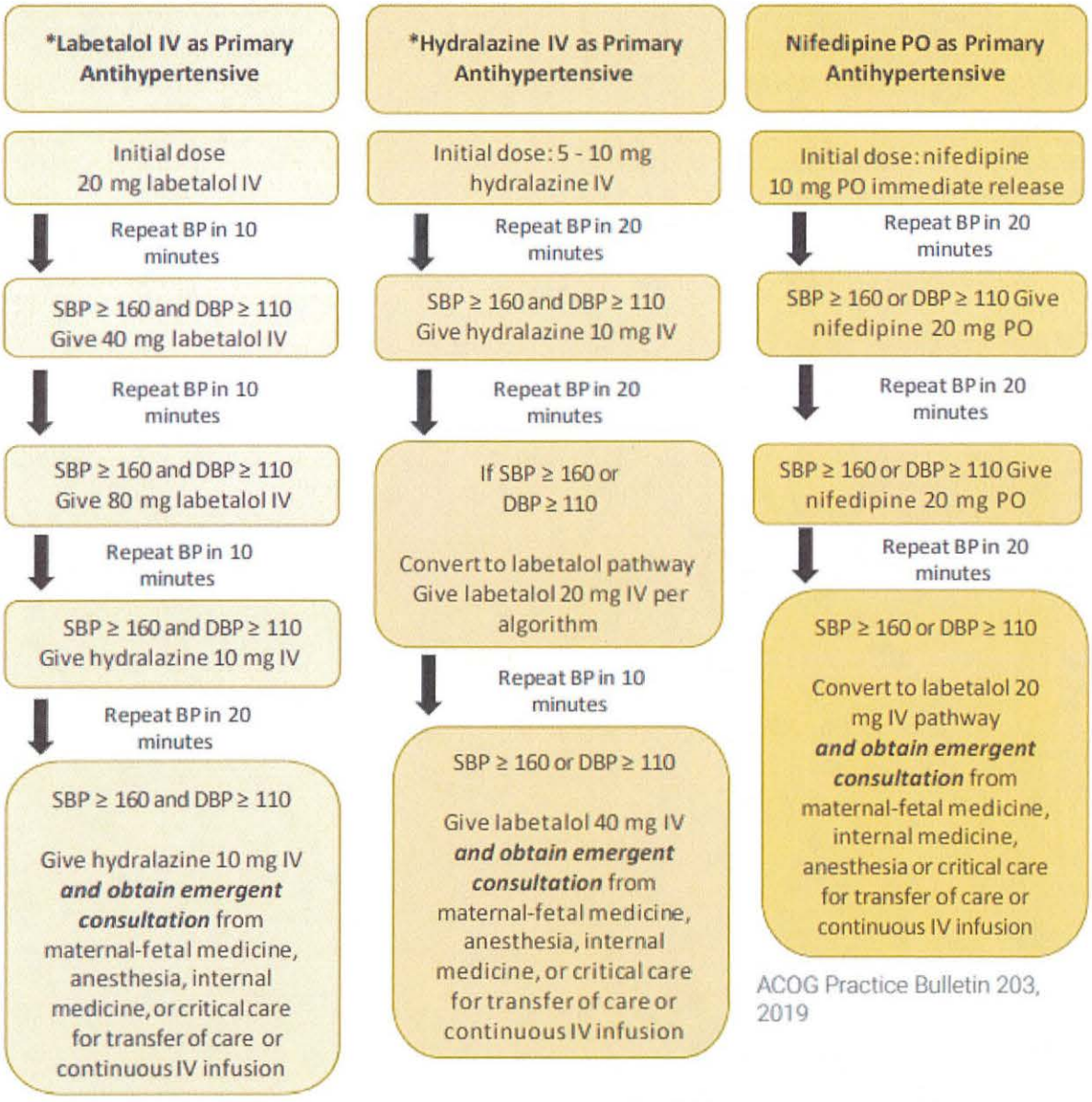
~~B. Severe Preeclampsia Nursing Assessment Frequency~~

	~~Severe Preeclampsia Intrapartum and Postpartum on Magnesium Sulfate~~
~~BP, Pulse, Respirations, SaO2~~	~~Every 30 minutes during maintenance Magnesium Sulfate Administration, if patient is Intrapartum, or is an unstable Antepartum or Postpartum. When the patient is stable the blood pressure may be every 4 hours or more frequent dependent on patient condition or providers orders.~~ ~~Continuous SaO2 during Magnesium Sulfate infusion for iIntrapartum.~~ ~~For Antepartum and Postpartum patient SaO2 check with Vital Signs.~~ ~~SaO2 Goal when the patient is pregnant is greater than 94%.~~
~~Lung Sounds~~	~~Every 2 hours for an Unstable Antepartum, Intrapartum or Postpartum (needing multiple IVP medications that cause tachycardia) or every 4 hours if the patient is considered stable.~~
~~Level of Consciousness, Edema, DTRs, clonus, Assessment for~~	~~Every 4 hours or more frequently dependent on pt condition. Notify provider of any changes in condition.~~

~~headache, visual disturbances, epigastric pain (RUQ)~~	
~~Fetal Status and uterine activity~~	~~Continuous Fetal Monitoring during a Hypertensive crisis until patient is stable, then per provider orders.~~
~~Temperature~~	~~Per Department Standards of Care (Antepartum, Intrapartum, or Postpartum)~~
~~I& O~~	~~Intake:~~ ~~Total hourly intake (IV and PO) when on Magnesium Sulfate should be less than125 mL/hr.~~ ~~NPO with ice chips or as permitted by provider.~~ ~~Output:~~ ~~Consider Foley placement with urometer~~ ~~Hourly- Calculate end of shift total and 24- hour totals~~

Attachment 1:

Antihypertensive Treatment Algorithm for Hypertensive Emergencies



ACOG Practice Bulletin 203, 2019

Target BP: 130-150/80-100 mm Hg

Once BP threshold is achieved:

- Q10 min for 1 hr
- Q15 min for 1 hr
- Q30 min for 1 hr
- Q1hr for 4 hrs

*Intravenous hydralazine or labetalol should be given over 2 minutes. In the presence of sinus bradycardia or a history of asthma, hydralazine or nifedipine are preferred as initial agents. If maternal HR > 110, labetalol is preferred.

~~**Utilize the Magnesium Sulfate Administration Policy, this policy, Eclampsia Policy and Orders to determine if assessment frequency needs to be more frequent than in the charts above. Vital signs and assessments may always be more frequent based on the patient condition.**~~

Tri-City Health Care Distr
Oceanside, California

DELETE – follow Administrative Policy: Event Reporting 396

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: -06/07 SUBJECT: Adverse Reaction to Meds

REVISION DATE~~(S)~~:

Department Approval:	02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. Patient medication events including adverse reactions must be reported appropriately and acted upon in a timely manner. This policy defines the procedure to be followed by the Center when a medication error/reaction/event occurs.~~

~~B. **POLICY**~~

~~1. The Center will adhere to the hospital's pharmacy policy(s) related to medication events/adverse reaction and utilize appropriate hospital reporting forms.~~
~~2. All adverse drug reactions/medication events will be reported immediately and will include notification of the practitioner who ordered the drug, as well as the patient/ family.~~
~~3. Appropriate documentation will be recorded in the medical record.~~
~~4. The pharmacy will report serious adverse drug reactions to the Food and Drug Administration, as required.~~

~~C. **PROCEDURE**~~

~~1. The nurse will:~~
~~a. Notify the attending physician of the medication event/reaction~~
~~b. Notify the patient/family of the incident~~
~~c. Complete the appropriate hospital reporting form~~
~~d. Return completed form to the Pharmacy immediately~~
~~e. Document the event/reaction, the orders received, and the effect/condition of the patient in the patient's medical record.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~**POLICY MANUAL**~~

ISSUE DATE: 06/07 **SUBJECT: Age-Specific Guidelines**

REVISION DATE~~(S)~~:

Department Approval:	**~~02/20~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. This Guideline has been developed to:
   a. Address the age-specific needs of various groups of patients that may be treated at the Center.
   b. Provide optimal age-specific care for the patient population served in the Center.

B. **POLICY:**

1. The program has been designed to meet the specific medical needs of the adult/ geriatric population.
   ~~2.~~**a.** Under special circumstances and on a case-by-case basis, needs of other patient populations may be considered.
   ~~3.~~**b.** Neonate patients will not be treated at the Center.
~~4. In the event that a patient from another age group is treated at the Center, age-specific guidelines will be utilized to optimize care.~~
~~5.~~**2.** Age-related needs will be considered in the plan of care for each patient.
~~6.~~**3.** Equipment and supplies used in the care of patients will be age-specific.
~~7.~~**4.** Other resource persons/departments will be consulted as needed to validate and enhance the care provided.
~~8. Employee performance appraisals will reflect age-specific evaluation.~~

C. **PROCEDURE:**

1. An age-specific plan of care will be developed for each patient treated at the Center.
2. Age-specific factors/elements of care associated with each age group will be addressed during every encounter by the clinic staff using the tables below.
3. Appropriate intervention specific to each age group will be identified during the initial visit and reviewed periodically for appropriateness.
4. Physical limitations/impairments, as well as learning or other deficits, will be considered when implementing educational/training measures.
5. The education provided will be given at the level of understanding for each patient and will include family members whenever possible.
~~6. Resource materials, persons and departments such as the ER will be consulted to ensure appropriateness of the treatment plan.~~

AGE-SPECIFIC GUIDELINES
NEONATE/INFANT (Birth to One Year)

NEONATES/INFANTS ARE NOT TO BE TREATED WITHIN THE CENTER FOR WOUND CARE & HYPERBARIC MEDICINE.

The clinic physician will contact the neonatologist/referring md to discuss the proper referral (s) for this patient.

