TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
December 15, 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 using the following information:

https://us02web.zoom.us/j/89603088986?pwd=TWdTVnRvd240bzVNM28vYmNDREh4UT09

Dial in #: (669-900-6833) To Listen and Address the Board when called upon:
Meeting ID:896 0308 8986; Passcode: 346744

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	October 2022 Financial Statement Results	10 min.	CFO
6	New Business a) Consideration and possible action to elect Board of Director Officers for calendar year 2023: 1) Chairperson 2) Vice Chairperson 3) Secretary 4) Treasurer 5) Assistant Secretary 6) Assistant Treasurer 7) Board Member	10 min.	Chair

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
	b) Consideration of proposed 2023 Board Meeting Schedule	5 min.	Chair
	c) Internal Communications – Discussion Only	15 min.	Dir. Sanchez
7	Old Business – None	-	-
8	Chief of Staff - a) November 2022 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on November 28, 2022	5 min.	COS
9	Consideration of Consent Calendar ***Requested items to be pulled require a second*** (1) Approval of Resolution 821, 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 Cepheid for testing supplies for COVID, Flu A/B and RSV for a term of 24 months, beginning January 1, 2023 and ending December 31, 2024, for an annual cost not to exceed $960,000 and a total cost for the term not to exceed $1,920,000. (3) Approval of an agreement with Immucor for pre-transfusion blood type and antibody screen testing for a term of 60 months, beginning January 1, 2023 and ending December 31, 2027, for an annual cost of $100,380 and a total cost for the term of $501,900. (4) Approval of an agreement with Pepsi Beverages Company for a term of 36 months, beginning January 1, 2023 and ending December 31, 2025, for an annual cost of $197,000 and a total cost for the term of $591,000. (5) Approval of an agreement with Abbott Laboratories, Inc. for chemistry immunoassay and infectious disease testing equipment and consumables for a term of.60 months, beginning January 1, 2023 and ending December 31, 2027, for an annual cost of $602,100 and a total cost for the term of $3,010,500. (6) Approval of the renewal of an agreement with Vereco, Inc. for TCHD's print management services to include copier maintenance, staffing copy center, courier services/toner/ink stocking and distribution, mail distribution services and document destruction services for a term of 60 months beginning January 1, 2023 and ending on December 31, 2027 for an annual cost of $1.3M a year and a total term cost of $6.5M. (7) Approval of a lease agreement with Sherev Heart and Vascular Clinic, Inc.,on a month-to-month basis, terminable upon 60 days' written notice, beginning December 1, 2023 and ending December 31, 2027. This lease remains within the current fair market value rate of $2.15 per square foot for a monthly revenue of $3,117.50. (8) Approval of the renewal of an agreement with Crothall Laundry	10 min.	Standard

	Agenda Item	Time Allotted	Requestor

Services, Inc. for TCMC's linen and laundry services for a term of 36 months, beginning January 1, 2023 and ending December 31, 2025 for an annual cost of $600,000 and a total cost for the term of $1,800,000.

(9) Approval of the renewal of the Hospital Medicine Program with Sound Physicians, dba Hospitalist Medicine Physicians of California, Inc. for a term of 24 months, beginning January 1, 2023 and ending December 31, 2024, at an annual cost not to exceed $3,449,840 and a total term cost not to exceed $6,899,680.

(10) Approval of the capital equipment purchase of a new Nihon Kohden Telemetry Monitoring system for nine (9) nursing units and an upgrade to the existing system in the Emergency Department which is proposed to begin on January 1, 2023 and ending December 31, 2023, for a total cost of $1,144,495.

(11) Administrative Committees

A. Policies

1. Patient Care Services Policies & Procedures

a. Activated Clotting Time Testing by Medtronic ACT Plus Procedure
b. Ambulance Transport for Patients Policy
c. Amnisure Placental Alpha – 1 Microglobulin (PAMG1) Test for Rupture of Fetal Membranes (ROM) – Procedure
d. Automated Dispensing Machine
e. Cardioversion, Elective Procedure
f. Chest Tube Management Procedure
g. Code STEMI Policy
h. Communicating with Physician/Allied Health Professional Using the Process SBAR Policy
i. Defibrillator Checks
j. Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy
k. HMS Plus Hemostasis Management System: Activated Clotting Time Heparin Assay, Heparin Dose Response Procedure
l. Medical Examiner Notification Policy
m. Nitrazine Test on Veginal Fluid Procedure
n. Obstetrical Patients Triage Policy
o. Ordering Non-District Provided Services for Patients Policy
p. Physician's Admission Responsibilities Policy
q. Point of Care Testing Competency Assessment Procedure
r. Private Duty Staff, Patient Acquired Policy
s. Restraints Used for Non-Violent Non-Self Destructive Behavior Policy
t. Siemens Rapidpoint 600 Procedure
u. Stroke Code, Emergency Department Procedure
v. Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy
w. Team NICU Response Plan
x. Urine Dipstick Analysis Manual Read Procedure
y. Urine Dipstick Analysis Using Siemens Clinitek Status + Connect Procedure
z. Ventricular Assist Device: Impella Nursing Care of

	Agenda Item	Time Allotted	Requestor

Patient
aa. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure

2. **Administrative 200 District Operations**
   a. 340B Outpatient Drug Pricing 295
   b. Conducting Examinations of Patient or Visitor Belongings and/or Room Policy 208
   c. Portable Space Heaters, Use of 247
   d. Recyclable Waste Policy 209
   e. Secure Environment 204
   f. Weapons Scanning in the Emergency Department 200

3. **Administrative 500 Compliance**
   a. Alternate Means of Communicating PHI 519

4. **Allied Health Professional Manual**
   a. Neonatal Standardized Procedures
   b. OB/GYN Standardized Procedures
   c. Pediatrics Standardized Procedures
   d. Psychiatry Division Standardized Procedures

5. **Emergency Operation Procedure (EOP) Manual**
   a. Emergency Operations Plan

6. **Engineering**
   a. Code Green Policy 8007
   b. Fire Drills 8014

7. **Environment of Care Manual**
   a. Disposing of Recalled Products 1030
   b. Employee Safety Information 1022
   c. Fire Plan (Code Red) 3005
   d. Life Safety Management Plan
   e. Safety Management Plan

8. **Home Care**
   a. Laboratory Orders

9. **Medical Staff**
   a. CME Speaker & Honoraria Reimbursement 8710-604
   b. Credentialing Policy, Mazor Robotic Assisted Surgery 8710-566
   c. Disaster Privileges 8710-553
   d. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710-600
   e. Emergency Department Call: Duties of the On-Call Physician 8710-520
   f. Joint Providership, Co-Providership 8710-692
   g. Ongoing Professional Practice Evaluation: OPPE and FPPE 8710-509
   h. Regularly Scheduled Series (RSS) 8710-606
   i. Temporary Privileges 8710-515

10. **NICU**
    a. Blood Product Aliquot Syringes, Emergency Preparation of

	Agenda Item	Time Allotted	Requestor

11. Outpatient Infusion Center
- a. Adverse Reaction (Medication Event)
- b. Hospital Admission from the Center

12. Patient Care Management
- a. Utilization review Process

13. Pharmacy
- a. Antidote Stocking
- b. Controlled Substances – Pharmacy Policy
- c. Discharge Prescriptions
- d. Drug Compounding for Medication not Commercially Available
- e. Drug Product Procurement and Inventory Management Policy
- f. Emergency Medication Tray for Crash Cart
- g. Floor Stock
- h. Hours of Operation and Authorized Access to the Pharmacy
- i. Medication Dispensing/Distribution
- j. Medication Management Program
- k. Medications Ordered STAT and at Specified Time Intervals
- l. Patients Use of Herbals and Natural Remedies
- m. Unusable Medications Policy

14. Radiology
- a. Radiology Policy Statement #100

15. Rehabilitation
- a. Discharge Criteria
- b. Documentation of Progress Note and Discharge Summary
- c. Fire-Internal Disaster Drill, Wellness Center 1507
- d. Home Evaluation 504
- e. Outpatient Medical Records 1001
- f. Physical Therapy Assistant Supervision 613
- g. Physical Therapy 603 Policy
- h. Referrals for Rehabilitation Services – 509
- i. Scope of Services – 104
- j. Supervision Requirements of Minors During Outpatient Rehabilitation
- k. Therapeutic Recreation Department Policy 901

16. Security
- a. Authorized Security Department Uniform and Safety Equipment 401
- b. Emergency Situation Officer Recall 803
- c. Hair and Grooming Standards for Security Officers 302
- d. Post Positions 202
- e. Release of Security Department Information 108
- f. Scheduled Time Off 303
- g. Solicitation and Union Activity on Medical Center Campus 236
- h. Work Schedule and Mandatory Overtime 106

17. Women & Newborn Services

	Agenda Item	Time Allotted	Requestor
	a. Discharge Process b. Skin to Skin Contact after Birth c. Standards of Care: Newborn **18. Wound Care** a. Skin Substitute/Cellular Tissue Products Inventory and Storage Process (12) Minutes a) November 17, 2022 – Regular Meeting (13) Meetings and Conferences – None (14) Dues and Memberships – None (15) Reports - None		
10	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
11	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
12	Comments by Chief Executive Officer	5 min.	Standard
13	Board Communications (three minutes per Board member)	18 min.	Standard
14	Report from Chairperson	3 min.	Standard
15	Total Time Budgeted for Open Session	1.5 hours	
16	Adjournment		

TCHD BOARD OF DIRECTORS
MEETING SCHEDULE
CALENDAR YEAR 2023

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

- January 26, 2023 (Last Thursday)
- February 23, 2023 (Last Thursday)
- March 30, 2023 (Last Thursday)
- April 27, 2023 (Last Thursday)
- May 25, 2023 (Last Thursday)
- June 29, 2023 (Last Thursday)
- July 27, 2023 (DARK)
- August 31, 2023 (Last Thursday)
- September 28, 2023 (Last Thursday)
- October 26, 2023 (Last Thursday
- November 30, 2023 (DARK)
- December 14, 2023

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

Proposed Schedule: December 9, 2022

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
November 16, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/16/2022 – 10/31/2024)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 12/16/2022 through 10/31/2024:

- **GRANGER, Shannon DO/Anesthesiology (ECHO)**
- **JUAREZ, Veronica MD/Emergency Medicine (TeamHealth)**
- **KUSHNIR, Matthew MD/Anesthesiology (ECHO)**
- **MA, Ruhong DO/Internal Medicine - Telemedicine (Sound)**
- **SHAIKH, Anwer MD/Oncology (The Oncology Institute)**

UPDATE TO PREVIOUS INITIAL APPOINTMENT:

Note: Below Providers have submitted documentation for privileges.

- **BARVALIA, Mihir MD** — **Cardiology**
- **NAGHI, Jesse MD** — **Cardiology**
- **SHEREV, Dimitri MD** — **Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
November 21, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/16/2022 – 10/31/2024)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 12/16/2022 through 10/31/2024.

- **ADAM, Jory PA-C/Allied Health Professional (PA Specialists)**
- **AMADOR, Lindsay CRNA/Allied Health Professional (ECHO)**
- **CARL, Emily CRNA/Allied Health Professional (ECHO)**
- **GRAYDON, Cassie NP/Allied Health Professional (San Diego Diagnostic Radiology)**
- **ORDUNO, Annette CRNA/Allied Health Professional (ECHO)**
- **ORDUNO Jr., Ramon CRNA/Allied Health Professional (ECHO)**
- **SCHMITT, Ryan PA-C/Allied Health Professional (PA Specialists)**
- **SIDLINGER, Kelly CRNA/Allied Health Professional (ECHO)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
November 16, 2022

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 01/01/2023 –12/31/2024)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 01/01/2023 through 12/31/2024, based upon practitioner specific and comparative data profiles and reports demonstrating ongoing monitoring and evaluation, activities reflecting level of professionalism, delivery of compassionate patient care, medical knowledge based upon outcomes, interpersonal and communications skills, use of system resources, participation in activities to improve care, blood utilization, medical records review, department specific monitoring activities, health status and relevant results of clinical performance:

- **AMBO, Stanley, MD/Pediatrics/Active**
- **CHEN, Heather, MD/Ophthalmology/Provisional**
- **CHO, Aaron, MD/Radiology/Active**
- **JOHNSTON, ERIC, MD/Ophthalmology/Provisional**
- **KATO, Kambrie, MD/Teleradiology/Active Affiliate**
- **KLARISTENFELD, Daniel, MD/General Surgery/Provisional**
- **KYAW, Naing, MD/Nephrology/Active**
- **MAYBERRY, Jennifer, MD/Radiology/Active**
- **MOON, Nah Yong, MD/Obstetrics & Gynecology/Provisional**
- **MOSTOFIAN, Eimaneh, MD/Obstetrics & Gynecology/Active**
- **NGUYEN, Minh, MD/Internal Medicine/Active**
- **POP, Simona, MD/Family Medicine/Refer and Follow**
- **SERRY, Rod, MD/Interventional Cardiology/Provisional**
- **SHAD, Javaid, MD/Gastroenterology/Active**
- **SHIH, Angela, DO/Internal Medicine/Provisional**
- **SINGH, Himani, MD/Oncology/Active**
- **WENGER, Scott, DO/General Surgery/Provisional**
- **WINE, David, MD/Internal Medicine/Refer and Follow**

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
November 16, 2022

Attachment B

RESIGNATIONS: (Effective date 12/31/2022 unless otherwise noted)

Voluntary:

- **BAILEY, Romana, MD/Neonatology**
- **LAWLER, Abigail, MD/Neurology**
- **PANSARA, Megha, MD/Pediatric Ophthalmology**
- **SIKICH, Michael, PAC/Allied Health Professional Health**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
November 16, 2022

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **June 30, 2023** would result in these privileges automatically relinquishing.

- **SHIH, Angela, MD** — **Internal Medicine**

REQUEST FOR EXTENSION OF PROCTORING REQUIREMENT

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and are approved for an additional 6 months to complete their proctoring for the privileges listed below. Failure to meet the proctoring requirement by **June 30, 2023** would result in these privileges automatically relinquishing.

- **CIZMAR, Branislav, MD** — **OB/GYN**
- **LIU, Richard, MD** — **Otolaryngology**
- **PADILLA, Patrick, MD** — **Orthopaedic Surgery**
- **SERRY, Rod, MD** — **Cardiology**

AUTOMATIC RELINQUISHMENT OF PRIVILEGES

The following practitioners were given six months from the last reappointment date to complete their outstanding proctoring. These practitioners failed to meet the proposed deadline and therefore the listed privileges will automatically expire as of **December 16, 2022**

- **BARCARSE, Erin, MD** — **OB/GYN**
- **DESADIER, Jason, DO** — **Emergency**
- **JAFFER, Jihad, MD** — **Physical Medicine and Rehabilitation**
- **MADHAV, Sandip, MD** — **Physical Medicine & Rehab**
- **MOON, Nah Yong, MD** — **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

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

PROCTORING RECOMMENDATIONS

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

- ALTER, Mark, MD — Telepsychiatry
- ALTSCHUH, Laura , MD — Emergency
- AVILA, Alfonso , MD — Emergency
- BALBUENA-ROOT, Melissa, MD — Teleneurology
- BARVALIA, Mihir, MD — Cardiology
- CARROLL, Sarah, MD — Otolaryngology
- DILLARD, Kira, MD — Teleneurology
- GARFF, Kevin, MD — Ophthalmology
- GARRISON, David, MD — Critical Care Medicine
- KLEIN, Michael, MD — Teleradiology
- MYATT, Toby , MD — Emergency
- PARKER, John, MD — Teleneurology
- RUTTENBERG, Todd , DO — Emergency
- SHIRKA, Romina, DO — Teleneurology
- SHUEN, Jessica , MD — Emergency
- SOHAL, Ravinder, MD — Teleradiology
- STIRDIRON, Marissa, MD — Telepsychiatry
- TAVAKOLI, Sirpa, MD — Psychiatry

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
November 21, 2022

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 12/16/2022 – 10/31/2024)

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- **SCHMITT, Ryan PA-C/Allied Health Professional (PA Specialists)**
- **SIDLINGER, Kelly CRNA/Allied Health Professional (ECHO)**

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Urology - (Revised 6/14)

Provider Name:

Request	Privilege

CERTIFICATION: The Division of Urology consists of physicians who are board certified or actively pursuing certification by the American Board of Urology, or able to demonstrate comparable ability, training, and experience.

SITES:
All privileges may be performed at 4002 Vista Way, Oceanside, CA 92056
Privileges annotated with (F) may be performed at 3925 Waring Road, Suite C, Oceanside CA 92056

Criteria for Admit, Consultation, and H&P:
Initial: Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.
Proctoring: Successful completion of procedure-specific proctoring satisfies proctoring for these privileges.

___ Admit patients

___ Consultation, including via telemedicine (F)

___ Perform history and physical examination, including via telemedicine (F)

___ **BASIC UROLOGY PRIVILEGES** - By selecting this privilege, you are requesting the Basic Urology privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Basic Urology Privilege Criteria
Initial:
1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology.
2. Documentation of at least of fifty (50) cases within the previous twenty-four (24) months.
Proctoring: Five (5) cases from the Basic Urology Privileges category
Reappointment: Fifty (50) representative blend of cases within the twenty-four (24) months reappointment period.

Abdominal procedure(s), incidental

Anterior exenteration

Colporraphy

Incisional hernia~~, incidental~~

Inguinal hernia~~, incidental~~

Lithotripsy

Male Genital System - all procedures for: Scrotum, Testis, Vas Deferens, Penis, Retroperitoneal Surgery

Radical cystectomy

Surgery of the lymphatic system, including lymph node dissection (inguinal, retroperitoneal, or pelvic)

Urinary System - all procedures for: Kidney, Ureter, Bladder, Prostate, Urethra

Provider Name:

Request	Privilege

Urodynamics: Foley catheter placement (F)

SPECIAL UROLOGY PRIVILEGES:

___ Fluoroscopy in accordance with hospital policy (Refer to Medical Staff Policy #528 and 528A)

___ **Laser Privileges Category** - By selecting this privilege, you are requesting the Laser privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Laser Privileges Criteria
Initial:
1. Documentation of completion of training for specific energy source(s) to be used; or
2. If training completed greater than two years prior to privilege request, submit case logs from previous twenty-four (24) months identifying specific energy source used.
Proctoring: One (1) case for each energy source
Reappointment: One (1) case for each energy source within the previous twenty-four (24) months

CO2 laser

Greenlight laser (diode)

Holmium laser

___ **Laparoscopic Nephrectomy/Renal Laparoscopy Category** - By selecting this privilege, you are requesting the Laparoscopic Nephrectomy/Renal Laparoscopy privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Laparoscopic Nephrectomy/Renal Laparoscopy Criteria
Initial Criteria:
1. Successful completion of an ACGME or AOA-accredited residency or fellowship program in urology that included training in laparoscopy; or
2. Successful completion of a hands-on training course for renal laparoscopic and/or laparoscopic nephrectomy procedures; or
3. Documentation of at least three (3) renal laparoscopic and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months (required if training was completed more than two years prior to application).
Proctoring: Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures
Reappointment: Three (3) renal laparoscopy and/or laparoscopic nephrectomy procedures within the previous twenty-four (24) months

Laparoscopic nephrectomy

Renal laparoscopy

___ Moderate sedation - Refer to Medical Staff policy 8710-517

___ **Robotic Surgery (da Vinci) Category** - By selecting this privilege, you are requesting the da Vinci Robotic Surgery privileges listed immediately below. Strikethrough and initial any privilege(s) you do not want.

Clinical Privilege Request Form

Urology - (Revised 6/14)

Provider Name:

Request	Privilege

___ Xi Robotic Privileges

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Da Vinci Robotic Surgery

___ Assist in Xi Robotic

Initial Criteria: Must meet initial and reappointment for Core Robotic assisted privileges and provide certificate of training for Xi Robotic from Intuitive prior to case

Proctoring: Must meet proctoring criteria for Assisting in Da Vinci Robotic Surgery

___ Sacral nerve stimulation

Sacral Nerve Stimulation Criteria

Initial:

1. Successful completion of an ACGME or AOA-accredited residency program and board certified or actively pursuing board certification in Urology; or successful completion of a urogynecology fellowship program; AND
2. Documentation of successful completion of a training course in sacral neuromodulation therapy; or
3. Documentation of performing at least six (6) sacral neuromodulation therapy stimulator tests and implant procedures within the previous twelve (12) months (required if training was completed more than two years prior to application)

Proctoring: One (1) case

Reappointment: Two (2) cases within the previous twenty-four (24) months

_____

Print Applicant Name

_____

Applicant Signature

_____

Date

_____

Division/Department Signature (By Signing this form I agree with the granting of these privileges indicated above.)

_____

Date

RESOLUTION NO. 821

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PASSED AND ADOPTED at a regular meeting of the Board of Directors of Tri-City Healthcare District held on December 15, 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

FINANCE, OPERATIONS & PLANNING COMMITTEE
DATE OF MEETING: December 15, 222
LABORATORY TESTING SUPPLIES PROPOSAL

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

Vendor's Name: Cepheid

Area of Service: Laboratory (Microbiology)

Term of Agreement: 24 months, Beginning, January 1, 2023 – Ending, December 31, 2024

Maximum Totals:

Monthly Cost	Annual Cost Not to Exceed	Total Term Cost Not to Exceed
$80,000	$960,000	$1,920,000

Description of Services/Supplies:

- TCMC currently subscribes to Vizient pricing with Cepheid for the following tests: MRSA, C. difficile, and Chlamydia/Gonorrhea.
- Due to the Emergency Use Authorization (EUA) for the COVID-19/Flu A&B/RSV otherwise known as "COVID quad plex", our Vizient subscription pricing does not include the COVID quad plex. This agreement is to secure pricing for COVID quad plex testing supplies.
- Without Contract a pricing agreement, the cost will increase from $68/test to $110/test effective January 1, 2023. We perform 30-40 COVID quad plex tests per day using the Cepheid instrumentation.

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

Person responsible for oversight of agreement: Tara Eagle, Asst. Director, Lab Services / Eva England, Senior Director

Motion:
I move that the TCHD Board of Directors authorize the agreement with Cepheid for testing supplies for COVID, Flu A/B, & RSV for a term of 24 months beginning January 1, 2023 and ending December 31, 2024 for an annual cost not to exceed $960,000, and a total cost for the term not to exceed $1,920,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
LABORATORY INSTRUMENT, REAGENT & CONSUMABLES PROPOSAL

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

Vendor's Name: Immucor

Area of Service: Laboratory

Term of Agreement: 60 months, Beginning, January 1, 2023 – Ending, December 31, 2027

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$8,365	$100,380	$501,900

Description of Services/Supplies:

- This agreement renews our current agreement (at same pricing) with Immucor. The agreement is a "reagent rental" and includes the cost and use of an instrument (Immucor Echo), any associated preventative maintenance and service for the instrument, and associated reagents and consumables.
- The instrument and reagents are used for identifying patient ABO blood group and antibody screening for clinically significant antibodies prior to blood product transfusion.

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

Person responsible for oversight of agreement: Tara Eagle, Asst. Director, Lab Services / Eva England, Senior Director

Motion:
I move that the TCHD Board of Directors authorize the agreement with Immucor for pre-transfusion blood type and antibody screen testing for a term of 60 months, beginning January 1, 2023 and ending December 31, 2027 for an annual cost of $100,380 and a total cost for the term of $501,900.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
BEVERAGE PRICING SALES PROPOSAL

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

Vendor's Name: Pepsi Beverages Company

Area of Service: Food and Nutrition

Term of Agreement: 36 months, Beginning, January 1, 2023 – Ending, December 31, 2025

Maximum Totals:

Term	Annual Cost	Total Term Cost
36 months	$197,000	**$591,000**

Description of Services/Supplies:

- Pricing agreement includes all Pepsi products for the cafeteria

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

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

Motion:
I move that the TCHD Board of Directors authorize the agreement with Pepsi Beverages Company for a term of 36 months, beginning, January 1, 2023 and ending, December 31, 2025 for an annual cost of $197,000 and a total cost for the term of $591,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
LABORATORY TESTING EQUIPMENT AND CONSUMABLES PROPOSAL

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

Vendor's Name: Abbott Laboratories, Inc.

Area of Service: Laboratory (Chemistry)

Term of Agreement: 60 months, Beginning, January 01, 2023 – Ending, December 31, 2027

Maximum Totals:

	Monthly Cost	Annual Cost	Total Term Cost
Instrument Service	$5,000	$60,000	$300,000
Reagents & Consumables	$45,175	$542,100	$2,710,500
Total	$50,175	$602,100	$3,010,500

Description of Services/Supplies:

- This is a reagent rental agreement that will replace 2 current reagent rental agreements with Beckman Coulter and Siemens for chemistry equipment. It includes the cost of the instrumentation (Abbott Alinity ci), preventative maintenance and service, along with consumables.
- These instruments and corresponding consumables provide the ability to perform chemistry, immunoassay, and infectious disease testing like glucose, cholesterol, troponin, and hepatitis.

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

Person responsible for oversight of agreement: Tara Eagle, Assistant Director, Lab Services / Eva England, Senior Director

Motion:
I move that the TCHD Board of Directors authorize the agreement with Abbott Laboratories, Inc for chemistry, immunoassay, and infectious disease testing equipment and consumables for a term of 60 months, beginning January 01, 2023 and ending December 31, 2027 for an annual cost of $602,100 and a total cost for the term of $3,010,500.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DECEMBER 15, 2022
PRINT MANAGEMENT SERVICES

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

Vendor's Name: Vereco, Inc.

Area of Service: Supply Chain Management

Term of Agreement: 60 Months; Beginning January 1, 2023 and ending on December 31, 2028

Maximum Totals:

Annual Cost	Total Term Cost
$1.3M	**$6.5M**

Description of Services/Supplies:

- Provide print management services to include copier maintenance and repair for 450 devices, staffing copy center, Marketing/Foundation support, and courier services, toner/ink stocking and distribution, document destruction (shredder) services and mail distribution.
- Includes 5-year lease of 159 Multifunction (copier/printer/fax) machines with Kingsbridge Healthcare Financing for $2.4M for the term.
- Vereco has agreed to decrease our rate by $15,284 per month ($183K yr.)
- TCMC has enjoyed excellent service with Vereco, Inc. for 10+ years.

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

Person responsible for oversight of agreement: Thomas Moore, Director-Material/Supply Chain Management / Ray Rivas, Chief Financial Officer

Motion:

I move that the TCHD Board of Directors approve the renewal of an agreement with Vereco, Inc., for TCHD's print management services to include copier maintenance, staffing copy center, courier services, toner/ink stocking and distribution, mail distribution services and document destruction services for a term of 60 months beginning January 1, 2023 and ending on December 31, 2028 for an annual cost of $1.3M and total term cost of $6.5M.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
Medical Office Lease Agreement Proposal – Sherev Heart and Vascular Clinic, Inc.

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

Physician's Name: Sherev Heart and Vascular Clinic, Inc. – Dimitri Sherev, MD (Cardiologist)

Premises: 2095 W Vista Way, Suite 107, Vista, CA 92083 (1,450 sq. ft.)

Term of Agreement: Beginning, January 1, 2023
(Month-to-month – terminable upon 60 days written notice)

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

Rental Rate for Sherev Heart and Vascular Clinic, Inc.:	**Revenue per Month**
Rental Rate of $2.15 per square foot, per month (1,450 rentable sq. ft.)	$3,117.50

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: (Revenue)	X	Yes		No

Person responsible for oversight of agreement: Jeremy Raimo, Sr. Director Business Development /Dr. Gene Ma, CMO

Motion:

I move that the TCHD Board of Directors authorize the Lease Agreement on a month-to-month basis terminable upon 60 days written notice beginning December 1, 2023. This proposal remains within the current fair market value rental rate of $2.15 per square foot, for a monthly revenue of $3,117.50.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
CROTHALL LAUNDRY SERVICES INC. LINEN AND LAUNDRY SERVICES PROPOSAL

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

Vendor's Name: Crothall Laundry Services Inc.

Area of Service: EVS

Term of Agreement: 36 months, Beginning, January 1, 2023 – Ending, December 31, 2025

Maximum Totals:

Monthly Cost	Annual Cost	Total Term Cost
$50,000	$600,000	$1,800,000

Description of Services/Supplies:

- Provide laundry services for all TCMC linen, scrubs, towels, etc.
- Despite significant fuel, labor, utility and facility increases, Crothall has agreed to keep our rate the same and lock the price for 3 more years.
- TCMC has had excellent service with Crothall for 10+ years.
- This is based upon our Group Purchasing Organization contract and terms that were competitively bid.

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

Person responsible for oversight of agreement: Hope Chaney, Environmental Services Manager/ Jeremy Raimo, Sr. Director

Motion:
I move that the TCHD Board of Directors authorize the agreement with Crothall Laundry Services Inc. for TCMC's linen and laundry services for a term of 36 months, beginning January 1, 2023 and ending December 31, 2025 for an annual cost of $600,000 and a total cost for the term of $1,800,000.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
PHYSICIAN AGREEMENT for ED ON-CALL COVERAGE: HOSPITAL MEDICINE SERVICES (Hospitalists)

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

Vendor's Name: Sound Physicians, dba Hospitalist Medicine Physicians of California, Inc.

Area of Service: Hospital Medicine- Hospitalists

Term of Agreement: 24 Months, Beginning, January 1, 2023 – Ending, December 31, 2024

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

Annual Program Cost	Annual Performance Achievement Compensation (At-Risk Amount)	Annual Program Total Cost (Not to Exceed)	Total Term Cost (Not to Exceed)
$2,699,840	$750,000	$3,449,840	**$6,899,680**

Description of Services/Supplies:

- Provision of a full-service, Hospital Medicine Program providing 24/7 coverage, 365 days per year
- Provide 24/7 patient coverage in accordance with Medical Staff Policy #8710-520 (Emergency Room Call: Duties of the On-Call Physician)
- Collaborate with hospital to design a quality program designed to improve outcomes utilizing key performance indicators
- Designate 2 Co-Medical Directors for the program to oversee quality outcomes, performance improvement, and recommendations for program innovation in alignment with contemporary best practices.

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 renewal of the Hospital Medicine Program with Sound Physicians, dba Hospitalist Medicine Physicians of California, Inc. for a term of 24 months, beginning January 1, 2023 and ending, December 31, 2024, at an annual cost not to exceed $3,449,840 and a total term cost not to exceed $6,899,680.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: December 15, 2022
TELEMETRY MONITORING SYSTEM PROPOSAL

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

Vendor's Name: Nihon Kohden

Area of Service: Nursing Services

Term of Agreement: 12 Months, Beginning January 1, 2023– Ending, December 31, 2023

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

Total Term Cost
$1,144,496

Description of Services/Supplies:

- Contract to provide a new Telemetry Monitoring System in 9 nursing units and upgrade the current system in the Emergency Department
- Cost includes a 5 year, no cost warranty
- Current system is near end of life
- This request is to match existing telemetry monitoring system in the Emergency Department
- Quote includes new cabling to all areas, as needed
- Nursing received quotes and tested 3 different systems and decided to match existing equipment due to lowest cost, familiarity and excellent maintenance history

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

Person responsible for oversight of agreement: Thomas Moore, Director-Material/Supply Chain Management / Ray Rivas, CFO, Candice Parras, CNE

Motion:
I move that the TCHD Board of Directors approve the capital equipment purchase from Nihon Kohden for a new telemetry monitoring system for nine nursing units and an upgrade to the existing system in the Emergency Department, which is proposed to begin on January 1, 2023 for a total cost of $1,144,495.

ADMINISTRATION CONSENT AGENDA
December 5th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Activated Clotting Time Testing by Medtronic ACT Plus Procedure	2 year review	Forward to BOD for Approval
2. Ambulance Transport for Patients Policy	3 year review, practice change	Forward to BOD for Approval
3. Amnisure Placental Alpha - 1 Microglobulin (PAMG1) Test for Rupture of Fetal Membranes (ROM) - Procedure	2 year review, practice change	Forward to BOD for Approval
4. Automated Dispensing Machine	3 year review, practice change	Forward to BOD for Approval
5. Cardioversion, Elective Procedure	3 year review	Forward to BOD for Approval
6. Chest Tube Management Procedure	3 year review	Forward to BOD for Approval
7. Code STEMI Policy	3 year review, practice change	Forward to BOD for Approval
8. Communicating with Physician / Allied Health Professional Using the Process SBAR Policy	3 year review, practice change	Forward to BOD for Approval
9. Defibrillator Checks	3 year review, practice change	Forward to BOD for Approval
10. Emergency Cart (Crash Cart) Cardiopulmonary Arrest Policy	3 year review, practice change	Forward to BOD for Approval
11. HMS Plus Hemostasis Management System: Activated Clotting Time, Heparin Assay, Heparin Dose Response Procedure	2 year review	Forward to BOD for Approval
12. Medical Examiner Notification Policy	3 year review, practice change	Forward to BOD for Approval
13. Nitrazine Test on Vaginal Fluid Procedure	2 year review, practice change	Forward to BOD for Approval
14. Obstetrical Patients Triage Policy	3 year review, practice change	Forward to BOD for Approval
15. Ordering Non-District Provided Services for Patients Policy	3 year review	Forward to BOD for Approval
16. Physician's Admission Responsibilities Policy	3 year review	Forward to BOD for Approval
17. Point of Care Testing Competency Assessment Procedure	2 year review	Forward to BOD for Approval
18. Private Duty Staff, Patient Acquired Policy	3 year review	Forward to BOD for Approval
19. Restraints Used for Non-Violent Non-Self Destructive Behavior Policy	3 year review, practice change	Forward to BOD for Approval
20. Restraints-Seclusion for Violent-Self-Destructive Behavior Policy	3 year review, practice change	Forward to BOD for Approval
21. Siemens Rapidpoint 500 Procedure	2 year review, practice change	Forward to BOD for Approval
22. Stroke Code, Emergency Department Procedure	3 year review, practice change	Forward to BOD for Approval
23. Swallowing, Food and Nutrition Considerations for Patients with Oro-pharyngeal Dysphagia Policy	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 5th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
24. Team NICU Response Plan	NEW	Forward to BOD for Approval
25. Urine Dipstick Analysis Manual Read Procedure	2 year review	Forward to BOD for Approval
26. Urine Dipstick Analysis Using Siemens Clinitek Status + Connect Procedure	2 year review	Forward to BOD for Approval
27. Ventricular Assist Device: Impella Nursing Care of Patient	3 year review, practice change	Forward to BOD for Approval
28. Whole Blood PT INR Using the Roche Coaguchek XS Plus Meter Procedure	2 year review	Forward to BOD for Approval
Administrative 200 District Operations		
1. 340B Outpatient Drug Pricing 295	3 year review	Forward to BOD for Approval
2. Conducting Examinations of Patient or Visitor Belongings and/or Room Policy 208	3 year review, practice change	Forward to BOD for Approval
3. Portable Space Heaters, Use of 247	3 year review, practice change	Forward to BOD for Approval
4. Recyclable Waste Policy 209	3 year review	Forward to BOD for Approval
5. Secure Environment 204	3 year review, practice change	Forward to BOD for Approval
6. Weapons Scanning in the Emergency Department 200	3 year review, practice change	Forward to BOD for Approval
Administrative 500 Compliance		
1. Alternate Means of Communicating PHI 519	3 year review	Forward to BOD for Approval
Allied Health Professional Manual		
1. Neonatal Standardized Procedures	2 year review, practice change	Forward to BOD for Approval
2. OB/GYN Standardized Procedures	2 year review	Forward to BOD for Approval
3. Pediatrics Standardized Procedures	2 year review	Forward to BOD for Approval
4. Psychiatry Division Standardized Procedures	2 year review	Forward to BOD for Approval
Emergency Operation Procedure (EOP) Manual		
1. Emergency Operations Plan	1 year review	Forward to BOD for Approval
Engineering		
1. Code Green Policy 8007	3 year review	Forward to BOD for Approval
2. Fire Drills 8014	3 year review, practice change	Forward to BOD for Approval
Environment of Care Manual		
1. Disposing of Recalled Products 1030	3 year review, practice	Forward to BOD for Approval
2. Employee Safety Information 1022	RETIRE	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 5th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
3. Fire Plan (Code Red) 3005	3 year review	Forward to BOD for Approval
4. Life Safety Management Plan	1 year review	Forward to BOD for Approval
5. Safety Management Plan	1 year review, practice change	Forward to BOD for Approval
Home Care		
1. Laboratory Orders	1 year review, practice change	Forward to BOD for Approval
Medical Staff		
1. CME Speaker & Honoraria Reimbursement 8710 - 604	1 year review	Forward to BOD for Approval
2. Credentialing Policy, Mazor Robotic-Assisted Surgery 8710-566	3 year review	Forward to BOD for Approval
3. Disaster Privileges 8710-553	3 year review	Forward to BOD for Approval
4. Educational Planning; Needs Assessment; Objectives; and Evaluation of a Continuing Medical Education (CME) Activity 8710 - 600	1 year review, practice change	Forward to BOD for Approval
5. Emergency Department Call: Duties of the On-Call Physician 8710-520	3 year review, practice change	Forward to BOD for Approval
6. Joint Providership Co-Providership 8710 - 602	1 year review	Forward to BOD for Approval
7. Ongoing Professional Practice Evaluation: OPPE and FPPE 8710-509	3 year review, practice change	Forward to BOD for Approval
8. Regularly Scheduled Series (RSS) 8710 - 606	1 year review, practice change	Forward to BOD for Approval
9. Temporary Privileges 8710-515	3 year review, practice change	Forward to BOD for Approval
NICU		
1. Blood Product Aliquot Syringes, Emergency Preparation of	2 year review, practice change	Forward to BOD for Approval
Outpatient Infusion Center		
1. Adverse Reaction (Medication Event)	3 year review	Forward to BOD for Approval
2. Hospital Admission from the Center	3 year review	Forward to BOD for Approval
Patient Care Management		
1. Utilization Review Process	3 year review, practice change	Forward to BOD for Approval
Pharmacy		
1. Antidote Stocking	3 year review	Forward to BOD for Approval
2. Controlled Substances - Pharmacy Policy	3 year review	Forward to BOD for Approval
3. Discharge Prescriptions	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 5th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
4. Drug Compounding for Medication Not Commercially Available	3 year review	Forward to BOD for Approval
5. Drug Product Procurement and Inventory Management Policy	3 year review	Forward to BOD for Approval
6. Emergency Medication Tray for Crash Cart	3 year review	Forward to BOD for Approval
7. Floor Stock	3 year review, practice change	Forward to BOD for Approval
8. Formulary System	3 year review, practice change	Forward to BOD for Approval
9. Hours of Operation and Authorized Access to the Pharmacy	3 year review	Forward to BOD for Approval
10. Medication Dispensing/Distribution	3 year review	Forward to BOD for Approval
11. Medication Management Program	3 year review	Forward to BOD for Approval
12. Medications Ordered STAT and at Specified Time Intervals	3 year review, practice change	Forward to BOD for Approval
13. Patients Use of Herbals and Natural Remedies	3 year review	Forward to BOD for Approval
14. Unusable Medications Policy	3 year review	Forward to BOD for Approval
Radiology		
1. Radiology Policy Statement #100	3 year review, practice change	Forward to BOD for Approval
Rehabilitation		
1. Discharge Criteria	3 year review	Forward to BOD for Approval
2. Documentation of Progress Note and Discharge Summary	3 year review	Forward to BOD for Approval
3. Fire-Internal Disaster Drill, Wellness Center 1507	3 year review	Forward to BOD for Approval
4. Home Evaluation 504	3 year review	Forward to BOD for Approval
5. Outpatient Medical Records 1001	3 year review	Forward to BOD for Approval
6. Physical Therapy Assistant Supervision 613	3 year review	Forward to BOD for Approval
7. Physical Therapy 603 Policy	3 year review	Forward to BOD for Approval
8. Referrals for Rehabilitation Services - 509	3 year review, practice change	Forward to BOD for Approval
9. Scope of Services - 104	3 year review	Forward to BOD for Approval
10. Supervision Requirements of Minors During Outpatient Rehabilitation	3 year review	Forward to BOD for Approval
11. Therapeutic Recreation Department Policy 901	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
December 5th, 2022

CONTACT: Candice Parras, CPCS

Policies and Procedures	Reason	Recommendations
Security		
1. Authorized Security Department Uniform and Safety Equipment 401	3 year review, practice change	Forward to BOD for Approval
2. Emergency Situation Officer Recall 803	3 year review, practice change	Forward to BOD for Approval
3. Hair and Grooming Standards for Security Officers 302	RETIRE	Forward to BOD for Approval
4. Post Positions 202	3 year review	Forward to BOD for Approval
5. Release of Security Department Information 108	3 year review, practice change	Forward to BOD for Approval
6. Scheduled Time Off 303	3 year review	Forward to BOD for Approval
7. Solicitation and Union Activity on Medical Center Campus 236	3 year review, practice change	Forward to BOD for Approval
8. Work Schedule and Mandatory Overtime 106	3 year review, practice change	Forward to BOD for Approval
Women & Newborn Services		
1. Discharge Process	3 year review, practice change	Forward to BOD for Approval
2. Skin to Skin Contact after Birth	3 year review, practice change	Forward to BOD for Approval
3. Standards of Care: Newborn	3 year review, practice change	Forward to BOD for Approval
Wound Care		
1. Skin Substitute/ Cellular Tissue Products Inventory And Storage Process	NEW	Forward to BOD for Approval

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**ACTIVATED CLOTTING TIME TESTING BY MEDTRONIC ACT PLUS**
Purpose:	To accurately measure the clotting time of heparinized patients.
Supportive Data:	Authorized to perform procedure: RN, LVN, Perfusionist, CV tech with appropriate orientation, training, and competency validation. ACT testing is under the direction, authority, jurisdiction and responsibility of the Laboratory Director.
Equipment:	Medtronic ACT Plus Medtronic ACTtrac (electronic QC) Temperature Verification Cartridge CLOTtrac HR controls Syringes, no larger than 10 mL 19-gauge blunt tip needle or other blood collection needle HR-ACT cartridges

A. **SPECIMEN:**

1. Fresh whole blood collected during angiogram or operative procedure, 400 microliters per cartridge channel.
2. Fresh whole blood specimens should be tested as quickly as possible following sample collection. Test within sixty (60) seconds when there is no anticoagulant on board. Test within two (2) minutes when the sample is heparinized.

B. **PROCEDURE:**

1. HR-ACT Patient Test:
   - a. From the Main Menu, select HR-ACT as the cartridge type.
     - i. Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
   - b. Verify the correct Patient ID in the upper right hand corner of the screen. If the ID is not correct, from the Main Menu enter the Patient ID (10-digit financial number / i.e. 600 #) and User ID (employee ID) numbers.
   - c. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve (12) hours).
   - d. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
   - e. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate patient sample to the level between the fill lines (400 microliters per channel).
   - f. Insert the cartridge into the ACT Plus, and close the actuator heat block to initiate the test.
   - g. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed.
   - h. Manually Transmit Patient Tests to the lab data manager and the patient's electronic health record: From the main menu, select Transmit Test Results. Select Transmit Patient Tests. Exit to the main menu.
2. To Remove and Add a New Cartridge Lot/ Exp Date:
   - a. From the Main Menu select Cartridge Lot.
   - b. Use the Up/Down arrows to select HR-ACT.
   - c. Press Remove Lot.
   - d. Use the Up/Down arrows to select and highlight the lot to be removed.
   - e. Press Remove Selected Lot to delete the selected cartridge lot number.
   - f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.
3. To Remove and Add a New Control Lot/ Exp Date:
   - a. From the Quality Control Menu select Control Lot.