AGE SPECIFIC GUIDELINES
TODDLER (1 Year to 4 Years)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Learning bladder and bowel control	Development of manual dexterity	Develops concepts by use of language	Significant persons are parents	• Use firm, direct approach • Use distraction techniques • Give one direction at a time
Abdomen protrudes	2 yrs – self feeding with occasional spilling	Sees things only from own point of view	Discovers ability to explore and manipulate environment	• Prepare child shortly before a procedure • Allow child choices when possible • Emphasize those aspects that require the child's cooperation
Decreased appetite and growth	Walks independently progressing to running, jumping, and climbing	Able to group similar items	Asserts independence & develops a sense of will, has temper tantrums	• Skills may regress due to illness or treatment • Emphasize the importance of mother or parent staying with child • Set limits
Temporary teeth erupt; all 20 deciduous teeth by 2½ to 3 years	Loves to experiment	Constructs 3-to-4-word sentences	Understands ownership "mine"	• Give permission to express feelings • Maintain safety at all times • Oral temps >2 as tolerated by child
Physiologic systems mature;	Goal directed behavior	Has a short attention span	Attached to security objects and toys	• Encourage parents to participate in care/ask for a return demonstration when teaching • Use age-appropriate toys.
Grows 2-2½" per year & 4-6" yearly	Fully formed sense of object permanence	Beginning memory	Knows own gender and differences of gender	• Equipment use; refer to manufacturer's instructions • Praise for good behavior
Elimination: 18 mo. bowel control 2-3 yrs daytime bladder control		Ties words to actions; can understand simple directions and requests	Able to put toys away	
Vital signs (parameters) Temperature 99 F +/- 1 Pulse 105+/-35 B/P 80-100 mmHg systolic & 60-64 mmHg diastolic			Plays simple games, enjoys being read to, plays alone	

AGE-SPECIFIC GUIDELINES
PRE-SCHOOL (4 Year to 6 Years)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Gains weight and grows in ht. 2-2½" per year Becomes thinner and taller Temperature 98.6 +/- 5 B/P 90/60 +/- 15 mmHg	Skips and hops Rollerskates, jumps rope Dresses/undresses independently Prints first name Draws person with 6 major parts Throws and catches a ball (5 years)	Major cognitive skill is conversation Understands that the amount of something is the same, regardless of shape or number of pieces. Able to classify objects; enjoys doing puzzles Understands numbers; can count Constructs sentences; questions things "why"	Significant persons are parents, siblings, peers Increasing independence and beginning to assert self, likes to boast and tattle Masters new tasks and acquires new skills Rewards and punishment modify behavior Plays cooperatively; able to live by rules; capable of sharing. May be physically aggressive Learns appropriate social manners 5-year-old uses sentences, knows colors, numbers, and alphabet	• Explain procedures, unfamiliar objects • Equipment: Refer to manufacturer's instructions • Encourage child to verbalize • Involve the child whenever possible • Maintain safety at all times • Assess and manage pain (offer distractions, e.g. count to 20) • Focus on one thing at a time • Give permission to express feelings • Praise for good behavior • Limit movement restrictions

AGE-SPECIFIC GUIDELINES
SCHOOL AGE (6-12 Years)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Permanent teeth erupt Starts pubescent changes Growth is slow and regular May experience "growing pains" because of stretching of long bones May experience fatigue Temperature 98.6 +/- 1 Pulse 75-100/minute B/P 84-120 systolic and 54-80 diastolic	Uses knife, common utensils and tools Cares for pets Draws, paints Makes useful articles Assists in household chores Likes quiet as well as active games 8-year-old: awkward, nervous energy	Capable of logical operation with concrete things Comprehends and can tell time Starts to think abstractly and to reason; can handle and classify problems; able to test hypotheses. Proud of school accomplishments Enjoys reading Starts to view things from different perspectives Increased attention span and cognitive skills Functions in the present Rule bound	Significant persons are peers, family, teachers Prefers friends to family Works hard to be successful in what he/ she does Belonging and gaining approval of peer group is important Behavior is controlled by expectations, regulations and anticipation of praise or blame Intention is considered when judging behavior Explores neighborhood Uses phone Plays games with rules	• Explain procedures in advance using correct terminology • Explain equipment • Allow child to have some control • Provide privacy • Assess and manage pain • Promote independence • Clearly define and reinforce behavior limits • Use visual aids; be concrete and specific • Relate to child's abilities • Remember that the school-age child's greatest fear is loss of control

AGE-SPECIFIC GUIDELINES
ADOLESCENT (13-18 Years)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Rapid growth of skeletal size, muscle mass, adipose tissue and skin Maturation of the reproductive system; development of primary and secondary characteristics Onset of menses in females and nocturnal emissions in males Vital signs approximate those of the adult	Awkward in gross motor activity Easily fatigued Fine motor skills are improving May need more rest and sleep in early adolescence	Increased ability to use abstract thought and logic Able to handle hypothetical situations or thought Ability to use introspection Internal growth of self-esteem Beginning development of occupational identity (what I want to be) Doesn't like to ask questions so they won't appear "stupid"	Interested and confused by own development Often critical of own features and concerned with physical appearance; compares self to peers Belonging to peer group is important and valued; may criticize parents Identity is threatened by treatment/procedure as adolescents are concerned about bodily changes and appearances Develop sexual identity Think they are invincible and that bad things won't happen to them	• Communication: Supplement explanations with rationale; encourage questions regarding fears; present explanations in logical manner and use visual aids. Offer educational materials to suit the patient's preferred method of education. Do not talk about the patient in front of them. • Providing care: Provide privacy, allow adolescent to maintain control, involve adolescent in decision-making and care. • Equipment: Refer to manufacturer's directions.

AGE-SPECIFIC GUIDELINES
ADULT (19-65)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Prone to health problems related to an inability to cope with new responsibilities Suicidal tendencies, alcoholism, drug abuse, eating disorders, tobacco abuse may surface Healthcare needs are related to preventative medicine to reduce the occurrence of chronic physical or emotional problems Adjustment to menopause (females) and sexual dysfunction (males) as they approach middle adulthood		Focused on time constraints and only want to learn what is practical for them May be dual caretakers (i.e. parent and children)	Emotional stress due to mate selection, vocational selection, assuming occupational roles, marriage, childbearing, financial pressures, and independence	• Communication: Involve family in patient's care and education. When educating adult patients, explain the benefits of adhering to treatment plan; otherwise, education may not be effective. • Equipment: Refer to manufacturer's instructions.

AGE-SPECIFIC GUIDELINES
GERIATRIC (66 and beyond)

Physical	Motor/Sensory	Cognitive	Psychosocial	Unit Specific Interventions
Decreased tolerance to heat/cold Increased wrinkles Declining cardiac/renal function Bones become more prominent/stiff joints Increased susceptibility to infection Increased susceptibility to high blood pressure Shrinkage in intervertebral disc Skeletal changes Skin changes Decreased organ functioning; decreased drug clearance and distribution	Decreased mobility Decreased ability to respond to stimuli Decreased visual acuity Hearing loss Decreased tolerance to pain Hesitant to respond; skills declining	Decrease in memory, slowing of mental functions Slower in learning Drop in performance	Concern for health increases Acceptance of death Decreased authority and autonomy Children leave home; become grandparents; reestablish as a couple Retirement/may pursue second career, hobbies Depression related to decreased physical, motor and cognitive abilities Concern related to limited income	• Patient and Family Education: Explain any instructions well to the patient & family. Don't assume that the patient understands anything. Ask the patient questions to verify understanding. Review important points repeatedly. • Communication: Explain all instructions well. Involve the patient in the examination. Use therapeutic touch as appropriate. • Environment/Safety: Keep room clutter-free; orient patient well to surroundings. Frequently assess room temperature to patient comfort. • Use of medical equipment: Refer to manufacturer's instructions.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Continuum of Care**

REVISION DATE~~(S)~~:

Department Approval:	**~~02/20~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/13**

A. **PURPOSE:**

1. Medical treatment is often specialized, focusing and/or targeting only the condition for which the patient presents. This results in fragmentation of medical care that can sometimes adversely affect the progress and wellbeing of the person seeking medical attention. Treatment of a patient must be all-inclusive to the extent possible or feasible and must consider such factors as:
   a. Insurance/primary care provider
   b. Physicians currently involved in care
   c. Other underlying illnesses/conditions being treated
   d. Current treatment regimens
   e. Medical services utilized by the patient
   f. Place and type of residence
   g. The Center considers integration of medical services to be an essential component of the purpose and model of the program. An individualized plan of care is developed for each patient treated, and reasonable effort is made to incorporate all pertinent agents/ agencies/therapies across the continuum of care.

B. **POLICY:**

1. The Center physician will communicate his/her recommendations for the plan of care to the patient's primary physician whenever possible.
2. Initial assessment of the patient will be conducted in such a way as to yield pertinent information that may impact the plan of care (Admission Assessment, H&P)
3. The clinical staff will work to incorporate other aspects of care discovered during the admission process, notifying the Center physician of issues that may require medical intervention.

C. **PROCEDURE:**

1. Physician Collaboration: Center physicians will collaborate with the patient's primary physician after initial visit, whenever possible.
2. Coordination of Care with Insurance/Primary Care Providers: Communication procedures for insurance/primary care providers will be established during the referral/admission period. The office coordinator will inform the clinic staff of the proper procedures to follow when opportunities to coordinate care are identified. Patient information will be provided as requested by the insurance/primary care agent following all applicable confidentiality regulations and policies. Every effort will be made to comply with case management protocols as directed by the providers.

3. Hospital Admission: Direct hospital admissions from the clinic will be conducted according to hospital policy. The Center staff will provide patient medical information, reason for admission and admission orders, if obtained. The patient will be transported to the assigned room/area by the clinic staff to ensure safe and appropriate transport.
4. Family Participation: Family members will be encouraged to participate in the plan of care and will be included in the education process. Significant others will be included in the process at the patient's request whenever feasible.
5. Patient/Family Education materials: Educational materials will be provided to the patient/family/caregiver whenever available and in varying forms. This may include educational sheets, video, brochures, etc. Materials will be developed to cover significant issues/conditions to the extent that is feasible and appropriate to the level of understanding, and in some cases the language spoken (currently Spanish added). All distributed materials will be recorded in the patient record.
6. Long-Term/Extended Care Facilities (LTCF/ECF): The long-term care facility plays a major role across the continuum of care. Collaboration in the plan of care will be encouraged with the patient's resident facility. Information regarding the treatment plan and other relevant information will be communicated to the facility within a reasonable amount of time after each patient visit. The clinician assigned to the patient will communicate by telephone as necessary with the assigned contact person to facilitate patient care.
7. Home Health Referrals: For optimal treatment benefits, appropriate home health referrals are arranged per MD order after home support resources have been evaluated. The clinician may identify the need for home health support and make the recommendation to the clinic physician. Home health agencies will be selected based on past track record with providing reliable and quality services or patient's preference. In some cases, patients are referred to their primary care providers to obtain home health support.
8. Home Instruction: After each clinic visit, the patient will be given written home instructions, which will be legible and ~~in~~ a large enough font (12) for most patients to read. The assigned clinician will review the instructions **verbally** with the patient before they leave the clinic. An interpreter will be used if necessary. The clinician will evaluate the patient's comprehension to determine if additional instruction, reinforcement, and/or follow-up telephone call will be necessary to ensure patient understanding.
9. Diagnostic Services: The Center staff will assist patients with their appointments for diagnostic services ordered by the Center physician, as appropriate. If the Center staff makes appointments at other facilities, the patient will be given verbal and written instructions.
10. Supplies & Equipment: Reasonable effort will be made to assist patients with obtaining their medical supplies, equipment, etc. At the patient's request, recommendations may be offered for DME, pharmacy, etc. that the Center knows to be reliable with providing the necessary product in a timely manner.
11. Telephone Support: Patients and their family can expect continued support from the Center staff during regular business hours during their tenure in the program. Patients/families are encouraged to call the Center for professional instruction and guidance or if they need clarity or additional information regarding the plan of care. Telephone inquiries will be directed to the appropriate personnel (e.g., case manager) for proper management. Telephone inquiries will be noted in the medical record. The Center physician will be notified for further orders, if indicated. When appropriate, the patient will be given information to contact the Center physician.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Diagnosis Specific Guidelines**

REVISION DATE~~(S)~~:

Department Approval:	~~02/20~~**07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/13**

A. **PURPOSE:**

1. Defines age-related diagnoses that may be treated at the Center

B. **POLICY:**

1. For each diagnosis listed, the Center's clinical staff will follow the approved wound treatment guidelines regardless of age.
2. The diagnoses that have been listed are provided by age category and are the most commonly treated in the age group designated.
3. Diagnoses have not been listed for the neonate or infant, **toddler, preschooler or school age** as they will not be treated in the Center.

~~Toddler (1-4 years)~~ ~~Preschool (4-6 years)~~ ~~School age (6-12 years)~~	Adolescent (13-18 years)	Adult (19-65 years) Geriatric (66 years+)
~~✓ Burns~~ ~~✓ Congenital foot deformities~~ ~~✓ Post trauma~~ ~~✓ Pressure, secondary to immobility~~ ~~✓ Spina Bifida~~	✓ Diabetes with neuropathy ✓ Diabetes with peripheral vascular disease ✓ Post-trauma ✓ Post-surgical wounds ✓ Sickle Cell Anemia ✓ Pressure ulcer, secondary to immobility ✓ Collagen/vascular disorders ✓ Burns ✓ **Arterial Insufficiency**	Sickle Cell Anemia ✓ Burns ✓ Diabetes with neuropathy ✓ Diabetes with peripheral vascular disease ✓ Venous statsis disease ✓ Collagen vascular disorders ✓ Post-trauma ✓ Pressure ulcer secondary to immobility

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Diagnostic Tests**

REVISION DATE~~(S)~~:

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Adminsitration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. Timely reporting of diagnostic test results is an important aspect of planning or changing the course of treatment.

B. **POLICY:**
1. Diagnostic tests relevant to the diagnosing and planning of the patient's care will be included in the medical record in a timely manner.
2. Ancillary/diagnostic testing may include:
   a. Laboratory
   b. Radiology
   c. Vascular lab

C. **PROCEDURE:**
1. The RN/case manager/PT will track/review all test results of their assigned caseload or physician assignment.
2. The clinician will notify the Center physician of significant findings as directed by the physician (telephone or fax) and document the communication in the medical record.
3. All results will be placed in the physician folder for review prior to placing in the patient chart.
4. Once reviewed and initialed by the clinic physician, the results will be filed in the appropriate section of the patient record by the clinic staff.
5. If the primary clinic physician is unavailable for critical or significant values, the patient's primary physician or designated on-call physician will be notified.
6. Critical/significant values will be given to the Center's Medical Director or designee for follow-up when physicians involved in the care of the patient are not available.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE:	**06/07**
REVISION DATE~~(S)~~:	
Department Approval:	**~~02/20~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

SUBJECT: Environment of Care (EOC)

A. **PURPOSE:**

1. In order to provide a safe environment for patients, visitors and staff, this policy identifies each aspect of the hospital's safety/EOC program as it relates to the clinic environment.

B. **POLICY:**

1. Patients and visitors to the Center can expect a safe and sanitary environment.
2. Associates of the Clinic will be ensured of a safe and sanitary work environment.
3. Members of the staff will be competent in the safety/EOC standards set forth by the hospital.
4. The clinic manager is responsible for the implementation of the safety/EOC program per hospital standards.

C. **PROCEDURE:**

1. All staff members will be knowledgeable of and comply with the safety standards of the hospital.
2. The Safety/EOC policies and procedures will be readily available to all associates and is located with the other P&P manuals.
3. The hospital will provide safety/EOC training during the general orientation program each associate receives in the 30-day period from the date of hire.
4. A unit-specific safety orientation will be presented to the new associate within the orientation period.
5. Safety/EOC-related inservices will be presented at **least quarterly and as needed**~~the monthly staff meetings~~.
6. All associates will complete the annual competency requirements of the safety/EOC program, as required by the hospital.
7. Safety-related incidents will be reported immediately, per hospital Incident Reporting policy.
8. Topics/issues/plans to be addressed in the safety/EOC presentations include but are not limited to:
   a. Safety management
   b. Disaster
   c. Emergency preparedness
   d. Life safety
   e. Utility management
   f. Bioterrorism preparedness
   g. Bomb threats
   h. OSHA's exposure control plan for bloodborne pathogens
   i. TB control plan

j. Electrical power safety
k. Loss of communication
l. Hazardous materials (includes biohazardous)
m. Fire safety
n. Disaster plan
o. MSDS program
p. Infection control plan
q. Emergency codes
r. Security plan
s. Medical equipment

D. For more specific information, refer to the hospital's Environment of Care Manual.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: History & Physical**

REVISION DATE(~~S~~):

Department Approval:	02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE**

1. Familiarity with the patient's medical history and current health status is essential to the plan of care developed for each patient seen at the Center. The initial process in the program consists of a thorough documentation of the patients' medical history and a physical examination. Factors to the chief complaint are the main emphasis of this process.

B. **POLICY**

1. As part of the initial evaluation, the Center physician will complete a history and physical **per Medical Staff Policy; Medical Record Documentation Requirements** ~~using the hospital-approved H&P form (must be legible) or may dictate a report if all the components of the Center's H&P form are addressed~~.
2. ~~As part of the preparation for surgery, a pre-operative history and physical will be done that meets the following conditions:~~
   a. ~~The H&P must be done prior to the procedure/admission, per hospital policy~~
   b. ~~If the H&P was done more than 7 days prior to the date of the surgery, the primary physician or designee must update the H&P by indicating "no change", dating and signing the H&P or recording any changes that have occurred before admission/surgery.~~
   c. ~~The patient must have medical clearance prior to any surgical procedure~~.

~~C. **PROCEDURE**~~

~~1. The Center physician will perform the initial exam and medical history review.~~
~~2. Any staff physician, primary physician, or designee may do the pre-operative H&P and clear the patient medically for surgery.~~
2. ~~The findings will be documented on the appropriate forms or dictated according to hospital policy/procedure~~.

C. **RELATED DOCUMENT:**

~~3.~~1. **Medical Staff Policy; Medical Record Documentation Requirements**

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~ &
HYPERBARIC ~~CLINIC~~ MEDICINE ~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Hospital Admission from the Center**

REVISION DATE(~~S~~):

Wound Care Department Approval:	~~02/20~~07/22
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. This policy delineates the procedure for an unplanned admission to the hospital directly from the Center.

B. **POLICY:**

1. Patient admissions to the hospital from the Center will be done in a safe and efficient manner.
2. The clinic physician will discuss the recommendation to admit the patient with the patient/family ~~and the patient's primary physician~~.
3. The Center will provide pertinent medical, demographic and treatment information to the hospital immediately upon admission.

C. **PROCEDURE:**

1. Upon evaluation by the clinic physician, if admission is deemed necessary, orders for admission will be generated.
   ~~a. The clinic staff physician will contact the patient's primary physician to discuss his/her recommendation to admit the patient (if the patient is not triaged to the ER)~~
   ~~b. If the primary physician concurs, the patient will be admitted under the care of the primary physician~~
   ~~c. The Admitting Department/nurse will be notified immediately by the support staff/receptionist about the pending admission.~~
   a. Wound Care Center (WCC) Registered Nurse (RN)/Case Manager will call the Administrative Supervisor (AS) and request a bed.
   b. AS will provide the name and phone number of the hospitalist that will admit the patient.
   c. WCC supervising physician will call the hospitalist and give report. The hospitalist will advise the supervising physician if they will accept the direct admit.
   d. If the patient is accepted for direct admission, the WCC RN/Case Manager will fax the demographic information to the AS.
   e. Depending on the bed availability the patient will do one of the following:
      i. Wait at the WCC for notice that a bed is available
      ii. Go straight to Registration at Tri-City Medical Center (TCMC)
      iii. Go home and wait for a call from the AS advising them that a bed is available and they should go to Registration at TCMC
   ~~d. A copy of pertinent medical, demographic and treatment information will be provided~~

~~e. The RN/case manager will provide a verbal report to the unit nurse to ensure continuity of care~~

f. The RN/case manager will act as liaison between the hospital and the family and answer any questions that might arise about the unplanned admission

g. If the patient is not accompanied by family or significant other, the RN/case manager will make the appropriate notifications

h. If the patient is a resident of an extended care facility, the RN/case manager will notify the Director of Nursing or designee about the pending admission

~~i. The surgeon and/or the surgeon's office will schedule any surgical procedures planned during the hospital admission~~

~~j. The patient will be kept in the Center and closely monitored until notified by the hospital Admitting Department or designated nursing unit. After clinic hours, the nursing supervisor will provide instructions for patient disposition.~~

~~k. The RN/case manager will coordinate the transfer of the patient to the designated nursing unit with a member of the Center staff and transport personnel, until the designated nursing unit officially receives the patient~~

~~l.~~**i.** If the patient is unstable and cannot be admitted immediately to an acute care bed, the patient will be transferred **via family member** to the **Emergency Department**~~ER after the ER has been notified~~.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: -06/07 **SUBJECT: Hypo-Hyperglycemia Management**

REVISION DATE~~(S)~~:

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Hypoglycemia and hyperglycemia may be a life-threatening situation, requiring an immediate response.
   a. Hypoglycemia occurs when diabetic patients who are taking oral hypoglycemic medication or insulin have:
      i. Not eaten enough
      ii. Exercised more than usual
      iii. Taken more ~~mediation~~**medication**
   b. Hyperglycemia occurs:
      i. When oral agents/insulin is not enough or has not been taken
      ii. As a result of illness, stress, or too much food
   c. This policy provides the guideline for management of this population at the Center

B. **POLICY:**

1. Patients being treated at the Center who are taking insulin or oral hypoglycemic agents will be monitored and treated as necessary for hypoglycemia (blood sugar level **less than (<)** 70mg/dl or **less than (<)**#120mg/dl in the patient receiving HBOT).
2. The most appropriate intervention to restore blood sugar level to within normal range will be utilized.
3. Patients with blood sugar levels **greater than (>)** ∃400mg/dl will be directed to the ER for treatment.