Patient Care Services Content Expert Review	Clinical Policies & Procedures	Nursing Executive Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/07, 10/10,01/14, 11/15, 12/19, 02/22	11/10, 02/14, 12/15, 01/20, 03/22	11/10, 02/14, 01/16, 02/20, 05/22, 06/22	04/18, 04/20, 08/22	03/14, 04/18, 05/20, 09/22	06/20, 12/22	01/11, 04/14, 05/18, n/a	01/11, 04/14, 05/18, 06/20

b. Use the Up/Down arrows to select the control type.
c. Press Remove Lot.
d. Use the Up/Down arrows to select and highlight the lot to be removed.
e. Press Remove Selected Lot to delete the selected lot number.
f. Press Add Lot Number and enter the lot number with the barcode scanner. The lot number and expiration date will populate their respective fields.
g. Press Set Range and enter the control range.
h. Press Enter to confirm the range.

C. **PRINCIPLE:**

1. The ACT Plus is a coagulation instrument intended for determining coagulation endpoints in fresh whole blood; the endpoint is formation of fibrin. The clotting times are performed in duplicate and the results for each channel, the average of the two channels and the difference are displayed.
2. High Range ACT (HR-ACT): The HR-ACT is a kaolin activated clotting time test performed on fresh whole blood where the heparin concentration is one (1) unit/ mL or higher.

D. **QUALITY CONTROL (QC):**

1. If proper QC is not performed or is out of range, the QC lockout feature will be engaged preventing patient testing until QC status is acceptable.
2. Quality Control testing for the ACT Plus is performed using a combination of liquid controls and electronic (ACTtrac) controls. According to Clinical Laboratory Improvement Amendments (CLIA) guidelines, two (2) levels of control for coagulation procedures should be performed every eight hours of patient testing.
3. Electronic Control: The ACTtrac is a battery-powered software used to identify instruments that no longer fall within mechanical calibration specifications.
   a. To perform an ACTtrac test:
      i. From the Main Menu, select ACTtrac as the cartridge type.
      ii. Enter zero (0) as the Patient ID and the appropriate User ID. (The system will not accept user ID's that have not been entered into the data management program).
      iii. Select the Quality Control menu. Select Control Type, press key until the same control range as selected on the ACTtrac is displayed. Verify the control lot #. Press Enter to confirm.
      iv. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      v. Push the Quality Control button again and select the second range to be tested by pressing the Control Type key until the same range to be tested on the ACTtrac is displayed. Press Enter to confirm.
      vi. Place ACTtrac into the heat block and close to start the test. The test is complete upon hearing an audible tone with the results displayed.
      vii. The ACT Plus will indicate if the QC passed or failed. This will complete the level one and level two electronic controls required every eight hours when the ACT Plus is in use.
4. Liquid Controls: Two (2) levels of liquid control are performed for the HR-ACT (CLOTtrac HR normal and abnormal). Used in conjunction with the ACTtrac electronic control, liquid controls are performed every seven days and with a change in cartridge lot number or new Shipment.
   a. Control storage and stability: Store controls in the refrigerator, between 2° and 10°C.
   b. Controls are stable until the expiration date on the package when stored at refrigeration temperatures. CLOTtrac controls are stable for two (2) hours following reconstitution.
   c. Preparation: Follow instructions on current package insert of controls if different than below.
      i. Remove controls and deionized water diluent from the refrigerator and bring to room temperature for approximately ten (10) minutes.

ii. Add 1.8 mL of deionized water to the lyophilized sheep blood.
iii. Allow at least ten (10) minutes for adequate rehydration of the normal control and twenty-five (25) minutes for rehydration of the abnormal control. Do not agitate or mix until completely rehydrated.
iv. Shake the control vigorously to mix until the red blood cells are uniformly dispersed and the control is completely reconstituted.

d. Performance:
i. Select HR-ACT as the cartridge type.
ii. Enter zero (0) as the Patient ID and the appropriate User ID.
iii. Select Quality Control. Select Control Type, press key until the correct control HR-NM or HR-AB is displayed. Press Enter to confirm. The current control lot number will be displayed.
1) Note: Lot numbers and expiration dates for cartridges and controls must be entered prior to running a test (see below).
iv. Pre-warm the cartridge for at least three (3) to five (5) minutes (up to twelve [12] hours).
v. Tap or shake the HR-ACT cartridge to re-suspend the kaolin activator.
vi. Using a syringe and blunt tip needle, fill each cartridge chamber with the appropriate control to the level between the fill lines 400 microliters per channel).
vii. Insert the cartridge into the ACT Plus and close the actuator heat block to initiate the test.
viii. The ACT Plus will incubate the control sample for 300 seconds and then begin the clot detection cycle.
ix. Clot formation is signaled by an audible tone, the actuator heat block opens and the results are displayed. The ACT Plus will indicate if the QC passed or failed.

5. Transmit Data: Quality Control Data must be manually transmitted to the laboratory data manager (via network connection). Each week, after performing liquid controls, transmit data.
a. From the Main Menu, select Transmit Test Results.
b. Press Transmit Unsent QC tests.
c. Press Transmit Unsent Patient tests.
d. Exit to the Main Menu.

E. **CALCULATIONS:**
1. The ACT Plus calculates the mean or average clotting time for the duplicate channels and the difference in seconds between channels when a High Range ACT test is performed.

F. **REFERENCE RANGE:**
1. Duplicate clotting times for the HR-ACT should fall within 10% of each other for baseline or normal samples and 12% of each other for prolonged or heparinized samples. The operable range of the Instrument is 25 – 999 seconds.
a. Normal Un-Heparinized Range: 96 – 172 sec
b. Therapeutic Range:
i. OR greater than or equal to (≥) 480 sec
ii. Cath Lab greater than or equal to (≥) 200 sec; based on clinical judgment
iii. IR greater than or equal to (≥) 200 sec; based on clinical judgment

G. **NOTES AND LIMITATIONS:**
1. The HR-ACT is intended for use with fresh whole blood where the heparin concentration is one (1) units/mL or greater. During cardiopulmonary bypass the HR-ACT may be affected by the following: dilution of plasma coagulation factors, the use of citrated blood products, use of anti-platelet agents, hypothermia, change in platelet number or function.
2. Interfering Substances: Activated blood specimens, either in-vivo (patient's coagulation mechanism activated) or in-vitro, due to improper sample collection and handling may cause

erroneous results. Sample collection and testing should be repeated if improper collection is suspected or if test results are questionable.

H. **MAINTENANCE:**

1. Record Maintenance on the Instrument Maintenance Log.
2. Routine Cleaning: Clean the exposed surfaces of the actuator and dispenser and the instrument case using a hospital approved disinfectant between patients' testing
3. Discard all of the completed testing materials and controls in the provided and approved waste containers.
4. Temperature Verification: Verification of the ACT Plus heat block should be performed once a month and may be done with a Temperature Verification Cartridge that is supplied with the instrument or with calibrated thermometer and water-filled cartridge.
    a. Using the Temperature Verification Cartridge:
        i. From the Quality Control menu enter User ID.
        ii. Select Temperature Adjustment.
        iii. Insert the Temperature Verification Cartridge into the actuator heat block.
        iv. Wait 10 minutes for temperature equilibration to occur.
        v. Press the button on the Temperature Verification Cartridge for temperature reading.
        vi. Enter the reading from the Temperature Verification Cartridge using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
        vii. Press Enter to confirm.
        viii. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
    b. Using a Thermometer:
        i. From the Quality Control menu enter User ID.
        ii. Remove the plunger assembly from a cartridge and fill with 0.2 to 0.3 mL of water.
        iii. Insert the cartridge into the actuator heat block.
        iv. Select Temperature Adjustment.
        v. Place a calibrated thermometer in one of the cartridge reaction chambers.
        vi. After about 5 minutes check the thermometer reading.
        vii. Enter the reading from the thermometer using the numeric keypad. The entered value will appear highlighted in the Thermometer Reading on the display.
        viii. Press Enter to confirm.
        ix. Select Repeat Adjustment variable function key to repeat the temperature adjustment if necessary.
    c. Notes:
        i. The instrument displayed temperature and thermometer measured temperature should read between 36.5° C to 37.5° C.
        ii. The thermometer temperature should be within ± 0.5° C of the instrument displayed temperature.
        iii. The time, date and temperatures of the thermometer and the display will be logged in the instrument's temperature log.
        iv. Wait a minimum of 10 minutes before repeat adjustments are performed.
        v. Values must be between 35° C and 39° C.
5. Actuator Assembly Cleaning:
    a. The Actuator Assembly should be cleaned monthly or as soon as possible after contamination with blood. The exposed surfaces of the actuator assembly (with the actuator heat block in the open position) should be cleaned with one of following cleaning detergents: isopropyl alcohol, methanol, propyl alcohol, glutaraldehyde, bleach, ethanol, Liqui-Nox®, parachlorometaxylenol, hydrogen peroxide, or mild detergent.
        i. Dip a swab in cleaning solution.

ii. Swab the flag lift wire, removing all blood.
iii. Swab inside the actuator assembly cover, especially the detector and emitter areas of the photo-optical sensor. Remove any excess cleaning solution with a dry swab. If blood should get into the detector of the lamp area and cannot be removed with a swab, Error Code "4" may be displayed.

I. **TROUBLESHOOTING:**

1. Refer to the ACT Plus Operator's Manual for Cause and Resolution for System Messages.

J. **REFERENCE(S):**

1. Medtronic ACT Plus Automated Coagulation Timer Operators Manual. Rev. 1.0, 4/04.
2. ACT Plus Individualized Quality Control Plan (IQCP) in Point of Care/ Lab binder.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Ambulance Transport Arrangements for Patients**

REVISION DATE~~(S)~~: 07/05, 07/07, 03/10, 08/13, 09/19

Patient Care Services Content Expert Approval:	**~~05/19~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~07/19~~10/22**
Nurseing Leadership ~~Executive Committee~~ Approval:	**~~07/19~~11/22**
Utilization Review Committee:	**08/19**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/19~~11/22**
Administration Approval:	**~~09/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/19**

A. **POLICY:**

1. If an ambulance is required for transportation, Case Management/Social Worker or nursing staff shall notify the ambulance company. If the Case Manager/Social Worker has placed the patient on a "Will Call" then the nursing staff will call the ambulance to provide them with a pickup time.

B. **MEDICARE:**

1. Medicare reimburses ambulance transports only when there is documented medical necessity and a physician's order specifying ambulance transport.
2. Medicare requires ambulance companies to submit signed medical necessity documentation with their bills.
3. Medicare allows only physicians, registered nurses, nurse practitioners, and physician assistants to sign the medical necessity form.
   a. Medical necessity reasons for ambulance transport include the following patient treatment needs and/or conditions:
      i. Ambulance transport for unstabilized fractures or spinal injury
      ii. Conditions that limit mobility
      iii. Patient is a danger to self or others or requires constant supervision due to disease or injury
      iv. Patient requires medical intervention during transport or advanced level care examples: chronic ventilators, trach dependent patients
      v. Patient is bed confined and is unable to get up from bed without assistance, unable to ambulate, and unable to sit in wheelchair or chair without assistance or supervision
      vi. Maternal transport to tertiary obstetrics centers
   b. The Case Manager/Social Worker or nurse shall review the "Certificate of Medical Necessity/**Physician's Certification Statement**" form for accuracy and sign prior to patient transport.

C. **OTHER PAYORS:**

1. Other payors reimburse ambulance transports only when there is a physician's order specifying ambulance transport at insurance discretion.
2. MediCAL Fee for Service (FFS) requires a physician's physical **signature**, not an electronic signature.

D. **PROCEDURE:**

1. Tri-City Medical Center (TCMC) staff arranging ambulance transport shall provide the following information to the ambulance company:
   a. Patient name
   b. Diagnosis related to transport
   c. Reason for ambulance transport, (i.e., one of the reasons listed above).
2. If the patient does not meet criteria for ambulance transport the Case Manager/Social Worker or nurse will advise the patient/patient representative.
   a. The ambulance will have the patient or the patient representative sign the Beneficiary Advisory of Financial Responsibility form if they feel the transport will not be covered by Medicare.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**AMNISURE PLACENTAL ALPHA-1 MICROGLOBULIN (PAMG1) TEST FOR RUPTURE OF FETAL MEMBRANES (ROM)**
Purpose:	~~To assist in the evaluation of vaginal fluid for the presence of amniotic fluid.~~ **The AmniSure ROM Test is a rapid, non-instrumented, qualitative immunochromatographic test for the in vitro detection of amniotic fluid in vaginal discharge of pregnant women.**
Supportive Data:	~~The AmniSure ROM test detects ruptured membranes by detecting placental alpha-1 microglobulin (PAMG-1), a protein marker in the amniotic fluid in vaginal secretions of pregnant women. This test is used for definitive purposes.~~ **The timely and accurate diagnosis of rupture of (fetal) membranes (ROM) is crucial because ROM may be associated with serious neonatal and maternal consequences. Failure to identify patients with ROM can result in the failure to intervene appropriately.** CLIA classified as Moderately Complex.
Equipment:	Test kit (with sterile swab, solution vial, test strip) Timer (with attached vial holder)

A. **PRINCIPLE:**

~~1. AmniSure ROM test is a rapid, non-instrumented, qualitative test for the detection of amniotic fluid in vaginal discharge of pregnant patients who report signs, symptoms, or complaints suggestive of rupture of membranes. Premature Rupture of Membranes (PROM) prior to 37 weeks' gestation complicates up to 12% of all pregnancies.~~

~~2.~~**1.** **The** AmniSure **ROM** uses the principles of immunochromatography to detect human PAMG-1 (placental alpha-1 microglobulin) protein present in amniotic fluid of pregnant women. **The test employs highly sensitive monoclonal antibodies that detect even a minimum amount of the protein, which is present in cervico-vaginal discharge after the rupture of the (fetal) membranes.** Placental Microglobulin was selected as a marker of fetal membrane rupture due to its unique characteristics (i.e. high level in amniotic fluid, low level in blood, and extremely low background level in cervico-vaginal discharge when the membranes are intact).

B. **PROCEDURE:**

~~1. Store the kit in a dry place at 4° to 24° C (40° to 75° F). DO NOT FREEZE. When stored as recommended the test is stable until the "use by" date on the foil pouch. Use within 6 hours after removing from foil pouch. Check integrity of package prior to use, and ensure that no excessive moisture is noted and no mechanical damage to the test strip is seen.~~

~~2.~~**1.** Open the test kit and remove contents.

2. ~~Shake the solvent vial to make sure all the liquid in the vial settles to the bottom.~~**Take the solvent vial by its cap and shake well to make sure all liquid in the vial has dropped on the bottom, then open the solvent vial and place in a vertical position.**

~~3. Open the solvent vial and place into vertical position. The metal loop on the side of the timer is the vial holder. You may place the solvent vial in this holder.~~

~~4. Specimen Collection and patient Identification:~~

~~a. Identify patient per Patient Care Services Policy: Identification, Patient.~~

~~b. Speculum examination is not required.~~

~~c. Position patient lying flat on back.~~

~~d. Wear gloves for infection prevention. Collect sample of vaginal discharge using sterile vaginal swab provided in kit.~~

Patient Care Services Content Review	Clinical Policies & Procedures	Nursing **Leadership** ~~Executive Committee~~	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/13, 11/15, 12/19, **03/22**	06/13, 12/13, 12/15, 01/20, **04/22**	12/13, 01/16, 02/20, **05/22, 06/22**	04/18, 04/20, **08/22**	01/14, 04/18, 05/20, **09/22**	06/20, **12/22**	04/14, 05/18, n/a	04/14, 05/18, 06/20

~~i. Remove swab from packaging using care not to touch anything prior to insertion into vagina.~~

~~ii. Holding swab in the middle of the stick carefully insert the polyester tip of the swab into the vagina until fingers contact the skin no more than 2-3 inches (5-7 cm) deep.~~

~~iii. Withdraw swab after one minute has elapsed.~~

~~5.~~**3. Remove the sterile swab from its package, the polyester tip of the swab should not touch anything prior to insertion into vagina, hold the swab in the middle of its shaft and carefully insert the polyester tip of the swab into the vagina until the fingers contact the skin (no more than 5-7 cm deep). Withdraw the swab from the vagina~~l **after one minute.**~~Place the swab into the vial.~~

~~6.~~**4. After the swab has been removed from the vagina, immediately place the polyester tip into the provided solvent vial and rinse by rotating for one minute.**

~~7. Rinse the swab by rotating for one minute.~~

~~8.~~**5.** Tear open the foil pouch at the test notches and remove the AmniSure **ROM** test strip.

6. Dip the white end of the strip (marked with arrows **facing downward**) into the **vial with** solvent.

~~9.~~**7. Remove the test strip from the vial if two lines are clearly visible in the test region or after 10 minutes sharp. Read the results by placing the test strip on a clean, dry and flat surface in a well-lit environment. A negative result must not be read until the full 10 minutes has elapsed.**

~~10. Allow the strip to remain in solvent for 10 minutes, unless two lines are clearly visible.~~

~~a. Note: a strong leakage will make results visible within minutes, while a small leak may take the full time. A negative result must not be read until the full 10 minutes has elapsed.~~

~~11. Read the results by placing the strip on a clean, dry flat surface.~~

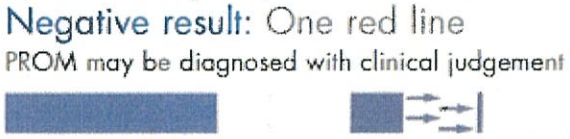
~~12. Do not read or interpret after 15 minutes have passed since placing the strip into the vial (or after 5 minutes from removing from vial).~~

~~13.~~**8.** Discard the testing and sampling materials into the waste management container.

C. REPORTING RESULTS:

1. There are three possible result interpretations:

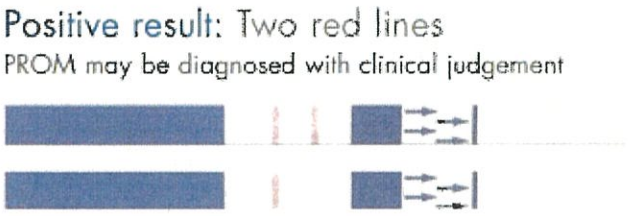
a. Negative, indicated by the presence of a control line and no test line.



i.

b. Positive, indicated by two lines in the test region.

i. The intensity of the test line may vary; the test result is valid even if the lines are faint or uneven.



ii.

c. Invalid, indicated by no lines or only a test line.

i. Invalid results require a retest.

ii. Report invalid tests to the POC coordinator. Do not throw away package with lot number on it.



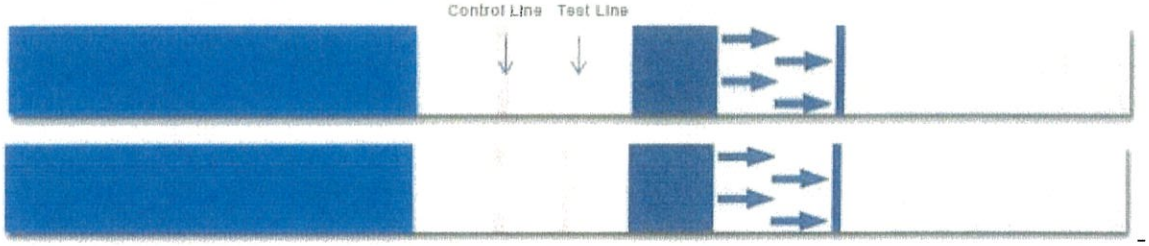
iii.

~~C.~~2. **Do not read or interpret after 15 minutes have passed since placing the strip into the vial.**

~~1. No membrane rupture (control line present)~~



~~2. There is a rupture (control line and test line present) [Test line may be very faint and/or broken. This is still considered positive.]~~



~~3. Test invalid (control line not present)~~



~~4. Notes:~~

~~a. The darkness of the lines may vary – do not try to interpret the test result based on the darkness of the line.~~

~~b. The test is valid even if the lines are faint or uneven.~~

~~5. For each test the following must be documented:~~

~~a. Date and time of testing~~
~~b. Operator's identification~~
~~c. Internal QC~~
~~d. Patient result~~

D. **DOCUMENTATION:**

~~1. Document according to current departmental procedures.~~

~~2. In I-View, first document the internal controls (internal qc, daily qc)~~

~~a. Pass = control line in the control region and background clears. Ok to report patient test.~~

~~b. Fail = control line absent and/or the background does not clear. Repeat patient with new test kit.~~

~~3. Once the internal QC is documented as "Pass", document the results as Positive or Negative.~~

1. Input results of the control line and test line through the glucometer.

2. Document the membrane status, date, time, color, amount and odor of fluid in the patients EHR.

E. **QUALITY CONTROL:**

1. **Internal Controls**~~Initial validation of internal control by demonstration of concordance with external controls was performed by the lab prior to test implementation.~~

   a. Each AmniSure ROM Test has built-in reagent and procedural controls to assure accurate reading of the results.

   b. The appearance of line in the control region verifies the integrity of the test procedure.

2. **External Controls**

   a. External controls (positive and negative) must be performed upon every new lot, **new** shipment, ~~-~~monthly on every box currently in use, and if there is suspicion that the product performance is compromised.