C. **PROCEDURE:**

1. Equipment:
   a. Finger puncture safety device
   b. Comfort Curve Accuchek Strip
   c. GTS – Glucose reflectance meter
   d. Fast-acting carbohydrate
2. Hyperglycemia assessment and treatment
   a. Notify the Center/supervising physician of all elevated glucose levels for further orders
   b. Observe for signs and symptoms of hyperglycemia
   c. Patients with blood sugar level ∃400mg/dl will be referred to the emergency room for treatment
   d. Patients with repeated episodes of elevated blood sugars will be considered for referral to a Diabetes Education Program

3. Hypoglycemia assessment and treatment:
   a. Notify the Center/supervising physician for decreased glucose levels (**less than [<]** 70mg/dl or **less than [<]** ~~#~~120mg/dl in the patient receiving HBOT)
   b. Observe for signs and symptoms of hypoglycemia
   c. Patients with blood sugar level **less than (<)** 70mg/dl will be treated as follows:
      i. NOTE: Patients receiving HBOT must be treated for hypoglycemia prior to entry into the hyperbaric chamber. Observational studies suggest that blood glucose decreases in diabetics undergoing HBOT by as much as 50mg/dl.
      ~~(1)~~**ii.** If a patient is able to swallow:
         ~~(a)~~**1)** Give patient one of the following (only the amounts listed):
            ~~2)~~**a)** 4 ~~oz~~**ounces** orange juice
            ~~3)~~**b)** 2-3 glucose tablets
            ~~4)~~**c)** 4 ~~oz~~**ounces** of regular soda (not diet)
            d) 1 cup water with 2 packets of sugar
      iii. If a patient is unable to chew:
         1) Give the patient 1 tube of oral glucose gel
      iv. If a patient is unable to follow direction, swallow or has a change in level of consciousness (LOC):
         ~~5)~~**1) Call Paramedics**
      ~~ii.~~**v.** If patient is on enteral feedings:
         ~~D.~~**1)** Administer 8 **ounces~~z~~ of** water with 2 packets of sugar through G-tube or NG tube
         ~~i. If hypoglycemia persists, send patient to ER~~
      ~~ii.~~**vi.** Re-check capillary blood sugar 15 minutes after treatment. If blood sugar level continues to be **less than (<)** 70mg/dl or **less than (<)**#120mg/dl in the patient receiving HBOT and/or signs and symptoms do not abate, repeat intervention in step (1) above (for patients who are able to swallow).
      ~~iii.~~**vii.** After patient has responded to initial treatment, give additional food. If next meal is more than 1 hour away, give 2 packages of cheese and crackers.
      ~~iv.~~**viii.** If patient's condition is unstable or hypoglycemic symptoms persist, notify the Center's supervising physician for possible referral to the ER for treatment.
      ~~v.~~**ix.** Instruct patients who develop hypoglycemia at the Center to monitor their blood sugar closely for at least 48 to 72 hours to prevent recurrence.
      ~~vi.~~**x.** When appropriate, use situation as a patient teaching opportunity. Teaching should be done after the hypoglycemia has been treated and resolved. Remind patient to:
         ~~a)~~**1)** Carry glucose tablets or other fast-acting carbohydrate such as candy
         ~~b)~~**2)** Never skip meals
         ~~c)~~**3)** Never skip medication

~~2.~~**4.** Documentation by supervising physician and/or RN
   a. Progress/clinician notes must include:
      i. Assessment prior to treatment
      ii. Treatment given
      iii. Response to treatment

~~E.~~**5.** NOTE: The elderly, debilitated, malnourished, or those with adrenal or pituitary insufficiency or alcohol intoxication are more likely to be susceptible to hypoglycemic episodes.
   a. Patients on biguanides (Glucophage), thiazolidinediones (Actos, Avandia) and/or alpha-glucosidase inhibitors (Precose, Glycet) are not likely to experience hypoglycemia except when receiving the oral hypoglycemic agents such as sulfonylurea and insulin.

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

~~G.~~**1.** A Core Curriculum for Diabetes Education, Second Edition 1998
~~H.~~**2.** American Association of Diabetes Educators

~~I.~~3. The Prevention and Treatment of Complications of Diabetes Mellitus, Dept. of Health and Human Services, Public Health Services, Center for Disease Control, Atlanta, GA 1991, Chapter 2, Acute Glycemic Complications, pp 8-20

~~J.~~4. Parker and C. Fife, Hyperbaric Nursing, Chapter VI, pp 217-226.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~ &
HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: 06/07 **SUBJECT: Medical Emergencies**

REVISION DATE:

Department Approval:	02/20
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. Sudden and unexpected medical events may occur at any time. To minimize adverse/detrimental affects to the patient, prompt/immediate response from a competent and qualified staff is required. This policy outlines the process by which the clinic remains current and capable to respond effectively to medical emergencies.

B. **POLICY:**

1. The provision for emergent care in the Center will remain current through the appropriate certification and practice of its staff members.
2. All clinical staff will maintain current CPR certification~~ and be competent in~~:
   ~~a. Identifying emergency situations~~
   ~~b. The proper notification/communication process~~
   ~~c. Palpating pulses~~
   ~~d. Maintaining an adequate airway~~
   ~~e. The use of oxygen therapy~~
   ~~f. Performing adequate chest compression~~
3. Response to an emergency by the clinical staff will be limited to basic CPR
4. Basic emergency response equipment will be readily available in the clinic at all times and in good working order.
5. Emergency equipment will be checked, per hospital policy, and replaced as necessary.

C. **PROCEDURE:**

1. Once a valid emergency situation has been identified, other clinic staff members will be called immediately to assist **and print patient demographics and medication list.**
   a. The support staff (or any available staff member) will dial 911.
   b. Basic CPR will be administered until the advanced emergency team has arrived
   c. The support staff, with the assistance and direction from the clinical staff, will be responsible for coordinating the patient/visitor traffic flow, as well as the advanced emergency responder traffic.
   d. The support staff will also maintain order in the clinic and be available for questions from patients/families, etc. while adhering to all applicable privacy and confidentiality policies and regulations.
   e. The RN/case manager/PT will coordinate the clinic's emergency response activity and remain with the patient at all times.

f. The RN/case manager/PT or designee will notify family/friends/caregiver of the emergency and provide a private waiting area. If family member or patient representative is not present, every effort will be made to contact the appropriate party.

2. The nurse manager, program director, or medical director will conduct mock emergency scenarios periodically to assess staff readiness.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Medical Record Review**

REVISION DATE~~(S)~~:

Department Approval:	**2/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Documentation of assessment findings, procedure/treatment, etc. and appropriate signatures must always be included in the medical record. Pursuant to the hospital policy, the following defines the process used to identify incomplete records and the steps taken to correct deficiencies in the Center.

B. **POLICY:**

1. All charts will be reviewed for incomplete information after each clinic visit and after discharge of patient from the program prior to transferring to the health information department of the hospital.
2. Incomplete records will be returned to the appropriate clinician for completion.
3. The quality management/improvement process will be utilized as needed to improve the compliance with record completion.

C. **PROCEDURE:**

1. The ~~office coordinator~~**clinic lead nurse** will review the medical record for incomplete information during the data entry process.
2. The ~~office coordinator~~**clinic lead nurse** will communicate the findings to the appropriate person(s).
3. When indicated, the clinic physician will be notified and the medical records put aside and labeled using the hospital's customary flagging method.
4. The clinician will be ~~response~~**responsible** for ensuring that the record is completed.
   a. The clinician works collaboratively with the ~~office coordinator~~**clinic lead nurse** to achieve record completion.
5. The hospital's medical staff rules and regulations will be followed to complete the medical record.
   a. If the record is not completed within 30 days, the medical director or designee will be notified.
   b. Identified patterns of record deficiencies will be reported to the Center's physician quality director for review.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~ &
HYPERBARIC MEDICINE ~~CLINIC~~

ISSUE DATE: 06/07 **SUBJECT: Minor Debridement**

REVISION DATE:

Wound Care Department Approval:	**~~02/20~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. It is necessary to distinguish between procedures that may be done at the Center and procedures that must be done in another setting, such as the operating room. This policy outlines the type of debridement procedure allowable at the Center.

B. **POLICY:**

1. All applicable medical staff regulations/bylaws will be followed when performing invasive procedures in the Center.
2. Minor debridement may be performed using topical or local anesthetic by the Center physician.
3. Procedures requiring narcotic analgesia/sedation and/or involved surgical intervention will be performed in the surgical suite.
4. The patient will be informed of the risks/benefits of the procedure and sign **a written consent upon admission and give verbal** consent prior to any invasive procedure, per hospital policy.

C. **PROCEDURE:**

1. The scope of service is determined by the Center staff physician for non-emergent operative and other invasive procedures in accordance with "Assessment of Patients" standards.
2. The determination of the appropriateness of the procedure(s) for a patient is based on:
   a. The patient's medical, anesthesia and drug history
   b. The patient's physical status
   c. The diagnostic data
   d. The risks/benefits of the procedure
   ~~e. The need to administer blood/blood components, which would preclude clinic debridement~~
3. The physician will discuss the risks/benefits associated with the procedure(s) as well as alternatives/options to the procedure(s) with the patient/patient representative before informed consent is **obtained** ~~signed~~.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE &~~CENTER~~
HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: 06/07 **SUBJECT: Nutritional Screening**

REVISION DATE:

Wound Care Department Approval:	**~~02/20~~07/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**
1. Adequate response to metabolic demands caused by certain illnesses/conditions is vital to the body's healing capabilities. Recognizing and treating malnutrition is often as important or equal to the primary diagnosis. Nutritional screening and management:
   a. Provides patient baseline nutritional status, which helps to determine appropriate course of action to ensure optimal nutritional support
   b. Allows the body to limit catabolism, promote healing, and go into an anabolic state.