~~3. Perform positive and negative QC procedure.~~

~~a. Positive control: use commercial stabilized positive control purchased through manufacturer, or use known Amniotic Fluid.~~

~~b. Negative control: use saline solution.~~

~~4. Daily (or day-of-testing) controls may be limited to the internal procedural control. Internal controls validate that adequate sample volume was present and adequate capillary migration of the sample has occurred.~~

~~5. To interpret internal controls:~~

~~a. Positive control: a colored line appearing on the control region~~

~~b. Negative control: a clear background on the control region.~~

~~c. Patient tests where the control line is not present or the background has not cleared must not be reported. Repeat testing with a new Amnisure test strip.~~

~~6. Procedure for Liquid External Controls:~~

~~a.~~**b.** Obtain liquid external controls **package** ~~(quality controls, QC, controls)~~ from the ~~lab's temperature controlled freezer and keep in a temperature controlled refrigerator in the unit~~ **lab** prior to testing. **The package contains:**

i. ~~PAMG-1 is present (positive) or absent~~ (negative) **control** ~~from the vials. SKIP the swab collection steps.~~

~~b.~~**ii. Two solvent vials**

c. Use the solvent vials provided ~~by the laboratory~~**in the package**. ~~Save the unused solvent vials from the test kits and return to the lab with results.~~

~~d. Open the vial provided by the lab, place in the vial holder~~

d. Uncap both controls and solvent vials. Pour each solvent to the corresponding controls, recap and shake vigorously for 30 secs to ensure reconstitution.

e. Tear open the foil pouch at the test notches and remove the AmniSure test strip.

f. Dip the white end of the strip (marked with arrows **facing downward**) into the **vial with** solvent.

g. Remove the test strip from the vial if two lines are clearly visible in the test region or after 10 minutes sharp. Read the results by placing the test strip on a clean, dry and flat surface in a well-lit environment.

~~f.~~**h. Interpret results as mentioned in the section above.**

~~g. Allow the strip to remain in solvent for 10 minutes, unless two lines are clearly visible.~~

~~h. Read the results by placing the strip on a clean, dry flat surface.~~

~~i. Do not read or interpret after 15 minutes have passed since placing the strip into the vial (or after 5 minutes from removing from vial).~~

~~7. To interpret external liquid controls:~~

~~a. Positive control = Positive, line in control region and line in test region (2 lines).~~

~~b. Negative control = Negative, line in control region and NO line in the test region (1 line).~~

~~c. Controls PASS if the positive control is positive and the negative control is negative. Test kits are ok to use for patient testing.~~

~~d. Controls FAIL if the positive control is not positive, the negative control is not negative and/or the control line does not appear. DO NOT use test kits for patient testing. Contact the Laboratory.~~

F. ~~LIMITATIONS:~~STORAGE AND STABILITY:

1. **Store the kit in a dry place at 4 to 25°C. Do not freeze.**
2. **When stored in the foil pouch at the recommended temperature, the test is stable until the "Use By" date on the foil pouch.**
3. **Use the AmniSure ROM Test within six hours after removing from foil pouch.**
~~8.~~4. **Each test is a single use disposable unit and cannot be reused.**

G. LIMITATIONS:

1. **The AmniSure ROM Test results are qualitative. Make no quantitative interpretation based on the test results.**
2. **Vaginal infections, urine and sperm do not interfere with the results.**
3. **When there is a significant presence of blood on the swab, the test can malfunction and is not recommended. In cases of only trace amounts of blood on the swab, the test still functions properly.**
4. **In very rare cases when a sample is taken 12 hours or later after a rupture, a false-negative result may occur due to obstruction of the rupture by fetus or resealing of the amniotic sac.**
5. **Use results in conjunction with other clinical information.**
6. **Failure to detect membrane rupture does not assure the absence of membrane rupture.**
7. **Women may labor spontaneously despite a negative test result.**
8. **The performance of the AmniSure ROM Test has not been established in the presence of the following contaminants: anti-fungal creams or suppositories, K-Y Jelly, Monistat Yeast Infection Treatment, Baby Powder (Starch and Talc), Replens Feminine Moisturizer or Baby Oil.**
9. **The performance of the AmniSure ROM Test has not been established in the presence of meconium in the amniotic fluid.**
9. **10. Placenta previa and performing digital exams prior to sample collection can lead to inaccurate test results.**
10. ~~Expect discrepant results from other methods used to test for ruptured membranes (Nitrazine, Ferning, and Pooling). AmniSure is more accurate and more sensitive than the other methods, and except in rare cases (with interfering substances or deviated procedure), should be considered correct.~~
11. ~~Test strip must be used within 6 hours from removing from foil pouch.~~
12. ~~A significant presence of blood on the swab can cause the test to malfunction. Do not report results. The test still functions properly with only a trace amount of blood on the swab.~~
13. ~~Do not interpret results greater than 15 minutes after placing the test strip into the vial.~~
14. ~~False negative results may occur when the sample is taken more than 12 hours after the fetal membrane rupture has occurred.~~
15. **11.** Test should not be performed within 6 hours after the removal of disinfectant solutions or medications from the vagina.
16. **12.** Test should be run immediately after sample is obtained. If sample ~~can not~~**cannot** be processed immediately for testing, it must be run within 30 minutes from collection time.

F. ~~**INTERFERING SUBSTANCES:**~~

1. ~~Vaginal infections, urine and sperm do not interfere with results.~~
2. ~~The performance of AmniSure has not been established in the presence of the following contaminants; meconiumn, anti-fungal creams or suppositories, KY Jelly, baby powder (starch and talc), Replens, and baby oil.~~

G. **H.** **RELATED DOCUMENT(S):**

1. Patient Care Services Policy: Identification, Patient

H. **I.** **REFERENCE(S):**

1. AmniSure International US package insert. ASP 1100-US0002. 8/10/2010
2. AmniSure Individualized Quality Control Plan (IQCP) in Point of Care/Lab binder
2. **3. AmniSure® ROM (Rupture of [fetal] Membranes) Test Package insert. 1090607 Rev. 04 2019/4/01**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 06/00 **SUBJECT:** Automated Dispensing System

REVISION DATE~~(S)~~: 07/05, 07/06, 07/09, 01/12, 03/18, 02/19

Patient Care Services Content Expert Approval:	~~01/19~~01/22
Clinical Policies & Procedures Committee Approval:	~~01/19~~04/22
Nursinge Leadership~~Executive Committee~~ Approval:	~~01/19~~05/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~01/19~~07/22
Medical Executive Committee Approval:	~~01/19~~09/22
Administration Approval:	~~01/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **POLICY:**

1. Automated Dispensing Systems (ADS) are used for medication dispensing and control in accordance with state and federal regulations and accreditation standards.
2. The pharmacy system administrator, in collaboration with hospital leadership, is responsible for ensuring the safety and security features of the ADS are properly configured and enforced.
3. The safe use of the ADS is a collaborative multidisciplinary process requiring appropriate use by all disciplines.
4. User groups and privileges are defined to control access to medications for specific practitioners and patient care areas.
5. Only Information Technology (IT) and authorized pharmacy personnel may activate a new user or renew a user's access code in the system.
6. Biometric user ID is utilized, or at minimum, passwords are changed every **three (3)**~~six (6)~~ months.
7. Sharing of user names and passwords is *prohibited.* All users are expected to follow hospital policies regarding confidentiality and passwords.
8. Medication removal, return, or waste under an invalid patient account is *prohibited.*
9. Automated dispensing cabinets (ADCs) are considered secured areas for medication storage.
10. ADCs are placed in areas that have minimal distractions **(preferred)**, allowing staff to concentrate on the task of selecting medications from the cabinet.

B. **PROCEDURE:**

1. System Access:
   a. Nurse Directors or their designees, and Credentialing Staff from the Medical Staff Office are authorized to submit a System Access Request form to request access to the Automated Dispensing System (ADS).
   b. Designated Pharmacy staff have the privileges to assign access to the ADS.
   c. The User identification (ID) and initial password will be assigned by IT.
   d. First time users will be prompted to register a fingerprint for the "Bio ID" function. Thereafter, the user will log onto the ADS with the User ID and fingerprint.
      i. All users are set up for Bio ID which is the preference, but may be switched to password ID if problem arises with Bio ID.
2. Users who forget their passwords will need to contact IT or use recovery system as available.

a. ADS privileges, areas of the hospital, security groups, override capabilities and console privileges are defined by the user's job title and role.
b. Access to ADSs will be assigned by work areas. These will be:
   i. Users who float outside their normal areas shall have visitor access granted at the new ADS by the ~~Assistant Nurse Manager (ANM) or Relief Charge~~ Nurse **Leader/designee**, Administrative Supervisor (AS) or pharmacist.
   ii. Travelers will be granted access for assigned unit until the end of contract or term date.
   iii. Registry nurses will be granted access with no ADS locations assigned. They will be granted visitor access at the station each time they work. The temporary activation remains in effect for fourteen (14) hours.
   iv. Registry staff other than nursing will be granted access appropriate to their role.
c. Human Resources will notify IT when a nurse has separated from the hospital.
d. Medical Staff Office will notify IT when a physician is separating from the hospital.
e. Periodically, and no less often than quarterly, Pharmacy will review user lists on the Server. Users without activity will be inactivated. Local users with Active Directory accounts will be inactivated.
f. Nursing personnel shall notify the Pharmacy Department when a unit which contains an ADC is closing. Once notification is received, the ADC shall be de-activated. De-activation of the AD will prevent utilization of the system. When the unit is reopening, nursing personnel shall notify the Pharmacy and the ADC shall be reactivated.

3. Medication Dispensing, Returning and Wasting
   a. Profile dispense
      i. Medication orders are reviewed by a pharmacist prior to administration of the first dose. Following the pharmacist's review/verification of the medication order, the medication is available for selection on the ADC patient profile.
      ii. Obtain medications from the ADC one patient at a time. Medications should not be obtained for multiple patients during a single ADC session.
      iii. Review each medication selected with the patient's medication administration record (eMAR).
      iv. Verify the inventory count when prompted.
      v. Administer the medications as soon as possible after removal from the ADC.
   b. Override dispense
      i. Override Dispense function may be used to access select hospital-approved medications that may be needed to treat an urgent/emergent clinical situation
      ii. When using the Override Dispense function the user determines, and witness (if required) confirms:
         1) An urgent situation exists, such that a delay may cause harm.
         2) The medication order is a valid order.
         3) The patient is not allergic to the medication ordered.
         4) The correct medication, dose and dosage form are being removed from the ADC
      iii. Override reports are routinely reviewed to identify and address reasons for overrides.
   c. Returns
      i. Medications must be returned promptly to the ADC when it is discovered that the medication will not be administered.
      ii. Unopened medications removed from the ADC that are not used are returned to the ADC return bin unless otherwise indicated by the ADS.
      iii. A witness is required when returning Class II-V controlled substances to the bin.
      iv. If the medication is not intact, follow the procedure for wasting medications.
   d. Waste
      i. Medications are wasted as close to the time of removal as possible, or after the removal transaction. If a witness is required, the person witnessing the wastage

shall confirm the correct medication and amount wasted in addition to documenting the transaction in the ADC system.

ii. See Tri-City Medical Healthcare District (TCHD) Waste Disposal Guidelines for appropriate disposal of medication that is being wasted including controlled substances.

iii. Medication waste is documented in the ADC station at the time the medication is actually wasted.

e. Controlled Drug Discrepancy:

i. Nursing is responsible for reconciling all ADC discrepancies prior to the end of a shift per the Patient Care Services Policy: Controlled Substance Management. Pharmacy staff can be utilized to run reports and assist with resolution.

ii. If the discrepancy was caused by pharmacy personnel, then Pharmacy is responsible for resolving the discrepancy.

iii. The pharmacy monitors for open discrepancies that have been unresolved for greater than 24 hours. The Controlled Substance Technician will contact the Nurse **Leader/designee**~~Manager or Charge Nurse~~ to make them aware of the need to resolve the discrepancy immediately. If no action is taken, the matter will be escalated to the Pharmacy Director, or designee.

iv. Documented Discrepancies are reviewed daily to ensure all documented discrepancies have been resolved accurately and confirm no controlled substances are unaccounted for.

v. If during the course of a discrepancy investigation controlled substances are unaccounted for, further appropriate action shall be taken. This could include an audit of individuals and reporting to appropriate agencies.

vi. Nurses shall perform a physical inventory of all controlled substances as stated in Patient Care Services Policy: Controlled Substance Management.

4. Reports:

a. Override Reports are run daily.

b. All C-II Safe Events - Ran daily and kept on file for three (3) years. Fulfills Board of Pharmacy requirements.

c. Charges and Credits- Run daily, billing is processed by the Medstation System Specialist for patients manually entered at the ADC. These billing adjustments are made directly into the hospital host computer system.

d. Documented Discrepancy Report- Run daily

e. C-II Safe vs. Pyxis MedStation Compare- Run throughout the day by staff accessing the CII Safe and reviewed by the Controlled Substance Technician.

f. C-II Safe Activity Log- Run daily and reviewed by the Controlled Substance Technician for unusual occurrences. This report is kept on file for three (3) years.

g. C-II Safe Open Discrepancy- Run daily (Monday through Friday) and reconciled by the Controlled Substance Technician.

h. Suggested Reorder Report- Run every Monday and Thursday by Pharmacy Buyer or designee.

5. Data Archival:

a. A redundant copy of all information is automatically stored on a hard drive within the C-II Safe.

C. **FORM(S):**

1. System Access Request Form (SAR) – Non-Provider
2. System Access Request Form (SAR) – Provider/Provider Office
3. Tri-City Medical Center Daily Audit and Disposition for Controlled Drugs

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

1. Patient Care Services (PCS) Policy: Controlled Substance Management
2. TCMC Waste Disposal Guidelines

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CARDIOVERSION, ELECTIVE (SYNCHRONIZED CARDIOVERSION)**
Purpose:	To outline the nursing management of adult/adolescent patients undergoing an elective cardioversion
Supportive Data:	Elective cardioversion is performed by a physician only.
Equipment:	Defibrillator with functioning synchronizer Multifunction cable and pads Emergency cart Medications as ordered by physician Oral airway, manual resuscitation bag with mask, and suction equipment Automatic blood pressure cuff Infusion Pump Electrocardiogram (ECG) Electrodes End tidal carbon dioxide monitoring

A. **POLICY:**

1. Elective cardioversions will be performed in procedural areas, Intensive Care Unit (ICU), and Telemetry.
2. The Registered Nurses' (RNs) role during an elective cardioversion is to assist the physician as ordered.
3. Review the following procedures
   a. Online Skills: Synchronized Cardioversion for detailed nursing responsibilities for pre-intra and post-procedure monitoring and assessment.
   b. Patient Care Services (PCS) Procedure: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure

B. **PROCEDURE:**

1. Complete Pre-Op/Pre-Procedure Checklist.
2. Notify and request attendance for respiratory therapist for procedure.
3. Keep patient NPO as ordered.
4. Position the patient in supine position or as ordered by physician.
5. Ensure suction equipment is readily available.
6. Place automatic blood pressure cuff on patient and set for desired time intervals.
7. Administer medications as ordered.
8. Place defibrillator in synchronization mode. Select energy level as ordered by Physician.
9. Assist physician with operating equipment as necessary.
   a. Turn off oxygen flowmeter during cardioversion to decrease risk of combustion.
   b. Ensure all personnel are clear of contact with patient, bed, and equipment during actual cardioversion to prevent from being shocked.
   c. Post-cardioversion, restart oxygen after electrical discharge completed.

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

1. PCS Procedure: Sedation/Analgesia Used During Therapeutic or Diagnostic Procedure
2. Online Skills: Synchronized Cardioversion

D. **REFERENCE(S):**

1. American Heart Association (AHA). (2016). *Advance cardiovascular life support:* Cardioversion p. 136-138.

PCS Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/00, 03/03, 07/03, 03/04 03/06, 04/09, 05/19, 05/22	07/11, 01/16, 06/19, 06/22	08/11, 01/16, 06/19, 07/22	10/16, 08/19, 08/22	n/a	10/11, 10/16, 09/19, 09/22	10/19, 12/22	11/11, 01/17, n/a	12/11, 01/17, 10/19

2. Urden, L., Stacy, K., and Lough, M. (2014). *Critical care nursing: Diagnosis and treatment.* Mosby's Inc, St. Louis: MO

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**CHEST TUBE MANAGEMENT**
Purpose:	To define the nursing interventions for assisting with the insertion of chest tubes for the adult and adolescent patients. To define nursing management of adult and adolescent patients with chest tubes.
Supportive Data:	Closed chest drainage systems are used to facilitate the evacuation of fluid, blood, and air from the pleural space, the mediastinum or both; to restore negative pressure to the pleural space; and promote reexpansion of a collapsed lung. Online Skill Chest Tube Insertion Procedure Online Skill Chest Tube: Closed Drainage System Procedure
Equipment:	~~1. One 250mL bottle of Normal Saline~~ ~~2.~~**1.** Chest Tube Dressing Change Equipment a. Silvasorb Gel or Povidone-Iodine Ointment b. 2-inch silk tape or micropore c. Normal Saline d. 4x4 gauze sponges e. 4x4 gauze drainage sponges ~~3.~~**2.** Chest Tube Removal Kit a. Suture removal kit b. ChloraPrep (triple swabsticks) ~~c. Silvasorb Gel~~ ~~d.~~**c.** 2 plastic clamps ~~e.~~**d.** 4x4 gauze sponges (package of 10) ~~f.~~**e.** Chux ~~g.~~**f.** 2 zip holders ~~h.~~**g.** 1 large red bag **h.** 2-inch paper tape ~~i.~~**3. Silvasorb Gel**

A. **PROCEDURE:**

1. Assisting with the Insertion of a Chest Tube
   a. Place Chest Tube Insertion Cart in patient's room.
      i. Set up chest drainage device (Refer to Online Clinical Skills ChestTube: Closed Drainage System Management).
      ii. Assisting physician/Allied Health Professional (AHP) (Refer to Online Clinical Skills Chest Tube Insertion).
      iii. Ensure chest x-ray is completed post-insertion per physician/AHP's order.
2. Chest Tube Monitoring, Nursing Assessment and Care
   a. Refer to Online Clinical Skills ChestTube Insertion.
   b. Ensure a Chest Tube Removal Kit is readily available in patient's room.
      i. Attach Chest Tube Removal Kit to Intravenous (IV) pole on Telemetry, Acute Care Services (ACS), and Progressive Care Unit.
   c. Secure chest drainage system to the IV pole using two zip holders. Silk tape may be used to secure the drainage system.
   d. Monitor the amount and type/color of drainage per the physicians/AHP' **orders.**
   e. Mark the collection chamber at the end of every shift and PRN with the date, time, and **initials**. Document the drainage amount in the medical record.

Patient Care Services Content ~~Expert~~Department ~~Review~~	Clinical Policies & Procedures	Nursing Leadership	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
4/09; 5/12; 11/15, 02/20, **09/22**	06/12, 12/15, 04/20, **10/22**	06/12, 01/16, 08/20, **11/22**	n/a	n/a	10/12, 09/16, 08/20, **11/22**	09/20, **12/22**	11/12, 10/16, n/a	12/12, 11/16, 09/20

i. The amount of drainage within the first two hours after insertion may be approximately 100 to 300 mL the amount of drainage should begin to decrease over the next few hours and days.

f. Assess the patient per physician/AHP orders. If no order for assessment, assess as outlined in Online Clinical Skills Chest Tube: Closed Drainage Systems.

g. Discuss with the physician/AHP and obtain an order to perform range of motion exercises for shoulder on the side of the chest tube site to prevent frozen shoulder secondary to immobility.

h. Discuss the need for physical therapist assistance with the physician/AHP. Ambulate patient per physician/AHP's order.
   i. If there is no order to ambulate, ensure patient sits on the side of bed to enhance ventilation, maximize lung inflation, and improve gas exchange.
   ii. Discuss the need for activity orders with physician/AHP.

i. Patient positioning:
   i. Elevate head of the bed (HOB) 30 to 45 degrees or per physician/AHP's order.
   ii. Lobectomy and all other lung surgeries: position patient on the non-operative side or per physician/AHP's order.
   iii. Pneumonectomy: position supine or on the operative side.
   iv. Reposition patient at least every two hours

j. Incentive Spirometry (IS)
   i. Ensure patient uses the IS as ordered by physician//AHP.

3. Dressing Change: Chest Tube Insertion Site
   a. Change chest tube insertion site dressing every other day and PRN, unless ordered otherwise by physician/AHP.
   b. Remove dressing and discard in appropriate receptacle.
   c. Clean chest tube insertion site with normal saline applied to sterile 4x4 gauze sponge.
   d. Pat insertion site dry with 4x4 gauze sponge.
   e. Apply Silvasorb gel or follow physician/AHP's order.
   f. Anchor chest tube to patient's skin.
   g. Apply one to two 4x4 drain sponges underneath the chest tube and 1-2 on top of the chest tube. Ensure chest tube is not kinked.
   h. Apply two to three 4x4 gauze sponges on top of the drain sponges.
   i. Apply silk tape or micropore over 4x4 dressing. (Do not use paper, foam or elastoplast tape to secure chest tube dressing.)
   j. Ensure drainage tubing is visible, not kinked, and properly positioned. Do not position or secure drainage tubing behind patient's back.
   k. Do not reinforce chest tube dressing. If dressing becomes saturated or soiled:
      i. Remove dressing
      ii. Assess connections
      iii. Apply a new dressing
      iv. Notify physician/AHP

4. Chest Tube Removal: Assist
   a. Ensure a Chest Tube Removal Kit is readily available and assist physician/AHP as needed.
   b. Monitoring the patient post-removal :
      i. Obtain chest x-ray as ordered.
      ii. Ensure adequate respiratory status. Assess the following:
         1) Breath sounds
         2) Heart rate
            a) Monitor cardiac rhythm on Cardiac Monitoring Units
         3) Respiratory rate and quality
         4) Oxygen saturation
         5) Notify physician/AHP for abnormal findings

iii. Monitor insertion site for bleeding. If bleeding is found, apply pressure and place a tight occlusive dressing over site. Notify the physician/AHP for persistent bleeding. (Persistent bleeding from the insertion site could mean the chest tube was against a vein of the chest wall before removal.)
iv. Monitor suture site and surrounding skin. Notify physician/AHP for abnormalities such as excessive redness, dark or inflamed skin with necrotic areas.
v. Monitor the site for signs of infection.
vi. Monitor insertion area for development of subcutaneous emphysema (Crepitus), which is an indication of an air leak into the surrounding tissues.
vii. Monitor for signs and symptoms of pericardial effusion or cardiac tamponade. i.e. distant heart tones, decreased blood pressure, tachycardia, pulsus paradoxus, narrowed pulse pressure
viii. Assess pain and medicate per physician/AHP orders

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

1. Online Clinical Skills: Chest Tube Insertion
2. Online Clinical Skills: Closed Drainage System Management

C. **REFERENCE(S):**

1. Elsevier: Online Clinical Skills Nursing Skills. (October 2019). Chest tube insertion. Retrieved from Tri-City Medical Center Intranet.
2. Elsevier: Online Clinical Skills Nursing Skills. (November, 2018). Chest tube: Closed drainage system management.: Retrieved from Tri-City Medical Center Intranet
3. Teleflex Medical. (2020). Understanding chest drainage. Retrieved from http://www.teleflex.com/en/usa/ucd/index.php
4. Urden, L.D., Stacy, K. M., & Lough, M. E. (2014). Critical care nursing. Diagnosis and Management. (7th ed.). St. Louis, MO: Elsevier

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 07/09 **SUBJECT: Code STEMI**

REVISION DATE~~(S)~~: 03/10, 08/11, 04/12, 09/13, 04/14 02/18, 03/19

Patient Care Services Content Expert Approval:	~~12/18~~08/22
Clinical Policies & Procedures Committee Approval:	~~01/19~~09/22
Nurse Executive Committee Approval:	~~01/19~~10/22
Division of Cardiology Approval:	01/19
Pharmacy & Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~02/19~~11/22
Administration Approval:	03/19
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. **PURPOSE:**
1. To provide a systematic method for responding to ST Elevation Myocardial Infarction (STEMI) patients.
2. To assure compliance with Centers for Medicare and Medicaid (CMS) and San Diego STEMI Guidelines as outlined by the County of San Diego Emergency Medical Services (EMS) STEMI Receiving Centers (SRC) Standards.

B. **POLICY:**
1. The Emergency Department (ED) physician, cardiologist or Mobile Intensive Care Nurse (MICN) determines when a patient meets STEMI criteria by reviewing the 12 lead ECG obtained in the hospital or pre-hospital.
2. The Rapid Response Team (RRT) Registered Nurse (RN) determines when an inpatient meets STEMI criteria by reviewing the 12 lead ECG.
3. The decision for medical management by Coronary Angiography, Percutaneous Coronary Intervention (PCI) or the use of fibrinolytics will be in accordance with the decision of the treating physician.
4. Hospital EKG's should be completed within a goal of 10 minutes of being ordered and delivered directly to a RRT RN or physician for interpretation.

C. **PROCESS FOR EMERGENCY DEPARTMENT PATIENTS:**
1. STEMI Team activation:
   a. ED Secretary will activate the Code STEMI at the direction of the physician
      i. Contacts Private Branch Exchange (PBX) at 66 and requests Code STEMI activation to the ED.
      ii. Pages the on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
         1) If no response within 5 minutes, contact PBX and requests STAT page for on-call Cardiologist to the appropriate ED phone number to consult with ED physician.
   b. MICN nurse will activate the pre-hospital STEMI based on ***Acute MI***/***ACUTE MI SUSPECTED*** on the field 12 lead ECG, or verbal report from the transporting agency of STEMI.
      i. Contacts PBX at 66 and requests Code STEMI activation to the ED.
2. STEMI Team Notification
   a. PBX operator will notify STEMI team members by sending a bulk page indicating Code

STEMI activation and indicate patient name and bed assignment in ED.
- i. Cardiac Cath Lab (CCL) team
- ii. EKG technician
- iii. Phlebotomist
- iv. Radiology technician

3. STEMI Team Response:
   a. Cardiologist will respond to page by calling ED and consulting with ED physician.
   b. Phlebotomist, EKG technician, and Radiology technician will report directly to patient bedside in ED within 10 minutes of receiving page.
   c. CCL team will respond to PBX confirming page was received and report to CCL and ED within 30 minutes of page.
4. STEMI Team Response Verification
   a. PBX will notify the Code STEMI originator of the STEMI team response.
   b. If no response from a CCL team member, PBX will notify the Cath Lab Supervisor on call.
5. STEMI Diversion Plan:
   a. MICN will maintain current status with the San Diego County MICN Data Entry Network as to the ability to receive STEMI patients.
   b. Cardiologist will be responsible for determining the need for STEMI Diversion.
   c. Criteria for Interfacility Transfer of patients, who are identified as STEMI patients, when PCI cannot be initiated, will be according to hospital policy.
   d. Diversion is called only when the patient is currently in the Cath lab, at no time will a STEMI Diversion be called if a patient is not currently in the Cath lab.
   e. In the event that Tri City is on STEMI diversion and the mobile intensive care nurse (MICN) receives a prehospital alert that a STEMI is in route, before diversion, the MICN will contact the CCL to discuss possible acceptance of the patient.
   f. Indications for Diversion:
      - i. CCL Room 1 and 2 are non-operational.
      - ii. CCL Room 1 non-operational and room 2 occupied with an electrophysiology case.
      - iii. CCL Room 1 non-operational and room 2 occupied with an STEMI case.
      - iv. STEMI patient in room 1 and room 2 occupied with an electrophysiology case.
      - v. Off hours and staff occupied with STEMI Case.
      - vi. Off Hours acceptance of a STEMI transfer patient.
      - vii. Hospital at BED Capacity.
      - viii. Equipment not available.
   g. **Notifications:**
      - i. Notify CCL Manager and CV Service line Administrator
      - ii. Notify Emergency Department (ER) of STEMI diversion Start and Finish time
      - iii. Notify Administrative Supervisor
1. Cancellation of Code STEMI:
   a. The ED physician or cardiologist evaluating the patient may, at his/her clinical discretion, cancel a STEMI activation.

B. **PROCESS FOR IN-PATIENTS:**

1. Patient complains of new onset chest pain or any other symptoms suggestive of Acute Coronary Syndrome (ACS) on an Acute Care Unit, the primary Registered Nurse (RN) shall assess the patient and notify the Rapid Response Team (RRT) and the unit ~~Assistant~~ Nurse ~~Manager~~ **Leader**~~(ANM) /Relief Charge RN~~**designee.**
2. Telemetry patients with new onset ST elevation, the primary RN shall:
   a. Initiate therapy as ordered and/or as outlined in the Patient Care Services (PCS) Standardized Procedure: Code Blue and Emergency Care (Cardiopulmonary Arrest): Chest Pain/(Related to Coronary Artery Occlusion or Spasm) AND
   b. Notify RRT and the unit ~~ANM/Relief Charge RN~~**Nurse Leader/designee**
3. Rapid Response RN shall:

a. Assess patient
b. Order STAT ECG by dialing (760) 802-9484 or via PBX
c. Treat patient per PCS Standardized Procedure: Rapid Response
d. ECG technician performs ECG and hand-delivers ECG to RRT RN
e. The RRT RN will review the ECG:
   i. If ECG is positive for ***Acute MI*** the RRT RN will:
      1) Dial 66 and request an IN-HOUSE CODE STEMI to room ___.
      2) Page attending physician to the patient's room to evaluate the patient.
      3) Call Pharmacy (x3012) to request delivery of STEMI Medication Kit
   ii. If ECG is negative for Acute MI, RRT treats patient according to standardized procedure. RRT or primary RN pages attending/physician for orders.
f. PBX operator initiates IN-HOUSE CODE STEMI by announcing an overhead page "IN-HOUSE CODE STEMI room ___", and by sending a STEMI activation page to:
   i. Cardiac Cath lab (CCL) team
   ii. Phlebotomist
   iii. Radiology technician
   iv. Respiratory
g. The attending physician will respond to the patient's room when an overhead IN-HOUSE CODE STEMI is paged. If no response by the attending physician within 5 minutes the RRT RN will call the hospitalist/on-call hospitalist. If no response from the hospitalist/on-call hospitalist in 5 minutes, the RRT RN will call ED charge nurse at 760-940-3509 for stat ER physician assistance to evaluate patient:
   i. Physician will verify the ECG
   ii. If positive for Acute MI, RRT RN will call PBX to page on call cardiologist to 760 802-3727
      1) If physician deems ECG to be negative for Acute MI, RRT will call PBX operator to cancel the IN-HOUSE CODE STEMI.
   iii. Attending physician, hospitalist/on-call hospitalist, ED physician communicates with the on-call Cardiologist.
h. A pharmacist or pharmacy technician will deliver a STEMI Medication Kit upon request from the RRT RN. If not delivered within 5 minutes, the RRT RN will place a second call to the Pharmacy and/or contact a pharmacy technician
i. Cath lab team reports to patient room to obtain report and transport patient to the CCL

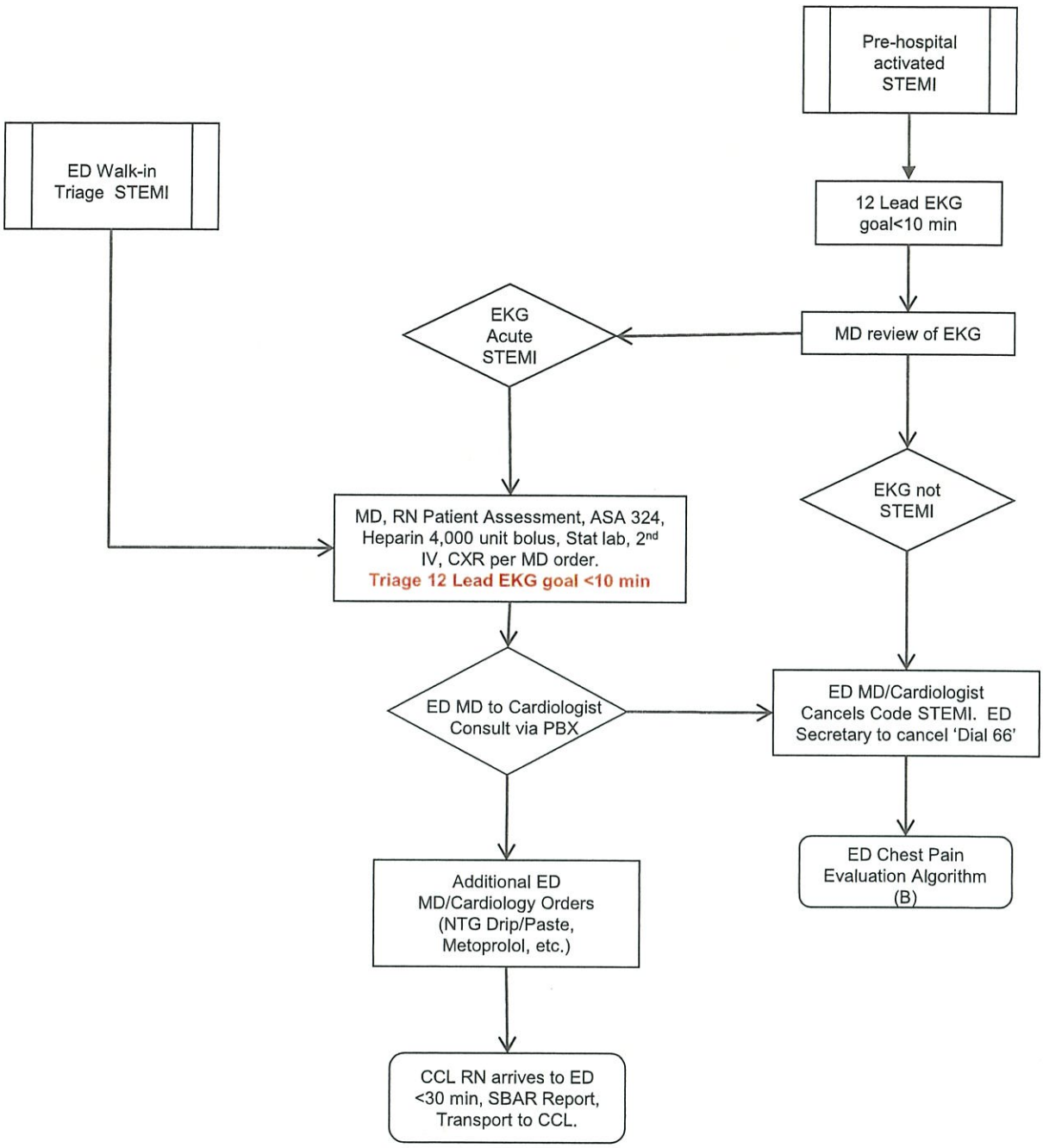
C. **RELATED DOCUMENT(S):**

1. Code STEMI - ED STEMI Pathway
2. Code STEMI Pre-hospital STEMI Algorithm
3. ED Walk-In Triage Process – Chest Discomfort & Equivalent
4. In-House Code STEMI Flowchart – Patient new onset ST elevation or chest pain
5. STEMI Packet Instructions

D. **REFERENCE(S):**

1. Cardiac Cath Lab Policies and Procedures
2. Medical Staff Policy 520 "Emergency Room Call: Duties of the On-Call Physician"
3. Patient Care Service Policy VI.D "Transfer of Patients"
4. Emergency Department Policies and Procedures
5. Emergency Department Bypass for ST-Segment–Elevation Myocardial Infarction Patients Identified With a Prehospital Electrocardiogram Akshay Bagai, James G. Jollis, Harold L. Dauerman, S. Andrew Peng, Ivan C. Rokos, Eric R. Bates, William J. French, Christopher B. Granger and Matthew T. Roe Circulation. 2013;128:352-359, originally published July 22, 2013 https://doi.org/10.1161/CIRCULATIONAHA.113.002339
6. California Code of Regulations Tittle 22. Social Security, Division 9. Prehospital Emergency Medical Services Chapter 7.1 ST Elevation Myocardial Infarction (STEMI) Critical Care System.

Code STEMI – ED STEMI Pathway



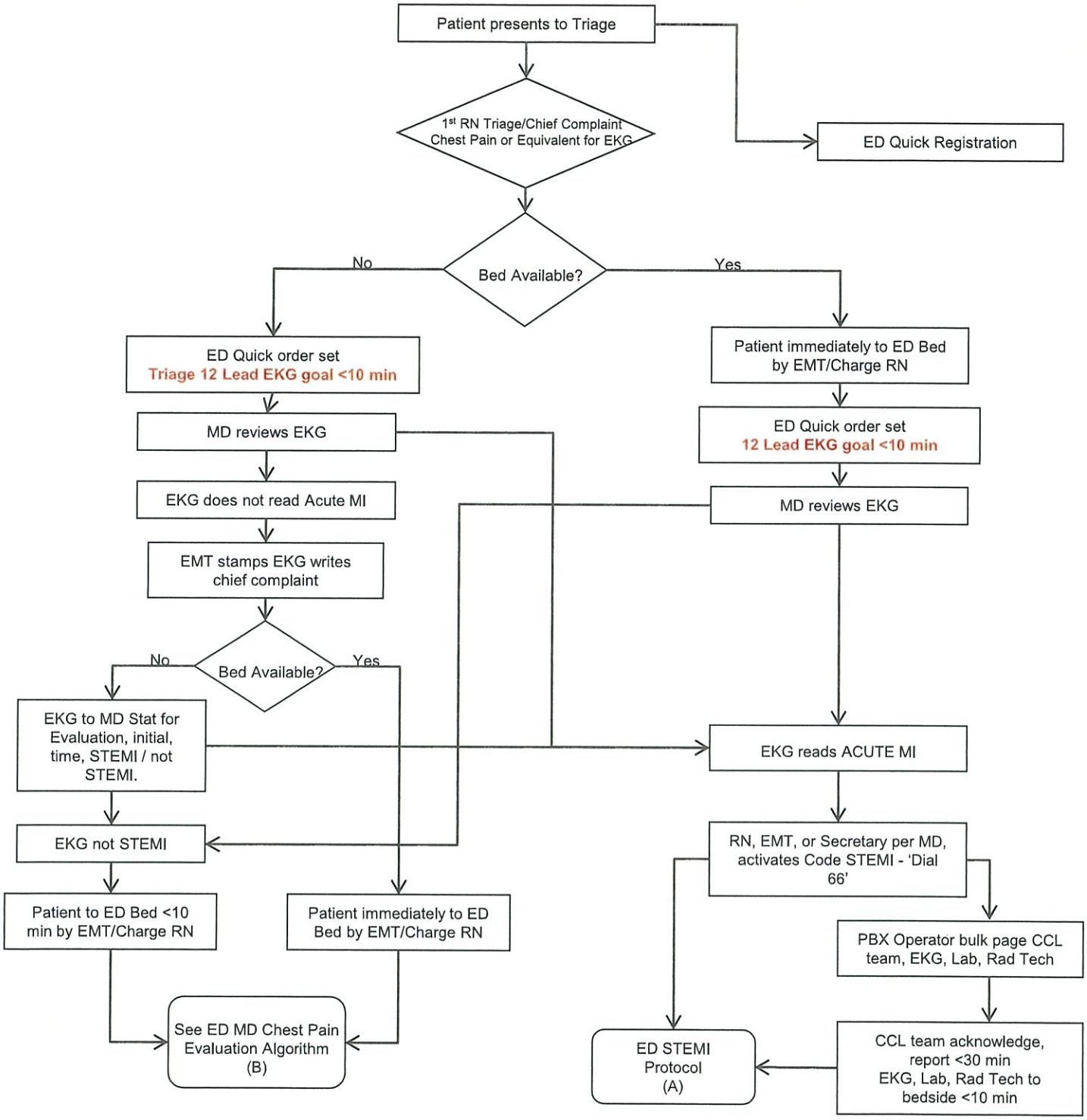
Cardiovascular HealthInstitute
Tri-City Medical Center

This Clinical Practice Guideline was developed to be of assistance to health care professionals by providing guidance and recommendations for particular areas of practice. The Guidelines should not be considered inclusive of all proper approaches or methods, or exclusive of others. The Guidelines cannot guarantee any specific outcome, nor do they establish a standard of care. The Guidelines are not intended to dictate the treatment of a particular patient. Treatment decisions must be made based on the independent judgment of health care providers and each patient's individual circumstances.

ode STEMI Pre-Hospital STEMI Algorithm

→ First Medical Contact to Device (FMC2D) Time Goal <90 minutes → → → → → → → → → → → → → → → → → → →

ED Walk-in Triage Process – Chest Discomfort & Equivalent



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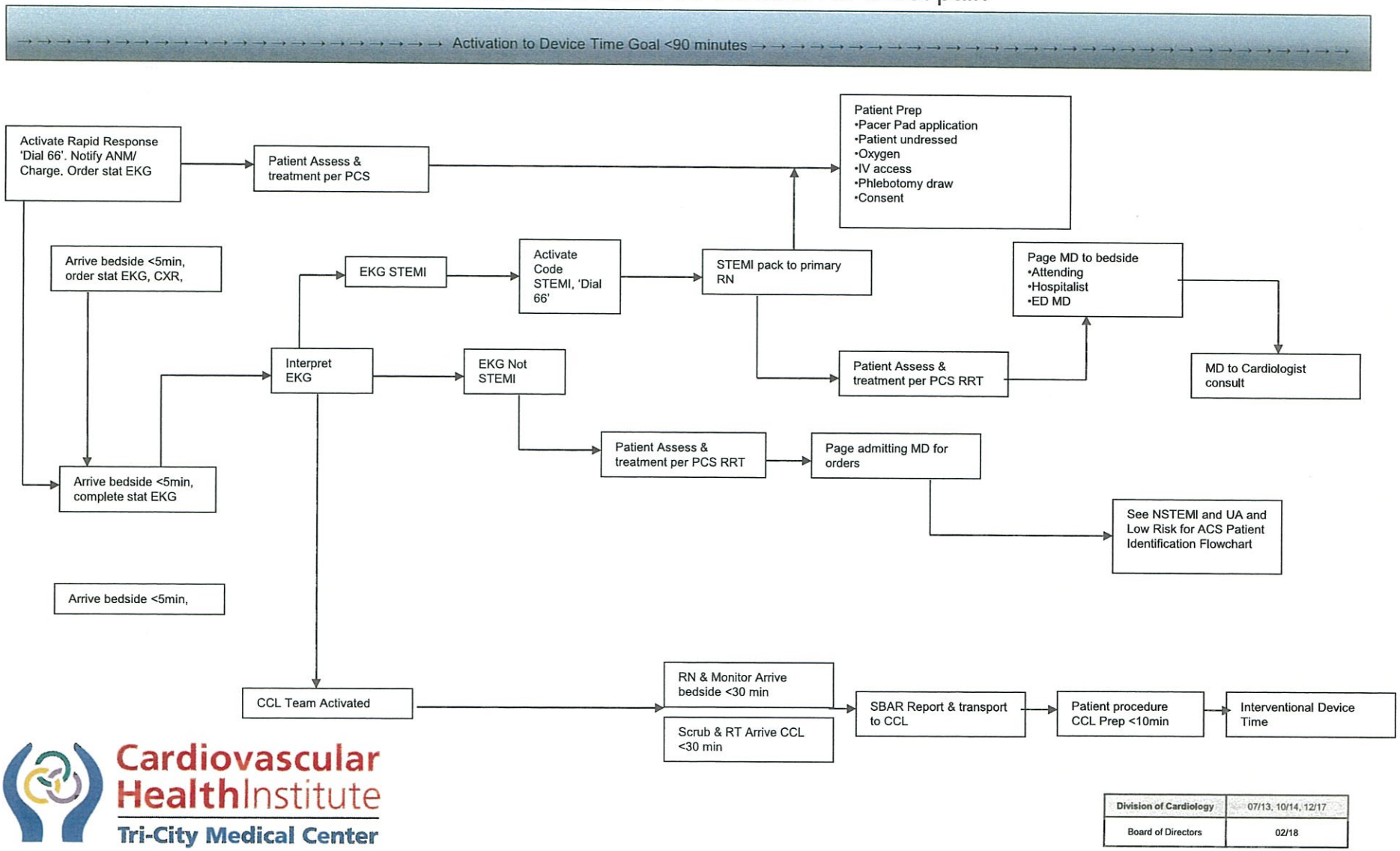
Division of Cardiology	09/12, 11/12, 12/17
Board of Directors	02/18

In-House Code STEMI Flowchart - Patient new onset ST elevation or chest pain



Cardiovascular HealthInstitute
Tri-City Medical Center

Division of Cardiology	07/13, 10/14, 12/17
Board of Directors	02/18

STEMI PACKET INSTRUCTIONS

Goal – First Medical Contact to Intervention <90 minutes

Unit Departure to CCL <30 minutes

Code STEMI Activation

- ❑ Activate Red STEMI Packet, provide to the Unit Secretary or Primary RN.