B. **POLICY:**
1. All patients entered into the wound management program will be screened nutritionally upon admission. In addition, patients may be screened prior to surgery if applicable, and more frequently as indicated.
2. Patients identified with nutritional needs during the screening process will have further evaluation as indicated.

C. **PROCEDURE:**
1. Nutritional screening is completed at the time of admission to the program, prior to surgery, and more frequently as indicated.
2. The indicators for poor nutritional status requiring intervention include:
   a. Loss of appetite, near or complete starvation for 5 or more days
   b. Recent unintended weight loss >10%-15% of normal body weight
   c. Increased metabolic needs (e.g., fever, trauma, infection, burns, surgery)
   d. Blood glucose levels out of control
   e. Fluid loss from open draining wounds
   f. Chronic illnesses such as diabetes, peripheral vascular disease, chronic open wounds, renal failure, liver disease, or thyroid disease
   g. Low percentage (<20%) of lymphocytes
   h. Anticipated prolongation of surgical recovery time, including time to return to adequate oral intake
   i. Muscle contractures/wasting/atrophy
   j. Significant weakness
   k. Temporal muscle wasting
   l. Depression, if it affects appetite/intake of nutrient-dense foods
3. The tests specific to nutritional deficit that may be ordered include:

a. Prealbumin
b. Serum albumin
c. Serum transferrin level
d. Hb A_{1c}
e. Lipid panel
f. CBC
g. Chem 7
h. The course of treatment is selected based on relevant clinical and laboratory findings, as appropriate.

4. Intervention may include prescribing one or more of the following:
   a. Nutritional supplements such as Vitamin C, Vitamin E, Zinc, or multivitamins
   b. Protein and caloric intake, e.g., Progen powder, Ensure, Nephro, Glucerna
   c. Anabolic steroids, e.g., Oxandrin
   d. Diabetes counseling
   e. Recommendation for increased muscle activity such as active or passive exercises
   f. Consultation with the hospital's registered dietician to assess and develop a treatment plan to improve nutritional status
   ~~g. Consultation with the hospital's Social Services Department for evaluation of home needs in the continuum of care~~

D. **REFERENCE(S)**:

1. Carney D, Meguid M, Current Concepts in Nutritional Assessment, ARCH SURG/VOL 137, Jan. 1992
2. Hensrudd DD, Nutritional Screening and Assessment, Med Clin North Am, 1999; 83:1525-1546
3. Bergstrom N, Bennett MA, Carlson CE, et al. Treatment of Pressure Ulcers Clinical Practice Guidelines, Number 15, Rockville, MD. Agency for Health Care Policy and Research, December 1994.
4. Pressure Ulcers in Adults: Prediction and Prevention. Clinical Practice Guideline, Number 3. AHCPR Publication 92-0047. Rockville, MD: Agency for Health Care Policy and Research, Public Health Service, US Department of Health and Human Services, May 1992.
5. American Diabetes Association: Evidence-based nutrition principles and recommendations for the treatment and prevention of diabetes and related complications. Diabetes Care 25 (Suppl. 1): S50-S60, 2002.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & ~~CENTER~~
HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: 06/07 **SUBJECT: Scope of Services**

REVISION DATE:

Department Approval:	**02/20**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **POLICY:**

1. The Center for Wound Care & Hyperbaric Medicine ("Center") provides advanced outpatient therapy/treatment for chronic non-healing wounds and ostomies consistent with specific medical needs of the patients. The primary goal of the Center is to provide vital services to the population at risk, which includes patients of multiple and differing socioeconomic and cultural backgrounds. These are patients with diabetes, rental failure, peripheral vascular disease, hypertension, and many other chronic illnesses and their sequelae.
2. The main objective of the program is to be a "Center of Excellence", providing state-of-the-art patient care service utilizing advanced treatment and prevention modalities.

B. **AGE POPULATIONS:**

1. The program has been designed to meet specific medical needs of the adult population. Under special circumstances and on a case-by-case basis, needs of other patient populations may be considered.

C. **TYPES OF PATIENTS:**

1. The patients seen in the Center are typically the outpatient population with chronic difficult-to-heal wounds, varying in age, who come to us from home or extended/long-term care facilities with underlying illnesses including:
   a. Age-related illnesses
   b. A variety of chronic illness, such as diabetes and its complications
   c. Multiple medical problems
   d. Auto-immune illnesses and their complications, such as vasculitis
   e. Post-traumatic injuries
   f. Vascular diseases, such as arterial and venous insufficiency
   g. Foot problems such as Charcot foot and diabetic foot ulcers
   h. Skin problems
   ~~h.~~**i. Non-healing post-op incisions**
2. Patients are also seen pre- and post-operatively for ostomy site markings, education, lifestyle adaptation, **peristomal skin issues** and appliance needs.

D. **CARE AND SERVICES PROVIDED**

1. The services provided by the Center include, but are not limited to chronic wound management/treatment including:

a. Wound debridement
b. Wound excision
c. Prescribing appropriate topical agents
d. Wound remodeling
e. Vascular assessment
f. Nutritional assessment
g. Infection control
h. Edema control
i. Offloading/pressure-relief methods and devices
j. Hyperbaric medicine as an adjunctive therapy for Medicare-approved indications

E. **HOURS OF SERVICE**

1. The Center is open 5 days per week, Monday through Friday, 8:00 AM to ~~5:00~~**4:30** PM.

F. **STAFFING PLAN**

1. The Center is staffed with:
   a. Medical staff ~~members~~**or contracted physicians** whose disciplines may include orthopedic surgery, general surgery, vascular surgery, plastic and reconstructive surgery, emergency medicine, podiatry and podiatric surgery, **family medicine,** internal medicine, infectious disease, endocrinology, radiology, nephrology, or dermatology. Qualified practitioners are selected based on:
      i. Interest in an interdisciplinary approach and collaboration in the care of chronic non-healing wounds
      ii. Proven skills in a relevant discipline
      iii. Medical and specialty experience
      iv. Established reputation in the medical community
      v. Hospital staff privileges
      vi. Ability to perform the requirements of the service to be rendered
   b. Clinic staff members include a full-time qualified clinical manager, nursing/clinical personnel and clerical support staff. The type and number are selected based on qualifications, experience and clinic needs. Clinic needs are determined by the number of active patients in the program, the type and the acuity of patients, the type of service required by the patients and the overall requirements of the clinic. The members of the staff may include registered nurses, licensed vocational nurses, nurse practitioners/physician assistants, Certified Wound Ostomy Continence Nurses, certified hyperbaric technicians, physical therapists, medical ~~assists~~**assistants**, and clerical staff.

G. **PLAN FOR IMPROVING QUALITY OF CARE**

1. The quality management program is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the Center. The key elements of the program are:
   a. Collection of meaningful data
   b. Selection of measurable indicators
   c. A valid method of data collection, management and storage
   d. Analysis of the data by qualified persons
   e. Reporting to pertinent hospital personnel and committees/teams
2. The clinic results are compared to national and/or system-wide benchmarks, when available, or the Center's own historical data. Unmet goals are perceived as opportunities for improvement. Corrective actions are relevant to improving the services rendered.

H. **STANDARD AND PRACTICE GUIDELINES**

1. The policies, procedures and standards of care are developed using the most recent scientifically valid practice guidelines. Sources include professional practice guidelines and

standards such as the American Society of Plastic Surgeons, American Medical Directors Association, American College of Foot and Ankle Surgeons, American College of Foot and Ankle Orthopedics and Medicine, Agency for Healthcare Research and Quality, Royal College of Nursing, Gerontology Nursing Interventions Research Center, American College of Radiology, American Academy of Family Physicians, American Association of Clinical Endocrinologists, American Academy of Orthopaedic Surgeons, American College of Physical Medicine and Rehabilitation, and the Centers for Disease Control and Prevention.

I. **COMPETENCY/EDUCATION**

1. Qualifications for the clinical staff of the program include:
   a. Clinical competency, as determined by level of care provided
   b. Current State license, where applicable
   c. Current BCLS, where applicable
   d. Credentialing by the medical staff, where appropriate
   e. Certification in hyperbaric medicine
2. Competency of the staff is based on:
   a. Education and training (licensing, certification and credentialing as appropriate)
   b. Ability to demonstrate the necessary skills to perform assigned duties
   c. Years of experience
   d. d. -Ability to communicate effectively with the medical staff, patients, and their families

~~J.~~**3.** Allied health professionals will either be hospital employees or be credentialed by the medical staff services, as permitted by Medical Staff Bylaws.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER&~~
HYPERBARIC MEDICINE ~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Standards of Care**

REVISION DATE~~(S)~~:

Department Approval:	**~~02/20~~08/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**10/22**
Administration Approval:	**11/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. Standards of care and practice must be delineated with the following objectives in mind:
   a. Provide patients and their families with an understanding of the services provided by the Center.
   b. Meet patient/family expectation, which is to have competent care providers when being treated at the Center.
   c. Define the standards of care and practice as required by governing and oversight bodies such as the Department of Health Services (DHS), Centers for Medicare and Medicaid (CMS) & The Joint Commission (TJC),

B. **POLICY:**

1. All clinical staff will follow the Nurse Practice Act and Standards of Care and Practice~~, and Consensus Standards from the Oncology Nursing Society (ONS) & American Society of Clinical Oncology (ASCO)~~ in the delivery of patient care.
2. The Center will operate according to the established standards, which addresses all aspects of care.
3. The standards of care and practice will be consistent with care and practice standards and mission of the hospital but will be specifically designed for the outpatient services provided at the Center. **See Wound Care Standards of Care and Practice**
4. Standards will be developed collaboratively with other relevant disciplines to maintain constancy in the level of care provided throughout the institution.
5. All activities including treatment plans, policies and procedures, documentation and performance improvement measures will correlate with the approved standards of care and practice.