Float RN / Tech

- ❑ Apply RADIOLUCENT pacer pads; anterior/posterior, cables pointing downward
- ❑ Undress patient completely, place clothing in belongings bag, encourage patient to void
- ❑ Obtain 1st vitals and bilateral BP's; BP q5 - 15 minutes thereafter
- ❑ Place patient on oxygen and insure oxygen tank on gurney is sufficiently full
- ❑ Make sure triple channel pump & portable defibrillator is available in room
- ❑ Complete patient belongings list and home medication list
- ❑ Shave patient's groin for procedure above knee to umbilicus both sides

Primary RN

- ❑ IV – 2 large bore (1 in left arm preferred), use extension tubing - Draw blood when starting IV (if possible)
  1) One red top, 2) One blue top, 3) One green top, 4) One small purple, 5) One large purple
- ❑ Medications: 1) Heparin bolus – NO drip (per physician order)
  2) Aspirin (ASA) (per physician order)
  3) Metoprolol (per physician order)
- ❑ Place preprinted consent on chart with patient sticker ready to be signed
  If no pre-printed consent is available, prepare as follows: "Cardiac catheterization with contrast and possible percutaneous transluminal coronary angioplasty with stent and possible sedation"
- ❑ Provide Red STEMI Packet to Cath Lab RN

Cath Lab

- ❑ Provide Red STEMI Packet to Cath Lab Tech for completion

Packet includes:
- STEMI Checklist
- Preprinted Consent

NOT A PART OF THE MEDICAL RECORD

Division of Cardiology	07/12, 12/17
Board of Directors	02/18

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**10/06**	**SUBJECT:**	**Communicating with Physicians/Allied Health Professionals (AHP) Using the SBAR Process**
REVISION DATE:	**07/09, 09/12, 03/16, 08/19**		

Patient Care Services Content Expert Approval:	**~~04/19~~05/22**
Clinical Policies & Procedures Committee Approval:	**~~05/19~~06/22**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~05/19~~07/22**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/19~~, 09/22**
Administration Approval:	**~~07/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **POLICY:**

1. The SBAR (Situation Background Assessment Recommendation) process shall be utilized to communicate with physicians/AHP, the Rapid Response Team, and Code Team members regarding patient status or a critical situation.

B. **PROCEDURE:**

1. Prior to calling the physician/AHP, follow these suggestions:
   a. Assess patient
   b. Discuss situation with resources (i.e. ~~Assistant~~ Nurse **Leader**~~Manager (ANM)~~ or designee, resource nurse, rapid response nurse)
   c. Review the chart for appropriate physician/AHP
   d. Know the admitting diagnosis and date of admission
   e. Read the most recent progress notes and review charting from the nurse who worked the prior shift
   f. Have available when speaking with physician/AHP:
      i. Patient's chart
      ii. List of current medications, allergies, intravenous (IV) fluids
      iii. Most recent vital signs
      iv. Most recent lab results
      v. Code status
2. When calling the physician/AHP, follow the SBAR process:
   a. (S) Situation: What is the situation you are calling about?
      i. Identify self, unit, patient, and room number.
      ii. Briefly state the problem, when it began, and how severe.
   b. (B) Background: Pertinent background information related to the situation may include the following:
      i. The admitting diagnosis and date of admission
      ii. List of current medications, allergies, IV fluids
      iii. Most recent vital signs
      iv. Lab results: provide the date and time test was completed and results of previous tests for comparison
      v. Other clinical information

vi. Code Status
vii. Relevant past medical history

c. (A) Assessment: Pertinent physical assessment findings
d. (R) Recommendation: What is the nurse's recommendation? Examples may be:
   i. **Change in level of care**~~Transfer patient to critical care~~
   ii. Come to see the patient at this time
   iii. Talk to the patient or family about code status
   iv. Any diagnostic tests needed
   v. A change in treatment order

3. Document the change in patient's condition and physician/AHP notification in the medical record.

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

1. SBAR Report to Physician

SBAR Report to Physician

SBAR report to physician about a critical situation (Ask physician "Are you familiar with this patient?")

S	**Situation** **I am calling about** <patient name and location> **The patient's code status is** <code status> **The problem I am calling about is < state what you are calling about>** (I am afraid the patient is going to arrest) **I have just assessed the patient personally:** **Vital signs are: Blood pressure ___/___, Pulse ___, Respiration ___ and temperature ___** **I am concerned about the:** Systolic blood pressure because it is less than 90 mm/Hg or greater than 200 mm/Hg Heart rate because it is less than 50 or greater than 130 beats per minute Respiratory rate because it is less than 8 or greater than 28 breaths per minute or threatened airway Oxygen saturation level is less than 92% despite oxygen therapy at _____liters via NC or _____ Temperature because it is less than 35.5 or greater than 40 degrees Celsius **Urine output** is less than 50 mL in 4 hours **Acute significant bleed**, new, repeated or prolonged seizures **Level of consciousness**, sudden unexplained agitation and confusion **Change in skin tone** (pale, dusky, gray, or blue) **Failure to respond** to treatment for an acute problem/symptom **The patient must be stabilized or a decision to transfer to a higher level of care must be made within 30 minutes.**
B	**Background** **The patient's mental status is:** Alert and oriented to person place and time. Confused and cooperative or non-cooperative. Agitated or combative Lethargic but conversant and able to swallow. Stuporous and not talking clearly and possibly not able to swallow. Comatose. Eyes closed. Not responding to stimulation. **The skin is:** Warm and dry Pale Mottled Diaphoretic Extremities are cold/warm **The patient is not or is on oxygen.** The patient has been on ____(l/min) or (%) oxygen for ____minutes (hours) The oximeter is reading ____% The oximeter does not detect a good pulse and is giving erratic readings.
A	**Assessment** **This is what I think the problem is** <state what you think is the problem> The problem seems to be **cardiac infection neurologic respiratory** _____ I am not sure what the problem is but the patient is deteriorating. **The patient seems to be unstable and may get worse, we need to do something.**
R	**Recommendation** **I suggest or Request that you** <say what you would like to see done> Transfer the patient to critical care Come to see the patient at this time Talk to the patient or family about code status Ask the on-call family practice resident to see the patient now **Are any test needed:** Do you need any test like: CXR, ABG, ECG, CBC, Labs {i.e. CBC, C7, C12, Magnesium CPK, Trop Other test? _____ **If a change in treatment is ordered then ask:** How often do you want vital signs? How long do you expect this problem will last? If the patient does not get better when would you want us to call again? Are there any new medication orders?

Revised: 08/19
Patient Care Services Policy: Communicating with Physicians/Allied Health Professionals (AHP) Using the SBAR Process

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**DEFIBRILLATOR CHECKS**
Purpose:	To ensure proper functioning of the defibrillator to ensure patient safety.
Supportive Data:	A defibrillator is a life support equipment used for the purpose of sustaining life, and whose failure to perform its primary function will lead to patient death in the absence of immediate intervention.
Equipment:	Zoll Defibrillator ~~M~~**R Series® Plus**~~series~~
Supplies:	**Two OneStep multifunction electrodes (Adult and Pediatric)** **6 - ECG lead packages** **2 - Gel pads (for external paddles, if present)** **2 - ECG paper pads** **Three lead ECG cable** **The following supplies apply to select models** • **SpO_2 cable** • **SpO_2 probe** • **$ETCO_2$ cable** • **Disposable $ETCO_2$ Adapter** • **Non-invasive Blood Pressure (NIBP) Cable** • **Blood Pressure Cuff**
Issue Date:	04/19

A. **POLICY:**

1. **Defibrillator daily visual checks shall be performed once a day.**
2. **Defibrillator manual testing shall be performed once a week. If the defibrillator is configured Off, manual testing will be performed daily.**
3. **All units** ~~Twenty-four (24) hour~~ **and episodic units (i.e., procedural areas)** ~~units~~ will check defibrillator **once a day** ~~every shift~~ while unit is open.
4. **The defibrillator must be plugged into a working outlet when not in use.**
5. **Defibrillators that will be stored longer than 90 days, remove the battery pack.**
6. **Check the device date and time once each month and document on the Crash Cart or Defibrillator checklist.**

~~1. The device date and time will be check once each month and documented on the Crash Cart Checklist.~~

~~2. Episodic unit (i.e., procedural areas) shall check defibrillators once a day when unit is open.~~

B. **DEFINITION(S):**

1. **Automatic Testing – System testing performed at pre-configured intervals**
2. **Manual Testing – System testing perform by a healthcare provider or designee once a week to check the following; defibrillator testing, pacer testing and recorder checks**
3. **Code-Readiness Testing – A system self-test performed whenever the unit is turned on, periodically during operation, whenever manual testing is initiated and automatically at pre-configured intervals.**

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

1. **Daily Visual Checks**
   a. **Defibrillator is plugged into a working outlet, (red power outlet, if available)**
   b. **Gray power cord is connected to the black pigtail located in the back of the defibrillator**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/18, **09/22**	01/19, **10/22**	01/19, **11/22**	n/a	n/a	n/a	04/19, **12/22**	n/a	04/19

c. Green "√" present in upper right hand corner analog display window
d. If Red "X" present, attempt to correct with a manual 30J (joules) test
e. If Red "X" persists, contact Biomedical Engineering (Biomed) immediately for further evaluation
f. AC light and battery light are steady green
    i. Green battery light = battery fully charged
    ii. Amber battery light = battery is charging
    iii. Flashing Amber/Green battery light = ensure battery is fully inserted into the battery well
        1) If not inserted, fully insert battery and observe for steady Amber or Green battery light
        2) If fully inserted, call Biomed for further evaluation
g. OneStep Pad is plugged into the Electro-Therapy Cable.
    i. Ensure a spare OneStep Pad set is available
h. Defibrillator and emergency cart have required supplies
    i. Check expiration dates on all supplies, discard expired supplies and replace
    ii. Check the following defibrillator checks:
        1) Condition
            a) Unit clean, no spills, clear of objects on top, case intact
        2) Hands-free Therapy Electrodes
            a) 1 set preconnected
            b) 1 spare set
        3) Paddles, if present
            a) Verify adult paddles are installed and are pushed all the way into their holders
            b) Paddles are clean, not pitted
            c) Release from housing easily
        4) Inspect cables for cracks, broken wires, connectors and ensure the following are present:
            a) ECG electrode cable, connector
            b) Defibrillator paddle cables
            c) OneStep cable, connector
        5) Batteries / External Power Supply
            a) A fully charged battery in unit
            b) Unit plugged into an outlet
        6) Disposable Supplies – check expiration dates, discard expired supplies and replace with supplies that are not expired.

~~1.~~**2.** Weekly Checks
a. Manual Defibrillator Testing (Checks)
    i. Ensure device is in Manual Mode and device is plugged into an outlet
    ii. Connect unopened OneStep electrodes to the OneStep cable or connect to the OnceStep or Multifunction (MFC) cable
    ~~2. Ensure the Multi-Function Cable is plugged into the unit.~~
    ~~a. The Multi-Function Cable should not be plugged into the test connector.~~
    iii. ~~Switch~~Turn to **MONITOR**~~RO~~monitor, listen for four (4) beep tone. The message MONITOR message on~~should~~ display.
    iv. ECG size X 1 (one)
    v. "PADDLES" OR "PADS" as lead selected
    vi. Paddles
        1) ~~See Addendum AB~~ Defibrillator Testing with Paddles

~~b. If staff need to adjust the time or date on the unit, depress the softkey on the far right prior to switching to MONITOR and adjust as needed (this should be performed every two weeks).~~

b. Defibrillator Testing Using Hand-Free Therapy

i. Ensure device is connected to power outlet.

ii. Turn the defibrillator off for at least 10 seconds.

iii. Turn the Mode Selector to ON

~~i.~~iv. Press the Manual Mode softkey.

~~ii.~~v. The unit emits a four-beep tone indicating successful completion of the power-on self-test. The ECG source is PADS and ECG size is X1. "DEFIB 120J Sel," and DEFIB PAD SHORT appear on the display. The ECG trace appears as a solid line while the OneStep cable is connected to either the Test Port or OneStep electrodes.

vi. Press the ENERGY SELECT buttons to set the energy to 30 joules

vii. Press the CHARGE button on the front panel

viii. When the charge-ready tone sounds, press the ENERGY SELECT buttons to set the energy to 20 joules. The defibrillator will disarm itself

ix. Press the ENERGY SELECT buttons to reset the energy to 30 joules.

1) Note: For testing, the unit discharges the defibrillator only if the energy is set to 30 joules.

x. Press the CHARGE button on the front panel

xi. When the Ready tone sounds, press the SHOCK button on the front panel until the shock is delivered.

1) The unit displays the message 30J TEST OK and prints a stripchart indicating 30J TEST OK and the delivered energy.

2) If TEST FAILED appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.

xii. Signing, dating and retaining the recorder output is not required.

c. PACER Testing

i. Ensure the device is connected to a power outlet

ii. Press the Manual Mode softkey

1) If the CONFIRM MANUAL MODE message displays, press the CONFIRM softkey to enter the Manual mode of operation.

iii. Turn the Mode Selector to PACER

iv. Turn the PACER RATE control to 150 pulse per minute (PPM).

~~i.~~v. Press RECORDER button

1) **On the stripchart verify that pacing stimulus, markers occur approximately every centimeter (10 small divisions or two [2] large divisions**

vi. Press **and hold** 4:1 button.

~~3.~~**1) Frequency of the pacing stimulus markers decrease, occurring approximately every 4 centimeters (40 small divisions or ~~, pulses occur every~~** 8 large divisions).

~~4. Stop recorder~~

~~a. Note that signing, dating and retaining the recorder output is not a requirement.~~

~~5.~~**vii. Turn ~~Set~~** PACER OUTPUT **control** to 0 mA and ensure that there is no CHECK PADS **or POOR PAD CONTACT** message.

~~i.~~viii. Disconnect **the OneStep ~~Multi-Function~~** Cable from the **test port or OneStep electrodes, and slowly turn the ~~unit. Set~~** PACER OUTPUT **control** to 16 mA **or more. The messages ~~and ensure that there is a~~** CHECK PADS **or POOR PAD CONTACT ~~message and~~ appear alternately. The pace** alarm **sounds, and Clear Pace Alarm softkey flashes**.

~~6.~~ix. ReCconnect **OneStep**~~multifunction~~ cable ~~to test connector and .~~ and press the *Clear Pace Alarm* softkey. The messages CHECK PADS and POOR PAD CONTACT disappear, and the alarm tone stops.

~~7. Press Clear Pace Alarm softkey; CHECK PADS message will disappear and pace alarm stops.~~

d. Recorder Check
   i. Turn the Mode Selector to ON.
   ii. Press the *Manual Mode* softkey.
      1) If the *COFIRM MANUAL MODE* message displays, press the *CONFIRM* softkey to enter the Manual mode of operation
   iii. Select the ECG lead.
   iv. Check the printer for an adequate supply of paper, then press the *RECORDER* button.
   v. Press and hold the *SIZE* button for at least 2 seconds.
      1) A calibration pulse of 1mV appears on the display while the button is held. The amplitude of the calibration pulse is independent of the SIZE setting
   vi. Inspect the recorder waveform for uniformity and darkness
   vii. Inspect for uniformity of annotated characters and completeness of words.
   viii. Check the printer speed by verifying that the resulting waveform is:
      1) 2.5 mm ±0.5 mm wide
      2) 10 mm ±1.0 mm high
   ix. Signing, dating, and retaining the recorder output is not required. ~~Saving or storing the recorder~~

~~8. Disconnect multifunction cable from test connector .~~

~~9. Switch unit to DEFIB and set energy to 30 joules~~

~~a. The messages CHECK PADS and POOR PAD CONTACTS will alternately display.~~

~~10. Plug the Multi-Function Cable into its test connector.~~

~~a. The message DEFIB PAD SHORT will display.~~

~~11. Press the CHARGE button on the front panel or on the apex paddle handle.~~

~~12. Wait for the charge read tone to sound and verify that the energy ready value displayed on the monitor registers 30 joules.~~

~~a. The message will read DEFIB 30J READY~~

~~b. The strip chart recorder will print a short strip indicating TEST OK energy delivered if the unit delivered energy within specifications. Note that signing, dating and retaining the recorder output is not a requirement.~~

~~c. During the Energy Delivery Test, unit will only discharge when energy level is set to 30 joules.~~

~~d. If TEST FAILED appears, contact Clinical Engineering (Biomed) or ZOLL Technical Service Department immediately.~~

~~C.~~3. ~~Plug device back into the electrical~~ **outlet**~~socket after testing is complete.~~

D. ONCE A MONTH TESTING:

1. SETTING DEFIBRILLATOR TIME AND DATE
   a. Turn the Mode Selector to ON
      i. If the CONFIRM Manual Mode message displays, press the *Confirm* softkey to enter the Manual mode of operations
   b. Press the *Manual Mode* softkey
   c. Press the Options softkey
   d. Press *More*
   e. Press *Set Clock*
      i. The month field will be highlighted
   f. Press the *Inc Value* or Dec Value softkeys to select the appropriate month

g. Press the Next Field softkey to set the selected month, and move the highlight to the next field (day)

h. Repeat steps 5 and 6 to set the correct day, year, hours, and selected month and minute values.

i. Note: The last field does not automatically scroll (wrap) to the beginning. You must press the *Prev Field* softkey to enter the values for the previous field.

ii. If you need to make corrections, press the *Prev Field* softkey to move the highlight to the field previously entered.

i. Press the *Enter* and *Return* softkey to set all values and return to normal monitoring mode.

E. DOCUMENTATION:

1. Document ~~D~~defibrillator checks ~~will be documented~~ on the Crash Cart Checklist.
2. All checks will be validated by the signature (no initials) of the licensed staff completing the checks.

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

1. Tri-City Medical Center Adult Crash Cart Checklist
2. Tri-City Medical Center Stand Alone Defibrillator Checklist
3. ZOLL R Series Plus R Series BLS Operators' Guide: Chapter 13 Maintenance

G. RELATED DOCUMENT(S):

1. PCS Emergency Cart (Crash Cart), Cardiopulmonary Arrest
2. Defibrillator Testing with Paddles

~~See Addendum BA~~

Defibrillator Testing with Paddles

WARNING! When performing this check, use your thumbs to operate the SHOCK buttons in order to avoid inadvertent shock. No portion of the hand should be near the paddle electrode plates.

To test the manual defibrillation function using paddles:

- Turn the unit off for at least 10 seconds.
  - Turn the Mode Selector to ON.
  - Press the Manual Mode softkey.
    - Note: If the CONFIRM MANUAL MODE message displays, press the Confirm softkey to enter the Manual mode of operation.
    - The unit emits a four-beep tone indicating successful completion of the power-on self-test.
    - The ECG source is PADDLES, and ECG size is X1. "DEFIB 120J SEL" appears on the display.
    - The ECG trace appears as a solid line while the paddles are seated in the paddle wells.
  - Press the ENERGY SELECT buttons to set the energy to 30 joules.
  - Press the CHARGE button on the apex handle.
  - When the charge-ready tone sounds, press the ENERGY SELECT buttons to change the selected energy to 20 joules. The defibrillator will disarm itself.
  - Press the ENERGY SELECT buttons to reset the energy to 30 joules.
    - Note: For testing, the unit discharges the defibrillator only if the energy is set to 30 joules.
  - Press the CHARGE button. When the charge-ready tone sounds, the message DEFIB 30J READY appears.
  - Press paddles firmly into their wells and using your thumbs, simultaneously press and hold the SHOCK buttons (one on each paddle) until the shock is delivered.
    - The unit displays the message 30J TEST OK and prints a stripchart indicating 30J TEST OK and the delivered energy.
    - ~~1.~~ If the message 30J TEST FAILED appears, contact appropriate technical personnel or the ZOLL Technical Service Department.

UNIT:_____ **TRI-CITY MEDICAL CENTER STAND ALONE DEFIBRILLATOR CHECKLIST** MONTH/YEAR: _____

Suggested Practice Reminder: Complete Weekly Defibrillator, Pacer and Recorder Checks on Wednesdays. Complete Monthly Date and Time Checks on the First Wednesday of the month.

Legend: ✓ = Present/Checked R = Replaced	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
DEFIBRILLATOR Number or ID:	Complete Visual Checks once a day. Defibrillator, Pacer and Recorder Testing once a week. Check Date and Time once a month.																														
VISUAL CHECKS – Complete once a day.																															
DEFIBRILLATOR TESTING – Complete once a week.																															
PACER TESTING – Complete once a week.																															
RECORDER TESTING – Complete once a week.																															
DATE AND TIME CHECK – Complete once a month.																															

DEFIBRILLATOR Number or ID:	Complete Visual Checks once a day. Defibrillator, Pacer and Recorder Testing once a week. Check Date and Time once a month.																														
VISUAL CHECKS – Complete once a day.																															
DEFIBRILLATOR TESTING – Complete once a week.																															
PACER TESTING – Complete once a week.																															
RECORDER TESTING – Complete once a week.																															
DATE AND TIME CHECK – Complete once a month.																															

DEFIBRILLATOR Number or ID:	Complete Visual Checks once a day. Defibrillator, Pacer and Recorder Testing once a week. Check Date and Time once a month.																														
VISUAL CHECKS – Complete once a day.																															
DEFIBRILLATOR TESTING – Complete once a week.																															
PACER TESTING – Complete once a week.																															
RECORDER TESTING – Complete once a week.																															
DATE AND TIME CHECK – Complete once a month.																															

SIGNATURE OF PERSON COMPLETING DEFIBRILLATOR CHECK																															

Zoll R Series Plus
Daily Visual Checks

- ☐ Defibrillator is plugged into a working outlet (red power outlet, if available)
- ☐ Gray power cord is connected to the black pigtail in the back of the defibrillator
- ☐ Green "√" present in upper right hand corner analog display window
  - ✓ If Red "X" present, attempt to correct with a manual 30J (joules) test
  - ✓ If Red "X" persists, contact Biomed immediately for further evaluation
- ☐ AC light and battery light are steady green
  - Green battery light = battery fully charged
  - Amber battery light = battery is charging
  - Flashing Amber/Green battery light = ensure battery is fully inserted into the battery well
    - ✓ If not inserted, fully insert battery and observe for steady Amber or Green battery light
    - ✓ If fully inserted, call Biomed for further evaluation
- ☐ OneStep Pad is plugged into the Electro-Therapy Cable
  - ✓ Ensure a spare OneStep Pad set is available
  - ✓ Electro-Therapy cable may be plugged into side Test Port if unit is specially programmed to test on the Test Port instead of the OneStep Pads.
- ☐ Defibrillator and emergency cart have required supplies
  - ✓ Check the following defibrillator checks:
    - Condition - Unit clean, no spills, clear of objects on top, case intact
    - Hands-free Therapy Electrodes (1 set pre-connected & 1 spare set)
  - ✓ Paddles, if present
    - Verify adult paddles are installed and are pushed all the way into holders
    - Paddles are clean, not pitted & release from housing easily
  - ✓ Inspect cables for cracks, broken wires, connectors and ensure the following are present:
    - ECG electrode cable connector
    - Defibrillator paddle cables (if applicable)
    - OneStep cable connector
  - ✓ Batteries / External Power Supply
    - A fully charged battery in unit
    - Unit plugged into an outlet
  - ✓ Disposable Supplies – check expiration dates, discard expired supplies and replace with supplies that are not expired.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Emergency Cart (Crash Cart), Cardiopulmonary Arrest**
REVISION DATE:	**06/03, 10/04, 11/06, 10/07, 06/08, 08/09, 08/12, 07/16, 03/19, 04/22**		

Patient Care Services Content Expert Approval:	~~12/21~~09/22
Clinical Policies & Procedures Committee Approval:	~~12/21~~10/22
Nursing Leadership Approval:	~~03/22~~11/22
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	~~03/22~~11/22
Administration Approval:	~~04/22~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/22

A. **POLICY:**

1. Emergency Carts (crash carts) shall be checked at least daily for integrity and expiring products by a licensed healthcare provider or designee on the unit. **Verification of the crash cart checks will be** ~~This is~~ documented by date and signatures in a logbook kept on top of the cart.
2. **The licensed healthcare provider or designee checking the crash cart will ensure missing or expired items are replaced immediately. If items cannot be replaced in a timely manner, the crash cart should be replaced by the Sterile Processing Department (SPD).**
3. Crash carts shall be stored in a visible or secure**d** location**s**.
4. **A crash cart may be left on a unit that is closed if properly secured.**
5. **Crash carts secured on a closed unit do not require checking until the unit is re-opened.** ~~A~~
   A licensed healthcare provider or designee will write "Unit Closed" in the logbook for the dates when the unit was closed.

~~a. The licensed healthcare provider or designee checking cart will ensure missing items are replaced immediately. If items cannot be replaced in a timely manner, the cart should be replaced by the Sterile Processing Department (SPD).~~

~~b. A crash cart may be left on a unit that is closed if properly secured.~~

~~i. The crash cart does not require checking until the unit is re-opened.~~

~~1) The licensed healthcare provider or designee will write "Unit Closed" in the logbook for the dates when the unit was closed.~~

~~2. Crash carts shall be stored in a visible or secure location.~~

~~3.~~**6.** SPD shall immediately replace any cart used during a Code Blue, Code Caleb or Code Pink with an Emergency Cart that has been checked for integrity and expiring products.

a. The replacement cart shall be deemed ready for use upon arrival to the unit.

b. After a code, **a licensed healthcare provider or designee shall ensure the crash cart and the contents of the crash cart are secured per Securing Emergency Cart Guidelines.** ~~as follows:~~

~~Remove the threetwo zip ties located in the crash cart. (2 - green zip ties to lock the medication tray and one white zip tie to lock the crash cart).~~

~~Use the green one (1) zip tie to the locksecure the medication tray by threading the one zip tie through one each hole on the front of medication tray and the adjacent holes on the clear lid of the medication tray.~~

~~Use the white second zip tie to secure (lock) the entire cart by threading the zip tie through the lock hole on the medication lock bar.~~

c. **Contact** ~~is used to lock the cart before it is returned to~~ SPD **to pick up the used crash cart.**

d. **Place the used locked crash cart in a location that is visible at all times to a healthcare provider until it is picked up by SPD.**

~~b. Place the used locked crash cart in a location that is visible at all times to a healthcare provider until~~ for cleaning. ~~it is returned picked up by to SPD.~~

~~c.~~**e.** ~~The used crash cart shall remain locked and monitored until it is returned to SPD.~~

~~4.~~**7.** The Code Blue Committee shall make recommendations for content changes based on code evaluations and recommendations from the American Heart Association.

B. **PROCEDURE FOR CHECKING CODE BLUE, CODE PINK AND CODE CALEB CRASH CARTS:**

1. All documentation of cart checks **will be** ~~is~~ completed on the department specific Emergency Equipment/Supplies Checklist. All fields must be completed **by the healthcare provider checking the chart,** ~~shall~~ **documenting their** ~~complete~~ **signature on the checklist form.** ~~and the document signed.~~

~~1.~~**2. Implement the following when completing emergency cart checklists**

a. Check the integrity of all locks/tags. If any lock/tag is broken, call SPD to replace the cart.
   i. Adult cart document:
      1) Lock number on the locking bar on the crash cart.
   ii. Pediatric cart document:
      1) Medication drawer expiration date and lock number
      2) ~~I~~**Intravenous** ~~V~~**(IV)** drawer expiration date and lock number
      3) Red Airway Bag expiration date and lock number
   iii. Neonatal cart document:
      1) Medication drawer expiration date and lock number
      2) IV drawer expiration date and lock number

b. Check the medication sticker and document medication expiration date.
   i. Ensure the sticker number matches the lock number.~~-~~ Notify Pharmacy of **if the following is present**
      ~~b.~~**1)** ~~a~~**A**ny lock number discrepancies.
      ~~i.~~**2)** ~~Notify Pharmacy of e~~**E**xpired medications.

c. Check non-medication supply sticker(s) and document the expiration dates.

d. Check IV solution sticker and document expiration date.
   i. Notify SPD if any supplies are expired.

e. Presence and function of suction equipment (except for neonatal cart).
   i. Suction unit shall be checked unplugged for adequate function.
   ii. Battery level of suction unit will be checked while unit is unplugged to ensure adequate charge.

f. Presence of Resuscitation Code Record and Evaluation/Debriefing form on clipboard appropriate to type of cart (adult, pediatric, neonatal).

g. Resuscitation algorithms appropriate for type of cart (adult, pediatric, neonatal).

h. The inventory lists are available on the cart.
   i. The list is maintained and updated by SPD.

i. **Six**~~One~~ pack of **electrocardiogram** ~~ECG~~ electrodes.

j. Presence of resuscitation bag (Ambu) and supplies appropriate for type of cart (adult, pediatric, neonatal).
   i. Check the **oxygen** mask to ensure the seal is sufficiently inflated.

k. Presence of oxygen tank (except for neonatal cart).
   i. Replace tank if gauge reads 1000 p.s.i. **(pounds per square inch)** or less.

l. Presence of extension cord/multi-outlet cord.

m. Presence of backboard (except for neonatal cart).

n. For Pediatric/Broselow Cart only:
i. Scissors
ii. Two (2) Alaris Pumps

~~2.~~**3.** For units with Automatic External Defibrillators (AED) **see Patient Care Services Policy: Automated External Defibrillator Checks, Philips**

~~a. Check unit for flashing hourglass~~
~~i. If hourglass is not visible or not flashing **a green light**, notify Clinical Engineering immediately.~~

~~b.~~**a.** ~~Ensure two (2) packs of AED pads appropriate for type of cart (except for neonatal cart), Ensure pads are not expired.~~**replace the pads immediately.**

~~c.~~**b.** ~~Note: HouseWide AED's are checked daily by Security Staff~~.

~~3. For units with defibrillators, check defibrillator for proper functioning per Patient Care Services Procedure: Defibrillator Checks.~~
~~a. Ensure defibrillator pads appropriate for type of cart (except for neonatal cart),~~
~~eEnsure pads are not expired~~.

C. **FORM(S):**
1. Tri-City Medical Center Crash Cart Checklists – Age Specific

D. **RELATED DOCUMENT(S)**:
1. Patient Care Services (PCS) Policy: Rapid Response Team
2. PCS Procedure: Defibrillator Checks
3. PCS Procedure: Malignant Hyperthermia Management
4. ~~Women & Newborn Services Procedure: Obstetrical (OB) Hemorrhage~~

Securing Emergency Care Guidelines

1. Remove the three zip ties located in the crash cart. (2 - green zip ties to lock the medication tray and one white zip tie to lock the crash cart).
   a. Use the green zip tie to lock the medication tray by threading one zip tie through each hole on the front of medication tray and the adjacent holes on clear lid of the medication tray.
2. Use the white zip tie to lock the entire cart by threading the zip tie through the lock hole on the medication lock bar.

UNIT:_____ **TRI-CITY MEDICAL CENTER ADULT CRASH CART CHECKLIST** MONTH / YEAR _____

Suggested Practice Reminder: Complete Weekly Defibrillator, Pacer and Recorder Checks on Wednesdays. Complete Monthly Date and Time Checks on the First Wednesday of the month.

Legend: ✓ = Present/Checked R = Replaced	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
YELLOW LOCK # (check mark if unchanged from previous day)																															
YELLOW LOCK # MATCHES ORANGE STICKER #																															
MEDICATION DRAWER EXP DATE																															
CART (STERILE SUPPLIES) EXP. DATE																															
IV SOLUTION DRAWER EXP DATE																															
SUCTION UNIT TESTED(test unplugged, ensure battery is charged)																															
CARDIOPULMONARY ARREST RECORDS & EVALS																															
RESUSCITATION ALGORITHMS																															
CART INVENTORY LISTS																															
AMBU BAG																															
O_2 TANKS (PSI >1000)																															
EXTENSION/OUTLET CORD																															
BACKBOARD																															
REMOVE EXTRANEOUS SUPPLIES FROM TOP OF CART																															
ECG ELECTRODES (Check Expiration Date)																															
ONESTEP ELECTRODES (Check Expiration Date)																															
GEL PADS (Check Expiration Date), Only if paddles present																															
DEFIBRILLATOR		Yes			No			For a "No response – Place a check mark in the box and leave this section blank.																							
VISUAL CHECKS – Complete once a day.																															
DEFIBRILLATOR TESTING – Complete once a week.																															
PACER TESTING – Complete once a week.																															
RECORDER TESTING – Complete once a week.																															
DATE AND TIME CHECK – Complete once a month.																															
SIGNATURE OF PERSON COMPLETING CRASH CART AND/OR DEFIBRILLATOR CHECKS																															

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**HMS PLUS HEMOSTASIS MANAGEMENT SYSTEM: ACTIVATED CLOTTING TIME, HEPARIN ASSAY, HEPARIN DOSE RESPONSE**
Purpose:	To monitor heparin management during cardiopulmonary bypass.
Supportive Data:	Point of Care Quality Assurance Procedure
Authorized to Perform:	Perfusionist

A. **DEFINITION:**

1. The Medtronic HMS Plus Hemostasis Management System Operator's Manual has been reviewed and found acceptable to National Committee for Clinical Laboratory Standards (NCCLS) standards. Testing should follow manufacturer instructions and recommendations as indicated in the user manual and package inserts. Exceptions or clarifications specific to Tri-City Medical Center are listed in this procedure.

B. **INTRODUCTION/PRINCIPLE:**

1. The HMS Plus instrument is an integrated system consisting of a component for tracking clot detection and computing results, a component for sample delivery, and the single use test cartridges for actual performance of the tests.
2. The detection process uses the plunger assembly within the cartridge. This assembly is lifted and dropped through the sample/reagent mixture by a lifting mechanism in the HMS Plus actuator. As the sample clots, a fibrin web forms around the daisy, located on the bottom of the plunger assembly, and impedes the rate of decent of the assembly. A photo optical system located in the actuator assembly of the instrument detects this change in fall rate. The end point of the test is the time at which clot formation is detected; from these clotting times, derived results are calculated for all tests.

C. **SPECIMEN:**

1. Fresh whole blood, collected in a 3 mL Monoject syringe that is supplied with the cartridges. Blood may be obtained either by venipuncture or from arterial or venous access lines. See instructions below.
   a. Venipuncture Collection: The venipuncture must be fast, non-traumatic, and the first 2 to 3 ml of blood collected and discarded in a separate syringe in order to prevent contamination of the test sample with tissue activator (thromboplastin) and the potential for erroneous results. Blood should flow quickly into the syringe.
   b. Indwelling Catheter Collection: Flush the line with 5 mL~~l~~ saline, and using separate, single use syringes, collect at least 5 mL~~l~~ or 6 dead space volumes of blood and discard prior to collection of the test sample in order to eliminate the risk of excess dilution and contamination of the sample with heparin from the catheter or line.
2. Minimum sample volumes:
   a. HDR 3.0 mL
      HPT (4 channel) 1.5 mL
      HPT (6 channel) 2.5 mL
      HPT and HR-ACT 2.5 mL
3. Handling Conditions:
   a. Specimens should be tested as quickly as possible following sample collection.
      i. HDR: within 60 seconds, since the specimen is ~~U~~unheparinized.
      ii. HPT and HR-ACT: within 60 seconds when there is no anticoagulant on board. Within 2 minutes when sample is heparinized.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
05/13; 11/15, 05/20, **07/22**	06/13; 12/15, 06/20, 08/22	06/13, 01/16, 07/20, **09/22**	04/18, 09/20	n/a	07/13, 04/18, 09/20, **10/22**	10/20, **12/22**	08/13, 05/18, n/a	08/13, 05/18, 11/20

D. **REAGENTS/SUPPLIES:**

1. Refer to HMS Plus Operator's manual, Chapter 4-2: Cartridge Design.
2. Refer to HMS Plus Operator's manual, Chapter 4-3: Types of Test Cartridges
   a. Heparin Dose Response (HDR): The HDR is a modified HR-ACT, which measures the *in vitro* anticoagulant response to a known concentration of heparin. This response can be used to evaluate a patient's resistance or sensitivity to heparin. It can also be used to estimate a minimum heparin dose required to achieve a desired target clotting time (HR-ACT).
   b. Heparin Assay (HPT): The Heparin Assay test uses the principle of heparin/ protamine titration to quantitatively determine the concentration of heparin in the sample. The heparin concentration determined by the HPT test is used to calculate any additional heparin required to maintain the patient at the [Protocol Hep Conc] entered into the system.
   c. Activated Clotting Time (HR-ACT): The HR-ACT is a functional evaluation of the intrinsic coagulation system. It evaluates heparin anticoagulation as well as numerous factors affecting intrinsic clotting.
3. Cartridge Preparation:
   a. HDR: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed in the heat block of the HMS Plus for at least 3 minutes prior to using.
   b. HPT: Gently shake or tap the cartridge before use. Pre-warming of the HPT cartridge is not required.
   c. HR-ACT: Cartridges should be gently shaken or tapped to re-suspend the kaolin and pre-warmed for at least 3 minutes in the heat block of the HMS Plus.
4. Precautions:
   a. HPT: If the heparin concentration is measured at Channel 1 in a Heparin Assay cartridge that does not have a zero (protamine) in Channel 1, the actual heparin may be lower than the measured value. Similarly, if it is measured in Channel 4 of a four-channel cartridge or Channel 6 of a six-channel cartridge, the actual heparin value may be higher than the measured value. In these cases, another test with a different cartridge (lower or higher as needed) should be run to confirm the result.
   b. Regarding Heparin Concentration: see HMS Plus Operators manual 2-6.
   c. Regarding Heparin Dose Response: see HMS Plus Operators Manual 2-6.
5. Instrumentation/Calibration:
   a. Refer to HMS Plus Operator's Manual, Chapter 1: Product Description: Application and Use. Refer to HMS Plus Operator's manual, Chapter 3: Installation and Setup. No user Calibration.

E. **QUALITY CONTROL:**

1. Refer to HMS Plus Operator's manual, Chapter 7: Maintenance and Quality control.
2. Liquid quality control must be run:
   ~~i.~~**a.** On each new lot/shipment of test cartridges (Refer to New Reagent Lot Validation)
   ~~ii.~~**b.** Once per week
   ~~iii.~~**c.** Electronic quality control must be run each 8 hours of use (once per shift)
3. New Reagent Lot Validation.
   a. For ACT and HPT cartridges, test liquid controls on new lots/shipments of cartridges before use.
      i. If controls fall within the Manufacturer established ranges, or "pass", the new lot/shipment of cartridges is considered acceptable for use.
   b. For HDR cartridges, run a patient on the old and new lots concurrently.
      i. For the new lot of reagent to be considered acceptable for use, the difference in results must be clinically insignificant, as determined by the Perfusionist.
   c. Indicate on the "New Reagent Lot Validation Log" that the lot number has been tested and is acceptable for patient use.

d. The laboratory will review control data to ensure that control and patient ranges are similar across different lots of cartridges.

4. Notes:
   a. Before performing a quality control test, valid lot numbers and expiration dates for both cartridges and controls must be entered. In the case of the HR-ACT controls the ranges for the controls must also be entered.
   b. Because controls are produced using prior USP heparin formulation, the heparin type should be set to [Porcine] to run liquid controls. Attempts to run the controls while in the [IU] heparin type setting will result in longer than expected run times for the control test and may produce a failed control result—run times exceeding 249 seconds. (Notice dated 3/8/10).
5. Instructions for performing Heparin Assay CONTROLS:
   a. Set heparin type:
      i. From main menu, select "instrument parameters"
      ii. Select "heparin type"
      iii. Toggle to [porcine]
      iv. Press "enter" to confirm selection
      v. Perform QC testing
   b. Quality control records are maintained in the instrument and periodically downloaded and reviewed by the Laboratory designee.

QC RANGES HEPARIN ASSAY:

Four-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Red/Yellow	0.0 – 0.9 RED	4	< 249 sec
Red/Yellow	0.0 – 1.5 YELLOW	3 or 4	< 249 sec
Tan/Silver	1.5 – 3.0 TAN	4	< 249 sec
Tan/Silver	2.0 – 3.5 SILVER	3 or 4	< 249 sec
Blue/Gold	2.5 – 4.0 BLUE	3 or 4	< 249 sec
Green/White	3.5 – 5.0 GREEN	3 or 4	< 249 sec
Purple/Black	4.5 – 6.0 PURPLE	3 or 4	< 249 sec

Six-Channel			
HPT Control	**Cartridge Type (mg/kg)**	**Required Channel Detection**	**Required Clotting Time**
Orange	0.0 – 2.5 ORANGE	5 or 6	< 249 sec
Blue/Gold	1.5 – 4.0 GOLD	5 or 6	< 249 sec
Green/White	2.5 – 5.0 WHITE	5 or 6	< 249 sec
Purple/Black	3.5 – 6.0 BLACK	5 or 6	< 249 sec

QC RANGES HR-Act:

Ranges will change lot to lot—refer to the package insert.	
CLOTtrac HR Normal	75 – 115
CLOTtrac HR Abnormal	270 – 710

F. **MAINTENANCE:**

1. Refer to HMS Plus Operator's manual, Chapter 7: Maintenance and Quality control.
   a. To be completed monthly:
      i. Verify dispenser volume delivery
      ii. Verify heat block temperature
   b. To be completed routinely:

i. Clean the instrument case and exposed surfaces of the actuator and dispenser of dust and dried blood
ii. Clean/ Replace salvage reservoir (located under the dispenser).

c. Maintenance is recorded on the Lab generated form: HMS Plus Maintenance Log.
d. Discard all the completed testing materials and controls in the provided and appropriate waste containers.