C. **PROCEDURE:**

1. The clinical manager/medical director and the clinical staff of the Center are responsible for developing the standards of care and practice.
2. The hospital format is utilized and defines the:
   a. Standard of care as the expected outcome
   b. Standard of practice as the scope of service, the person responsible, and the timeframe for completion
3. The standards will be reviewed and approved by Patient Care Services prior to implementation.
4. All policies and procedures will be developed/revised utilizing the established standards.
5. The performance improvement (PI) efforts will incorporate the standards in the PI activities.
6. The designated infusion center team will review the standards biannually.

7. The Standards of Care and Practice are delineated on the following pages.

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

~~7.~~1. **Wound Care Standards of Care and Practice**

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	1. The patient will have a competent and qualified registered nurse responsible for planning, directing and evaluating his/her care.	RN	Ongoing	1. The clinician systematically evaluates the quality and efficacy of nursing practice. a. Participates in performance improvement (PI) activities as appropriate to the individual's position, education and training, and practice environment. • Identifies key functions important for monitoring • Identifies measures used to monitor quality and efficacy of patient care • Collects data to monitor quality and efficacy of patient care • Analyzes data to identify opportunities for improving care • Make recommendations to improve nursing practice • Participates with team efforts to evaluate clinical practice or health services • Assists with the development of policies and procedures to improve performance. b. Use PI information to initiate change in practice c. Use PI information to initiate change in healthcare delivery 2. The clinician evaluates his/her own nursing practice in relation to professional practice standards and relevant statutes and regulations. a. Engages in performance self-appraisal on a regular basis, identifying areas of strength, as well as areas for professional practice development b. Seeks constructive feedback regarding his/her own performance c. Takes appropriate action to achieve identified goals d. Participates in peer review, as appropriate 3. The clinician maintains proficiency in current professional activities. a. Maintains current state licensure b. Meets the current mandatory educational requirements for employees of the hospital including completion of the orientation and annual reorientation processes c. Has knowledge of and uses established hospital and Center policies and procedures in accomplishing patient care d. Meets or exceeds performance standards as indicated on the annual performance appraisal

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	STANDARD	RESPONSI-BILITY	TIME-FRAME	SCOPE OF SERVICE
Aspects of Care	(continued)	RN	Ongoing	e. Participates in ongoing educational activities relevant to current practice f. Seeks experience to maintain skills g. Participates in and seeks knowledge about the activities associated with the continuum of care 4. The clinician contributes to the professional development of peers as well as the other levels of caregivers a. Shares knowledge and skills with colleagues and others b. Provides the Center's staff with constructive feedback regarding practice c. Contributes to an environment favorable to ongoing clinical education 5. The clinician collaborates with the patient/family/caregiver and healthcare providers in providing consistent care. a. The clinician communicates with the patient/family/caregiver regarding patient care and nurse's role in the provision of care b. The clinician consults with healthcare providers including pharmacist for patient care as needed c. The clinician makes appropriate referrals to agents/agencies for continuity of care d. The clinician collaborates with interdisciplinary staff as appropriate to coordinate all aspects of care 6. The plan of care and the provision for care is conducted in a manner that protects and advocates on behalf of the patient. a. The State's Nurse Practice Act guides the nurse's practice b. The clinician ensures the confidentiality of the patient/family c. The clinician acts as the patient/family advocate d. The clinician delivers care in a non-judgmental and nondiscriminatory manner that is sensitive to the diversity of individual patient needs e. The clinician delivers care in a manner that preserves and protects patient autonomy, dignity and rights f. The clinician seeks appropriate resources to help formulate ethical decisions 7. The clinician uses research findings in practice. a. The clinician uses interventions substantiated by research, which are approved as appropriate to the individual's scope of practice, position,

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				education and practice environment b. The clinician participates in research activities as appropriate to the individual's scope of practice, position, education and practice environment
Aspects of Care	2. The patient will have care and interventions directed toward the support and maintenance of normal and improved physiological status and not experience avoidable complications	RN	Ongoing	The clinician will: 1. Assess the patient's current health status and pertinent information of present and past history. 2. Collaborate with physician and other healthcare providers in planning care. 3. Observe and report signs and symptoms of complications. 4. Provide nursing interventions as appropriate. 5. Document all findings of assessments, interventions and changes of the plan of care.
Aspects of Care	3. The patient will have care and interventions directed toward support of emotional, psychological and spiritual needs.	RN	Ongoing	The clinician will: 1. Assess patient needs, identify desired outcomes, and design specific nursing interventions to achieve goals involving: a. Emotional needs • Observes behavior that reflects patient's emotional needs • Assesses possible contributing factors for behaviors • Determines needs related to behaviors • Identifies resources for meeting the emotional needs b. Psychological needs • Supports the patient during tests/procedures • Encourages questions and expression of feelings • Makes appropriate professional referrals for counseling, as appropriate • Provides for patient privacy c. Spiritual • Acknowledges and supports the patient's religious prohibitions/ restrictions, etc. 2. Evaluate effectiveness of intervention and documents in the patient's record
Aspects of Care	(continued)	RN	Ongoing	

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
Aspects of Care	4. Before initiation of a ~~chemotherapy regimen~~, **wound care of HBOT treatment**, each patient is given ~~written documentation, including~~, at minimum **information and education.**~~:~~	RN	Ongoing	a. Information regarding his/her diagnosis b. Goals of therapy c. Planned duration of **treatment** ~~chemotherapy, drugs,~~ and schedule d. Confirm with the patient his/her planned treatment **at each Wound Center visit**~~prior to each cycle;~~ ~~e. Information on possible short- and long-term adverse effects~~ ~~f.~~**e.** ~~Regimen- or drug-specific risks~~ **Treatment** or symptoms that require notification and emergency contact information, including: • How to contact the **Wound Center**~~practice or organization;~~ • Symptoms that should trigger a call; • Who should be called in specific circumstances ~~(oncologist or other provider)~~ ~~g.~~**f.** Plan for monitoring and follow-up ~~h.~~**g.** Patient education materials should be appropriate for the patient's reading level/literacy and patient/caregiver understanding.
Aspects of Care	5. On each clinical visit or day of treatment ~~during chemotherapy administration,~~ staff:	RN	Ongoing	A. Assess and document clinical status and/or performance status B. Document vital signs and ~~weight~~**pain assessment** C. Verify allergies, previous reactions, and ~~treatment-related toxicities~~ **patient treatment tolerance** D. Assess and document psychosocial concerns and need for support; taking action when indicated. E. At each clinical visit ~~or day of treatment during chemotherapy administration~~, staff will review the patient's current medications including over the counter medications and complementary and alternative therapies. Any changes in the patient's medications are

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	STANDARD	RESPONSI-BILITY	TIME-FRAME	SCOPE OF SERVICE
				reviewed and documented by a practitioner during the same visit.
Environ-ment	The patient can expect to be treated in a safe, sanitary, comfortable and therapeutic environment.	All staff	Ongoing	1. The staff will: a. Assure that equipment and supplies will: • Be maintained in good/safe working order • Be readily available • Be kept clean b. Dispose of waste properly by following hospital waste policies including • ~~chemotherapy safety and handling policies~~ • Biohazardous waste policy & procedure • Sharps use & disposal policy & procedure c. Take measures that prevent cross-infection and transmission of potentially infectious/communicable microorganisms by: • Following hospital transmission-based precautions as it relates to the practice in the clinic • Handwashing/hand antisepsis (1) Before and after patient contact (2) Before and after contact with patient wounds (3) Before performing or assisting with clinic procedures (4) After contact with contaminated surfaces/equipment (5) After contact with body substances or mucous membranes • Maintain aseptic and clean technique, as appropriate • Maintain a clean and sanitary environment d. Provide for patient's safety by: • Locking wheels of chairs, wheelchairs when transferring or assisting patients from one area to another • Never leaving disoriented/confused patients unattended • Assisting patients with visual deficit when ambulating • Assisting patients with unsteady gait when navigating around the clinic • Placing call bells at every patient chair • Placing personal belongings as close as possible to patient • Using appropriate equipment based on age and size

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
				e. Providing assistance and protection in life-threatening events by: • Following hospital's emergency procedures, e.g., fire, disaster, security, etc. • Following emergency cardiac event protocol
Assessment	The patient will be assessed for his/her biophysical, psychological, social, nutritional, functional, comfort and educational needs to determine the course for the plan of care.	RN/PT	Initial visit	1. During the initial visit the clinician will: a. Complete or assist patient with completing the general information requirements and include information, as appropriate, from family members, friends, caregivers and care providers. b. Review available medical history records c. Record relevant medical data including: • Laboratory findings • Allergies • Current medication • Activities of daily living • Nutritional status • Mobility • Social habits such as consumption of tobacco, caffeine, alcohol, and recreational drugs • Past and present medical history • Past hospitalizations, surgeries, invasive procedures • Review of systems • Vital signs - TPR & BP • Pain assessment • Evidence of, or suspicion of, abuse ~~d.Assess pain~~ ~~e.~~**d.** Assess barriers to learning functional assessment ~~f.~~**e.** Evaluate home environment ~~g.~~**f.** Assess transportation needs ~~h.~~**g.** Complete appropriate age specific assessment for the adolescent, adult and geriatric patient that includes consideration for: • Growth & development • Emotional needs • Cognitive status

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	STANDARD	RESPONSI-BILITY	TIME-FRAME	SCOPE OF SERVICE
~~Assessment~~	~~(continued)~~	~~RN~~	~~Initial visit~~	• Educational needs • Social needs • Daily activity needs
Reassess-ment	The patient will be reassessed for compliance and response to treatment at each visit.	RN	Ongoing	The patient is reassessed at each visit for: 1. Compliance with the plan of care a. Response to treatment b. Understanding of home instructions c. Changes in care, medication, new illness, hospital visits d. Wound condition e. Supply/equipment needs f. Signs and symptoms of complications g. Continuing care needs h. Pain level i. Mobility status j. Mental status k. Educational needs l. Acuity
Patient/ Family Education	The patient/family/ caregiver will be knowledgeable about the nature of the patient's illness and will be included in the plan of care and the treatment procedures necessary to restore the patient back to optimal health.	RN	Ongoing	Nursing will: 1. Assess and document the level of understanding that the patient/family caregiver demonstrates about the patient's illness and healthcare needs. 2. Assess and document the patient's ability and readiness to learn. 3. Develop individualized teaching/learning plans. 4. Collaborate with the clinic physician and other team members to provide continuity of the teaching plan. 5. Provide support and information to patient/family to include: a. Orientation to the Center program b. Explanation of tests and procedures c. Safe and effective use of medications and expected responses and side effects

STANDARD OF CARE				STANDARD OF PRACTICE
FUNCTION	**STANDARD**	**RESPONSI-BILITY**	**TIME-FRAME**	**SCOPE OF SERVICE**
~~Patient/ Family Education~~	~~(continued)~~	~~RN~~	~~Ongoing~~	d. Safe and effective use of equipment and supplies e. Patient care techniques f. When to call and how to reach the center g. Access to available community services h. Obtaining assistance from other health disciplines 6. Utilize appropriate teaching methods and tools 7. Evaluate the effectiveness of the teaching 8. Document learning assessments and interventions and patient/family response to educational efforts
Patient Rights	The patient will have a sense of acceptance as a person and of value as a human being and will maintain a sense of personal identity	All clinic staff	Ongoing	The staff will: 1. Protect, to the extent possible, all patient information according to all applicable regulatory and hospital requirements. 2. Approach the patient with a respectful and compassionate attitude by: a. Conveying a sense of concern and warmth b. Identifying themselves at each encounter c. Responding appropriately to patient needs 3. Assist patient to maintain a sense of personal identity by: a. Communicating what the patient can routinely expect, as well as the tests, procedures and treatments performed b. Respecting the patient's right to inquiry and information regarding their illness, the plan of care and associated procedures/treatments c. Making patients/family aware of their rights and the procedure to follow when they have complaints or concerns d. Encouraging patient/family participation in planning care e. Acting as patient advocate f. Use patient's proper name or the stated preference

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~&~~ HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: 06/07 **SUBJECT: Vascular Screen**

REVISION DATE~~(S)~~:

Department Approval:	~~02/20~~08/22
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	10/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. Successful wound treatment/repair is dependent upon sufficient blood flow and oxygen perfusion to the tissue area. This policy outlines the processes/testing necessary to establish vascular integrity.

B. **POLICY:**

1. All patients with lower extremity wounds will be screened for vascular function.
2. More advanced testing may be indicated/ordered as a result of initial screening process.
3. Where H&P and non-invasive testing indicate a significant obstruction, a vascular **or IR** consult will be ordered.

C. **PROCEDURE:**

1. Utilizing the approved form, the clinical staff will screen patients with lower extremity wounds for vascular function during initial visit and/or when changes occur using one or both of the following methods:
   a. Palpating appropriate pulses, i.e., dorsalis pedis, posterior tibial
   b. If no palpable pulses, a hand-held Doppler will be utilized to check for audible pulses following manufacturer instructions.
2. Documentation will include:
   a. Pulses
      i. P = ~~Present~~**Palpable**
      ii. D = ~~by~~ Doppler
      iii. A = Absent
   b. Color of extremity
      i. WNL (within normal limits)
      ii. Pale
      iii. Mottled
      iv. Red
      v. Pigmented
      vi. ~~Other~~**Dusky**
      ~~vi.~~**vii. Black**
   c. Temperature of extremity
      i. WNL
      ii. Warm
      iii. Cool

~~iii.~~**iv. Cold**

d. Skin integrity of extremity
   i. ~~WNL~~**Dry**
   ii. ~~Dry~~**Moist**
   iii. Rash
   iv. Erythema
   v. Weeping

3. Result of initial screen will be reported to the admitting physician.
4. The clinic physician may order more advanced testing, such as ~~Laser~~**Arterial** Doppler, ~~ABI~~**Venous** Duplex Scan, Angiogram, etc. after initial evaluation.
   a. If the test is to be performed in the hospital vascular lab, the ~~clinician~~**clinic office staff** ~~will complete the appropriate request form and obtain required physician signature~~**will fax the signed order to appropriate vascular lab staff**
   b. **The** support staff will **give the patient the phone number to the appropriate vascular lab to schedule an appointment. If the patient is unable to schedule an appointment, the Support staff will** arrange the patient appointment with the vascular lab and notify patient with date, time and location and arrange transportation if needed.
5. Patients with test results showing significant obstruction will be referred for vascular consultation.

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
September 29, 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 September 29, 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
Dr. Gene Ma, Chief Medical Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky 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, seconded by Director Gleason and unanimously passed to approve the agenda as presented by a roll call vote.

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 September 29, 2022 Regular Board of Directors Meeting Agenda.

   Cathy Cronce, RN and Edmundo Garcia, CNA Labor Relations Representative requested to speak under Public Comments.

5. Reports – Information Only

a) Geriatric Emergency Department Accreditation

Dr. Cary Mells, Chairman of the Department of Emergency Medicine presented a report on Tri-City's Geriatric Emergency Department Accreditation (GEDA). He explained the American College of Emergency Physicians set up an accreditation process to ensure older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. The project began 3-4 years ago and was spear-headed by the Gary and Mary West Foundation. Today every hospital in San Diego County has achieved the GEDA accreditation, making San Diego county the first in the nation to achieve this milestone.

Directors asked questions and congratulated Dr. Mells on the accreditation.

6. August, 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 – $55,094
- Operating Expense – $59,846
- EBITDA – ($891)
- EROE – ($3,250)

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

- Average Daily Census – 120
- Adjusted Patient Days – 15,239
- Surgery Cases – 979
- ED Visits – 9,083

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

- Net Operating Revenue – $27,411
- Operating Expense – $29,700
- EBITDA – ($205)
- EROE – ($1,599)

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

- Average Daily Census – 122
- Adjusted Patient Days – 7,978
- Surgery Cases – 476
- ED Visits – 4,679

Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

7. New Business - None

8. Old Business - None

9. Chief of Staff

September 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 26, 2022

Dr. Showah presented the Medical Staff Credentials which included 12 Initial Appointments, 23 Reappointments, 15 Voluntary Resignations, 1 Request for Extension of Proctoring, 1 Automatic Relinquishment of Privileges and 1 Additional Privilege Request. Dr. Showah also reported the Medical Staff Office have processed over 50 applications this past month, most of which were for temporary privileges.

It was moved by Director Gleason and seconded by Director Younger to approve the September 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 26, 2022.

10. Consideration of Consent Calendar

Chairperson Chavez requested the following two agenda items be pulled:

- 10 (5) Approval of the implementation of a Critical Care Intensivist Program with CEP America-Intensivists PC dba Vituity, for a term of 36 months, beginning November 1, 2022 and ending October 31, 2025, at an annual cost not to exceed $1,336,487 and a total term cost not to exceed $4,09,461; and

- 10 (12) Approval of the First Amendment Lease Agreement Renewal with OPS Enterprises, LLC at 3617 Vista Way, Oceanside, CA for an additional fourteen (14) year term beginning October 1, 2022 and ending September 30, 2036.

It was moved by Director Coulter and seconded by Director Mizell to approve the Consent Calendar minus the items pulled.

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. Discussion of items pulled from Consent Calendar

10 (5) Approval of the implementation of a Critical Care Intensivist Program with CEP America-Intensivists PC dba Vituity, for a term of 36 months, beginning November 1, 2022 and ending October 31, 2025, at an annual cost not to exceed $1,336,487 and a total term cost not to exceed $4,09,461.

Dr. Gene Ma, Chief Medical Officer explained the benefits of the Critical Care Intensivist Program for both the patient and caregivers that will provide 24-7 critical

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
September 29, 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 September 29, 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
Dr. Gene Ma, Chief Medical Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky 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, seconded by Director Gleason and unanimously passed to approve the agenda as presented by a roll call vote.

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 September 29, 2022 Regular Board of Directors Meeting Agenda.

   Cathy Cronce, RN and Edmundo Garcia, CNA Labor Relations Representative requested to speak under Public Comments.

5. Reports – Information Only

a) Geriatric Emergency Department Accreditation

Dr. Cary Mells, Chairman of the Department of Emergency Medicine presented a report on Tri-City's Geriatric Emergency Department Accreditation (GEDA). He explained the American College of Emergency Physicians set up an accreditation process to ensure older patients receive well-coordinated, quality care at the appropriate level at every ED encounter. The project began 3-4 years ago and was spear-headed by the Gary and Mary West Foundation. Today every hospital in San Diego County has achieved the GEDA accreditation, making San Diego county the first in the nation to achieve this milestone.

Directors asked questions and congratulated Dr. Mells on the accreditation.

6. August, 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 – $55,094
- Operating Expense – $59,846
- EBITDA – ($891)
- EROE – ($3,250)

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

- Average Daily Census – 120
- Adjusted Patient Days – 15,239
- Surgery Cases – 979
- ED Visits – 9,083

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

- Net Operating Revenue – $27,411
- Operating Expense – $29,700
- EBITDA – ($205)
- EROE – ($1,599)

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

- Average Daily Census – 122
- Adjusted Patient Days – 7,978
- Surgery Cases – 476
- ED Visits – 4,679

Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

7. New Business - None

8. Old Business - None

9. Chief of Staff

September 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 26, 2022

Dr. Showah presented the Medical Staff Credentials which included 12 Initial Appointments, 23 Reappointments, 15 Voluntary Resignations, 1 Request for Extension of Proctoring, 1 Automatic Relinquishment of Privileges and 1 Additional Privilege Request. Dr. Showah also reported the Medical Staff Office have processed over 50 applications this past month, most of which were for temporary privileges.

It was moved by Director Gleason and seconded by Director Younger to approve the September 2022 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on September 26, 2022.

10. Consideration of Consent Calendar

Chairperson Chavez requested the following two agenda items be pulled:

- 10 (5) Approval of the implementation of a Critical Care Intensivist Program with CEP America-Intensivists PC dba Vituity, for a term of 36 months, beginning November 1, 2022 and ending October 31, 2025, at an annual cost not to exceed $1,336,487 and a total term cost not to exceed $4,09,461; and

- 10 (12) Approval of the First Amendment Lease Agreement Renewal with OPS Enterprises, LLC at 3617 Vista Way, Oceanside, CA for an additional fourteen (14) year term beginning October 1, 2022 and ending September 30, 2036.

It was moved by Director Coulter and seconded by Director Mizell to approve the Consent Calendar minus the items pulled.

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. Discussion of items pulled from Consent Calendar

10 (5) Approval of the implementation of a Critical Care Intensivist Program with CEP America-Intensivists PC dba Vituity, for a term of 36 months, beginning November 1, 2022 and ending October 31, 2025, at an annual cost not to exceed $1,336,487 and a total term cost not to exceed $4,09,461.

Dr. Gene Ma, Chief Medical Officer explained the benefits of the Critical Care Intensivist Program for both the patient and caregivers that will provide 24-7 critical

care physician coverage. Dr. Ma asked that the Board consider moving the term of the agreement up one month to begin October 1, 2022.

It was moved by Director Gleason and seconded by Director Coulter to amend the start date for the implementation of a Critical Care Intensivist Care Program with CEP America Intensivists PC dba Vituity to October 1, 2022 and ending September 30, 2025.

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 (12) Approval of the First Amendment Lease Agreement Renewal with OPS Enterprises, LLC at 3617 Vista Way, Oceanside, CA for an additional fourteen (14) year term beginning October 1, 2022 and ending September 30, 2036.

Mr. Jeremy Raimo, Senior Vice President of Business Development stated the initial submission on the Lease Agreement with OPS was 14 years, however we were able to negotiate better terms and savings with a 7-year lease. Mr. Dietlin further explained the original agreement was a 10-year agreement which is up and restated at fair market value (FMV).

It was moved by Director Gleason and seconded by Director Chaya to amend the term of the Lease Agreement with OPS Enterprises, LLC to a seven (7) year term beginning October 1, 2022 and ending September 30, 2029.

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**

12. Comments by Members of the Public

Chairperson Chavez invited comments from the public. Comments were received from the following persons:

- Edmundo Garcia, CNA Labor Rep
- Kathy Cronce, RN, Chair of the Professional Practice Committee

13. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO stated many of the issues brought up by today's speakers are happening at health facilities across the county and nationwide. However, we are

making progress in that we have filled over 400 positions this calendar year. The large number of travelers were needed in order to fill the needs of the community.

Mr. Dietlin commented on the Geriatric Emergency Accreditation report given by Dr. Mell's earlier today. He noted Dr. Mells and his group were already working on the accreditation process prior to the county's involvement and kudos to the team for being on the forefront of that.

Mr. Dietlin thanked the Foundation for hosting the Physician Appreciation Reception and for all the support the Foundation has provided including the funds for the Emergency Department remodel.

Mr. Dietlin reported currently Tri-City has three (3) COVID-19 positive inpatients (the lowest number we have seen in a long time) and county-wide there are 191.

Mr. Dietlin provided an update on the Psychiatric Health Facility collaborative between the county and Tri-City. Mr. Dietlin stated in a short period of time he anticipates the initiative coming to fruition with the announcement on the ground breaking.

Lastly, Mr. Dietlin stated earlier today we heard from our independent financial statement auditors that for the 10th year in a row Tri-City has a clean audit with no adjustments. Mr. Dietlin thanked the accounting and finance staff for their hard work and integrity in our financials.

Director Chaya thanked the Foundation for hosting the Physician Appreciation Reception.

Director Chaya reported October 10th is World Mental Health Day and a good time to raise awareness of mental health issues around the world. She is proud that Tri-City is taking on the Psychiatric Health Facility project with the county.

Director Coulter had no comments.

Director Gleason thanked Dr. Mells for the report on the Geriatric Emergency Accreditation and stated it is equally wonderful that all Emergency Departments in San Diego are accredited.

Director Gleason stated she is very confident that the hospital is moving forward in a positive manner. We have a strong foundation and now it is time to accomplish some of the things we have been trying to do in the last couple of years.

Director Mizell also thanked the Foundation for hosting the Physician Appreciation Reception.

Director Mizell commented on the recent story in the Heart of Tri-City Newsletter related to birth of premature twins and the wonderful care provided by TCMC's NICU team. He also commented on another story in the Heart of Tri-City Newsletter regarding the opening of the Pacific View OB/GYN clinic.

Lastly, Director Mizell reported that our own Aaron Byzak will be in the Carlsbad High School Hall of Fame and congratulated Aaron on that honor.

Director Sanchez stated she is happy about the direction Tri-City Medical Center is going. She also commented on remarks made by today's speakers and stated the Board is committed to hearing everyone's viewpoint. Lastly, Director Sanchez commented on the importance of sharing our positive stories not only with the public but with staff members as well.

Director Younger congratulated Dr. Mells on the Geriatric Emergency Department Accreditation.

Director Younger also commented on the remarks made by today's speakers.

14. Report from Chairperson

Chairperson Chavez reported the Board is "dark" in October. The next Board meeting is scheduled for November 17, 2022 followed by the December Board meeting on December 15, 2022.

Chairperson Chavez encouraged everyone to get their flu vaccine and COVID boosters.

17. Adjournment

There being no further business, Chairperson Chavez adjourned the meeting at 4:23 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

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

September 29, 2022 –2:30 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 2:00 p.m. on September 1, 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 via teleconference were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief, Patient Care Services
Dr. Gene Ma, Chief Medical Officer
Jeremy Raimo, Senior Director of Business Development
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 2:30 p.m. with attendance as listed above.

2. Approval of agenda

   It was moved by Director Gleason and seconded by Director Younger to approve the agenda as presented. The motion passed unanimously by a roll call vote.

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

   Chairperson Chavez made an oral announcement of the items listed on the September 29, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Hearing on Reports of the Hospital Medical Audit or Quality Assurance Committees and Reports Involving Trade Secrets with dates of disclosure to be determined.

4. Motion to go into Closed Session

   It was moved by Director Younger and seconded by Director Coulter to go into Closed Session at 2:05 p.m. The motion passed unanimously.

5. At 3:00 p.m. the Board returned to Open Session with attendance as previously noted.

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

   a) The Board heard Reports relating to Quality Assurance and Trade Secret matters and took no action.

7. New Business

   a) Consideration to accept the Fiscal 2022 Financial Statement Audit

   Mr. Ray Rivas, CFO introduced Kyle Rogers, Senior Manager and Brian Conner, Partner with Moss Adams.

   Mr. Rogers and Mr. Conner presented the results for the year-ended June 30, 2022 Fiscal Year Financial Statement Audit. Mr. Conner and Mr. Rogers reported the auditors will issue an unmodified opinion which reflects the Financial Statements are presented fairly and in accordance with accounting principles generally accepted in the United States of America. In addition, there were no material weaknesses or proposed adjustments and no difficulties were encountered in performing the audit. Mr. Conner stated this is a definition of a clean audit and is a great accomplishment.

   Directors asked questions that were answered by the auditors, along with Ray Rivas, CFO.

   Mr. Dietlin commented on several things that occurred this past year that affected the bottom line. Contract labor became an issue like health systems have never seen before and it had a direct impact on the results. He also commented on the delay in IGT which could have been an additional $12 million to the bottom line and would have resulted in a positive EBITDA. Mr. Dietlin stated the future has been difficult to predict during this unprecedented pandemic, however we have been able to fill a significant number of positions and are also working on reducing our length of stay (LOS). Mr. Dietlin stated the Tri-City team did an unbelievable job in bringing in the resources needed, when they were needed most, to serve the medical needs of our community. He expressed his appreciation to the staff during this continued unprecedented time period.

   It was moved by Director Sanchez to accept the Fiscal 2022 Financial Statement Audit. 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**

7. Adjournment

Chairperson Chavez adjourned the meeting at 3:31 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

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

October 12, 2022 – 4:30 o'clock p.m.
Via Teleconference

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 4:30 p.m. on October 12, 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 M. Younger

Absent was Director Nina Chaya, M.D.

Also present were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief Patient Care Services
Dr. Gene Ma, Chief Medical Officer
Jeremy Raimo, SVP, Business Development
Jennifer Paroly, Foundation President
Jeff Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Director Chavez, called the meeting to order at 4:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Mizell to approve the agenda as presented. The motion passed (6-0-0-1) with Director Chaya absent.

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

   Chairperson Chavez made an oral announcement of the items listed on the October 12, 2022 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Reports Involving Trade Secrets and Conference with Legal Counsel regarding one matter of Potential Litigation.

4. Motion to go into Closed Session

It was moved by Director Gleason and seconded by Director Younger to go into Closed Session at 4:35 p.m. The motion passed (6-0-0-1) with Director Chaya absent.

5. At 5:00 p.m. the Board returned to Open Session with attendance as previously noted.

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

The Board in Closed Session heard Reports involving Trade Secrets and took no action.

The Board in Closed Session was advised regarding a Potential Litigation matter and took no action.

7. New Business

a) Consideration to approve an Agreement with CNC Contractors Corp. for construction of the ED Remodel Project.

Mr. Steve Dietlin, CEO reported bids have been received for the ED Remodel Project. The remodel will improve the look, feel and function of our Emergency Department. The Board is being asked today to consider awarding the qualified bid to CNC Contractors Corp. which will allow us to move forward with the construction phase of the project. He noted the project is primarily being funded by our Tri-City Hospital Foundation.

Following discussion, it was moved by Director Gleason, seconded by Director Coulter and passed (6-0-0-1) with Director Chaya absent to approve an Agreement with CNC Contractors Corp. for construction of the ED Remodel Project.

7. Adjournment

Chairperson Chavez adjourned the meeting at 5:00 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending October 31, 2022

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	13,283.34	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)	6,262.83	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)	4,310.00	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
CreekView Orhopaedic Bldg, LLC 1958 Via Centre Drive Vista, Ca 92081 **V#83025**	Approx 4,995	$2.50	(a)	2,997.00	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)	1,722.00	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)	7,142.39	09/01/21	10/31/31	**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)	8,320.84	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)	30,907.00	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)	14,447.11	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,754.00	02/01/20	10/31/22	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**93,146.51**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending October 2022

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
6185	ONS ONC	101222 EDU	425.00	83334	WIEBOLDT, BERNADETTE
7290	REGISTRATION FOR VALUE BASED	102622 EDU	340.00	82008	TRUDEAU, MONICA
8700	AHIMA CCS	92822 EDU	299.00	84171	RUBI GRRIEGO
8740	MSN FAMILY NURSE PRACTITIONER	90822EDU	5,000.00	84176	JULIE HERBST
8740	PHARMACY	100622 EDU	120.00	82580	DROLSHAGEN, ASHLEY
8740	ADDICTION CONFERENCE	102022 EDU	200.00	82938	FRIENDBERG, HILLARY
8740	CONFERENCE	102722 EDU	200.00	83767	DAGMARA KOLASA
8740	RADIATION SAFETY	102022 EDU	115.00	78903	NIGGLI KAREN
8740	CCR EXAM	101722 EDU	200.00	81426	DACOME OLIVIA
8740	CHARGE	101722EDU	150.00	81863	LAMUNA, JOY

**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.