G. **PROCEDURE:**

1. Refer to HMS Plus Operator's manual, Chapter 5: Operating Instructions.
   a. Note: Users of the HMS Plus must be aware of which type of heparin is being administered and configure the HMS Plus appropriately. Due to the change in potency, when NEW USP heparin is used, the HMS instrument "heparin type" must be set to "IU" to ensure correct blood dispensing and calculations of results. (Notice dated 12/19/09)
   b. Instructions for performing HPT and HDR PATIENT tests with new USP Heparin:
   c. Set heparin type:
      i. From main menu, select "instrument parameters"
      ii. Select "heparin type"
      iii. Toggle to [iu]
      iv. Press "enter" to confirm selection
      v. Perform qc testing

H. **CALCULATIONS:**

1. Refer to HMS Plus Operator's manual, Chapter 4-10: Calculations.
   a. Blood Volume Calculations
   b. Heparin Dose Response Calculations
   c. Heparin Bolus Dose Calculations
   d. Heparin Assay Calculations

I. **TECHNICAL NOTES:**

1. Refer to HMS Plus Operator's manual Chapter 2: Warnings and Operational Precautions.

J. **LIMITATIONS:**

1. Refer to HMS Plus Operator's manual, Chapter 2: Warnings and Operational Precautions.
2. Difficulty in collection of the sample for testing may result in activation and erroneous results. If the test results do not correlate with the patient's clinical picture the test should be repeated on a new sample.

K. **REPORTING RESULTS:**

1. Results are recorded in the patient medical record.
2. POCC evaluates held up patients' results that are pending to post on patients' charts whenever needed.

L. **FORM (S):**

1. ACT/HMS Plus New Reagent Lot Validation Log
2. HMS Plus Maintenance Log

M. **REFERENCE(S):**

1. Medtronic HMS Plus Hemostasis Management System Operator's Manual. 2012 Rev. 1C
2. Medtronic. HEPtrac™ Electronic Quality Control Operator's Manual, 1998.
3. Medtronic. Heparin Assay Cartridges. Package Insert. 2004. A10740001-02.
4. Medtronic. Heparin Assay Controls. Package Insert. 2004. A08717001-01.
5. Medtronic. HR-ACT Cartridges. Package Insert. 2003. UC200402200ML.
6. Medtronic. HR-ACT Controls. Package Insert. 2004. A08718003-01.
7. Medtronic. Heparin Dose Response Cartridges. Package Insert.

8. NCCLS Point-of-Care In Vitro Diagnostic (IVD) Testing; Approved Guideline, AST2-A, Volume 19, Number 9, June 1999.
9. HMS Plus Individualized Quality Control Plan (IQCP)

ACT HMS NEW REAGENT LOT VALIDATION LOG

Unit:	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Two levels of liquid control must pass manufacturer established ranges to be acceptable for use. Instructions: Before a new lot of test cartridges is placed into use, perform QC abnormal and normal on each lot. Indicate on this log 1.) if QC passes, and 2.) if the lot of cartridges is acceptable for use. If QC fails, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.
☐ **CATH LAB** (1002009) ☐ **OR 6** (9001585) ☐ **OR 5** (9001456)	

CARTRIDGE: **ACT-HR**

Date	New Lot		QC Normal	QC Abnormal	Ok for Use? (Yes/ Initial)
	Lot	Exp	Pass? (Yes or ✓) (If No, indicate any corrective action taken)		
					/
					/
					/
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					/

CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

ACT HMS NEW REAGENT LOT VALIDATION LOG

☐ **OR6** (9001585) ☐ **OR5** (9001456)	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Instructions: Before a new lot of test cartridges is placed into use, perform a patient test concurrently on the new lot and previous lot in use. Indicate on this log 1.) if the difference between results is clinically insignificant, and 2.) if the lot of cartridges is acceptable for use. If the difference is clinically significant, or for any reason causes concern, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.

CARTRIDGE: **HDR**

Date	New Lot		Patient: Proj Hep Concent.			Ok for Use? (Yes/ Initial)
	Lot	Exp	Prev Lot	New Lot	Clinically Insignificant ? (Yes or ✓)	
						/
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						/
						/
						/

CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

ACT / HMS NEW REAGENT LOT VALIDATION LOG

☐ **OR6** (9001585) ☐ **OR5** (9001456)	Purpose: To provide documentation that new lots and shipments of reagent (test cartridges) have been tested for acceptability before use. Liquid control must pass manufacturer established ranges to be acceptable for use. Instructions: Before a new lot of test cartridges is placed into use, perform QC on each lot. Indicate on this log 1.) if QC passes, and 2.) if the lot of cartridges is acceptable for use. If QC fails, perform further testing, or contact the lab and/or manufacturer before placing into use. Indicate any corrective action taken.

CARTRIDGE: **HPT {R=RED} {T=TAN} {S=SILVER} {B=BLUE} {G=GREEN}**

Date	New Lot			QC		Ok for Use? (Yes/ Initial)
	Color	Lot	Exp	Hep Test Conc.	Pass? (Yes or ✓) (If No, indicate any corrective action taken)	
						/
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CORRECTIVE ACTION:

Date	Problem, Resolution, Comments, Etc:

HMS PLUS MAINTENANCE LOG

☐ **OR6** (9001585)
☐ **OR5** (9001456)

Purpose: To provide documentation of regular maintenance and cleaning of instruments.
Note: Daily QC records are maintained in the instrument DM system—user lockout will engage if QC has not been successfully completed.
Instructions: Record monthly maintenance on this log. Document problems and corrective actions below.
Records will be reviewed by the Laboratory designee and stored in the lab.

Year	Month	Routine Cleaning (exposed surfaces/ salvage reservoir)		Verify Heat Block Temperature		Verify Dispenser Volume Delivery		Review (Lab use)
		Date	Operator	Date	Operator	Date	Operator	
20___	January							
	February							
	March							
	April							
	May							
	Jun							
	July							
	August							
	September							
	October							
	November							
	December							

DATE	PROBLEM	CORRECTIVE ACTION	REVIEW

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/64

SUBJECT: Medical Examiner Notification

REVISION DATE: 06/64, 09/91, 07/97, 09/00, 04/02, 06/03, 08/05, 06/06, 08/08, 01/11, 06/11, 02/15, 10/17

~~POLICY NUMBER: IV.Z~~

Patient Care Services Content Expert~~Department Review~~ Approval:	**~~07/17~~05/2209/22**
Clinical Policies & Procedures Committee Approval:	**~~08/17~~06/2210/22**
Nursing Leadership ~~Executive Council~~ Approval:	**~~08/17~~11/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~09/17~~11/22**
Administration Approval:	**12/22**
Professional Affairs Committee Approval:	**~~10/17~~ n/a**
Board of Directors Approval:	**10/17**

A. **PURPOSE:**

1. To identify cases that must be reported to the Medical Examiner pursuant to California Health and Safety Code (Section 102850) as well as to Government Code, State of California (Section 27491).

B. **POLICY:**

~~1. Only the mortuary needs to report the death to the Medical Examiner's Office in cases where it has been more than 20 days since the doctor who is signing the death certificate has seen the decedent and which is otherwise not reportable to the Medical Examiner.~~

1. In accordance with California State Law, **Tri-City Medical Center** (TCMC) must notify the Medical Examiner (858-694-2895) regarding all patients whose death meets the following criteria:
   - **a. Acute alcoholism, Drug addiction, Aspiration**
   - **b. Communicable Disease**
   - **c. Death in whole or in part by criminal means, in prison or while under sentence**
   - **d. Deaths due to old or recent injuries or accidents**
   - **e. Deaths without underlying etiologic cause**
   - **f. Drowning, Fire, Gunshot, Stabbing, Strangulation, cutting**
   - **g. Known or suspected homicide suicide or accidental poisoning, hanging**
   - **h. Operating room or postoperative deaths**
   - **i. Subdural and subarachnoid hemorrhages**
   - **j. Sudden Deaths**
   - **k. Sudden infant death syndrome**
   - **l. Unidentified person**
   - **m. Unusual Deaths**
   - **~~a.~~n. Violent deaths**
   - ~~b. Known or suspected homicide. (This would include any delayed (days to years) death resulting from any non-accidental trauma. Example: quadriplegic from a gunshot wound 10 years ago, remote head injury, or suspected elder abuse.)~~
   - ~~c. Known or suspected suicide. (This would include any delayed (days to years) death resulting from any accidental injury. Example: person with organ failure due to an intentional medication overdose.)~~

~~d. A result of an accident, injury, trauma, or mishap either old or recent. (This would include any delayed (days to years) death resulting from any accidental injury. Example: person with a brain injury from a fall or motor vehicle accident, burns or drowning, pulmonary embolism or other complication following trauma, medication, or surgical error.)~~
~~e. Grounds to suspect that the death occurred in any degree from a criminal act.~~
~~f. No physician in attendance (No medical history).~~
~~g. Wherein the deceased has not been attended by a physician in twenty (20) days prior to death.~~
~~h. Wherein the deceased has not been attended by a registered nurse who is a member of a hospice care interdisciplinary team in the twenty (20) days to death.~~
~~i. Wherein the physician is unable to state the cause of death. (Must be genuinely unable and not merely unwilling).~~
~~j. Without medical attendance.~~
~~k. During the continued absence of the attending physician and surgeon.~~
~~l. Indications the death is the result of an acute alcohol and/or prescription or illegal drug overdose.~~
~~m. An infectious process, such as AIDS or hepatitis, which may pose a threat to public health.~~
~~n. A sudden unexpected infant/child death.~~
~~o. A death resulting from a complication during a recently performed surgical procedure.~~
~~p. Death of an inmate/prisoner or in custody patient.~~
~~q. All deaths of patients in state mental hospitals.~~
~~r. All deaths where there is no known next of kin.~~
~~s. Fatal events occurring at decedent's place of employment.~~
~~t. Dead on arrival (DOA) to determine whether the cause of death is known, whether or not it is due to non-natural causes.~~
~~u. Emergency Room deaths before a diagnosis can be established.~~
~~v. Operating Room (OR) or Postoperative deaths where negligence or accident is suspected.~~
~~w. Anesthetic deaths whether it occurs in the OR, recovery room or elsewhere.~~
~~x. Unidentified persons regardless of circumstance of death~~
~~y. All deaths where the suspected cause of death is Sudden Infant Death Syndrome (SIDS).~~
~~z. Food poisoning / accidental poisoning~~
~~aa. Maternal deaths during childbirth~~
~~bb. Any death without an underlying etiologic specific underlying cause (sepsis, shock, cardiac arrest, multi-organ failure, etc.)~~
~~cc. Coma – all deaths in which the patient is comatose~~
~~dd. All violent, sudden or unusual deaths~~

2. An investigator from the Medical Examiner's Office will review the decedent's demographic information, medical history, and circumstances surrounding the death to determine whether to accept the case for an investigation or issue a waive number.
   a. Waive numbers **will be documented** ~~have~~ **in** the following format: WV## - ##### **and** ~~**will be documented.**~~
   ~~a.~~**b. Case number: year-xxxxx**
3. Note: Death involving the above criteria must be reported even if a physician is willing to sign the death certificate. The State requires all death certificates to record both an actual and underlying cause of death.

C. **REFERENCE(S):**

1. County of San Diego (2016) Deaths Reportable to the Medical Examiner's Office [Facsimile to Tri-City Medical Center]. San Diego, CA.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**NITRAZINE TEST ON VAGINAL FLUID**
Purpose:	To assist in the evaluation of vaginal fluid pH for the presence of amniotic fluid.
Equipment:	Gloves Swab Phenaphthazine/Nitrazine paper pH 5.0 buffer and pH 7.0 buffer

A. **DEFINITIONS:**

1. Buffer - a solution that resists changes in pH when acid or alkali is added to it. Buffers typically involve a weak acid or alkali together with one of its salts.
2. CLIA - Clinical Laboratory Improvement Amendments
3. Nitrazine- see Phenaphthazine
4. pH – a measure of hydrogen ion concentration, a measure of the acidity or alkalinity of a solution.
5. Phenaphthazine- commonly known as nitrazine, a pH indicator dye used in healthcare.
6. POC – Point of Care
7. QC – Quality Control, performed to ensure the validity of test and test results.
8. Vaginal fluid – fluid that drains from the opening of the vagina.

B. **POLICY:**

1. The nitrazine test is a screening test performed on amniotic fluid to evaluate a suspected rupture of membranes. A Registered Nurse (RN) is authorized to perform this procedure. Testing is under the supervision of the Laboratory Point of Care (POC) Coordinator and under the jurisdiction of the Laboratory Medical Director.

C. **PRINCIPLE:**

1. Phenaphthazine paper is a Nitrazine indicator paper with a wide range of colors- intended for invitro, semi quantitative determination of pH in the 4.5 – 7.5 range, used to interpret the alkaline nature of vaginal fluid. This test involves putting a drop of fluid obtained from the vagina onto paper strips. The strips change color depending on the pH of the fluid.

D. **SPECIMEN:**

1. Patient Preparation:
   a. This procedure may be performed during a speculum examination.
2. Type of Specimen:
   a. Vaginal Fluid

E. **REAGENTS/SUPPLIES:**

1. Phenaphthazine/ Nitrazine paper
   a. Storage: Room Temperature
   b. Stability : Unopened – until expiry on the dispenser; Opened – 6 months
2. pH 5.0 buffer and pH 7.0 buffer
   a. Storage: Room Temperature
   b. Stability: Until expiry date on the bottle

F. **INSTRUMENTATION:** N/A

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership ~~Executive Council~~	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
7/03, 4/04, 4/06; 6/09, 07/15, 05/18, 11/19, **03/22**	07/11, 08/15, 0718, 12/19, 01/20, **04/22**	08/11, 09/15, 07/18, 02/20, **05/22**	03/16, 08/18, 04/20, **08/22**	n/a	10/11, 04/16, 08/18, 05/20, **09/22**	09/18, 06/20, **12/22**	11/11, 05/16, n/a	11/11, 05/16, 09/18, 06/20

G. **QUALITY CONTROL (QC):**

1. QC Materials: pH 5.0 buffer and pH 7.0 buffer.
2. Test the control buffers per POC testing procedure.
3. Perform QC **test with a new lot and** ~~every~~ **monthly.**
4. Document results **through the glucometer** ~~on the Point of Care Quality Control Log~~.
5. If the control results are not within acceptable limits the test is considered invalid and further patient testing is not allowed until corrective action steps are successful and documented.

H. **PROCEDURE:**

1. Quality Control:
   a. Tear off a strip of Phenaphthazine paper from the roll.
   b. Dispense a drop of the pH 5.0 buffer solution onto the strip of pH paper.
   c. Immediately match the color of the pH paper close with the closest color on the color chart supplied with the Phenaphthazine paper dispenser.
   d. Repeat steps 1-3 with pH 7.0 buffer solution.
   e. Record the QC result **through the glucometer** ~~on the Nitrazine QC Log~~.
2. Patient Testing:
   a. Perform hand hygiene and apply gloves.
   b. Verify patient identification according to policy.
   c. Swab the fluid pooling in the vagina or along the sidewall of the vagina (avoiding the cervix) using a cotton tip applicator.
   d. Touch the applicator to the test paper ensuring the chemically treated paper is totally moistened.
   e. Read the nitrazine paper immediately.
   f. Compare the paper visually to the color scale printed on the outside of the nitrazine dispenser.

I. **CALCULATIONS: N/A**

J. **EXPECTED VALUES/ REFERENCE RANGES/ ACTION VALUES**

Color	pH	Report As
Yellow	~~5.0~~4.5	Negative: Membranes probably not ruptured
Yellow-green	**5.0**	
Olive	5.5	
Olive-green	6.0	
Blue-green	6.5	Positive: Membranes probably ruptured
Blue-gray	7.0	
Deep blue	7.5	
Unclear or other color	?	Equivocal: May be due to blood, cervical mucus or semen

K. **DOCUMENTING~~REPORTING~~ RESULTS:**

1. **Input results through the glucometer**
2. **Document** ~~Record~~ the result in the electronic health record. Enter the following:
   a. Date and time.
   b. Result – negative, positive or equivocal
   c. ~~Name of person performing test if recording for another person~~

L. **TECHNICAL NOTES:**

1. The base stock color of the Phenaphthazine paper may vary from lot to lot, from tan to olive green. This will not affect the accuracy of the results.
2. Normal amniotic fluid is neutral (pH 7.0) or slightly alkaline (pH 7.25). In the presence of amniotic fluid the moistened nitrazine paper will change from a yellow color to a dark blue color.
3. Color comparison recommended under a combination of fluorescent light and daylight.

4. Nitrazine test is considered a waived test under (CLIA) 88 Federal Regulations.
5. Personnel performing the testing must be certified prior to performing patient testing. Certification is achieved through a training program coordinated by the nursing education department in conjunction with the lab. Competency is assessed and documented annually. Competency records are maintained on the nursing units.
6. Proficiency testing is coordinated through the laboratory staff and performed by testing personnel on the nursing units.

M. **LIMITATIONS:**

1. The nitrazine test is not considered a definitive test for diagnosing ruptured membranes.
2. A false negative result may occur if there has been prolonged rupture of membranes (longer than 24 hours) or when only a small quantity of fluid is present.
3. A false positive may occur if vaginal secretion has been contaminated with blood, urine or antiseptic solution. The pH of blood, vaginal mucus and some secretions associated with vaginal infection is also alkaline.

~~N. FORM(S):~~

~~1. Point of Care Quality Control Log – Nitrazine~~

~~O.~~**N. REFERENCE(S):**

1. Kennedy, B.B., Ruth, J.R., Martin, E.J. (2009). *Intrapartum management modules – A perinatal education program (4th ed.)*. Wolters Kluwer Health/Lippincott Williams & Wilkins: Philadelphia, PA.
2. Clinical Laboratory Improvement Amendments of 1988 Federal Regulations
3. Micro Essential Laboratory. pHizatest® Phenaphthazine paper. Package Insert. Cat. No. 934. ~~2008~~**Nov 15, 2019.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	07/11	SUBJECT:	Obstetrical and Postpartum Patients in the ED~~, Triage~~
REVISION DATE:	03/12, 04/16	~~POLICY NUMBER: IV.XX~~	

Patient Care Services Content Expert Approval:	03/22
Clinical Policies & Procedures Committee Approval:	~~06/15~~04/22
Nursing Leadership~~Executive Council~~ Approval:	~~07/15~~05/22
Department of OB/GYN Approval:	~~12/15~~08/22
Department of Emergency Medicine Approval:	~~01/16~~10/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~02/16~~11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~04/16~~ n/a
Board of Directors Approval:	04/16

A. PURPOSE:

1. To provide guidelines for determining appropriate disposition and treatment of obstetrical (OB) patients at different gestational ages (GA) who present to Labor and Delivery (LD) or the Emergency Department (ED).

B. POLICY:

1. OB patients with obstetrical complaints/concerns and GA greater than or equal to 20 weeks 0/7days will be evaluated in LD.
2. Pregnant patients with non-obstetrical complaints/concerns of any GA shall be evaluated and treated in the ED.
   a. These situations may include, but are not limited to:
      i. Major trauma victims
      ii. Patients involved in a motor vehicle accident
      iii. Patients with unstable airway, difficulty breathing, or painful breathing
      iv. Patients with cardiac complaints
      v. Patients needing surgical procedures
      vi. Patients with orthopedic complications or ocular emergencies
      vii. Patients with infectious diseases (varicella, parvovirus, influenza, COVID-19, etc.) or suspicious rash which may be contagious to other pregnant patients
      viii. Patients complaining of flu-like symptoms (fever, cough, body aches etc.)
   b. Patients with a GA greater than or equal to 20 weeks 0/7days, the ED physician will consult the OB physician to determine fetal monitoring needs:
      i. An LD RN performing external fetal monitoring evaluation in the ED.
      ii. The ED RN may evaluate/confirm the fetal heart rate with a hand held doppler device.
      iii. An ultrasound performed by the ultrasound technician.
3. Patients less than 20 weeks 0/7days GA will be seen in the ED. An OB consult will be obtained by the ED physician, if indicated.
   a. A patient less than 20 weeks 0/7days GA may be evaluated in LD at the joint discretion of the attending OB provider and the LD Charge RN. Such conditions may include, but are not limited to:
      i. Pyelonephritis
      ii. Diabetes

iii. Incompetent Cervix
iv. Inevitable/active miscarriage

b. Admission of these patients will be considered on a case by case basis by the LD Charge RN.

4. An ED RN will gather the following information from the patient when presenting to the ED prior to calling the LD Charge RN.
   a. Patient Name
   b. Gestational Age/Estimated Due Date
   c. Gravida and Para (G/P)
      i. Gravida: number of pregnancies
      ii. Para: number of live births
   d. OB provider or Clinic name
   e. Chief complaint for presenting to the hospital
   f. Vital Signs (VS): Blood Pressure (BP), Heart Rate (HR), Respiratory Rate (RR), Oxygen level (SpO2), Temperature (T), Fetal Heart Tones, numeric pain level.
      i. Notify LD Charge RN for any of the following VS:
         1) Systolic BP greater than or equal to 140mmHg or Diastolic BP greater than or equal to 90mmHg, repeat in 15 minutes.
         2) HR less than 40 beats per minute or greater than 110 beats per minute
         3) RR less than 12 breaths per minute or greater than 25 breaths per minute
         4) SpO2 less than 95% on room air
         5) T greater than 38°C/100.4°F
         6) Fetal Heart Tones less than 110 beats per minute or greater than 160 beats per minute.

5. Patients who present to the ED and delivery is determined to be imminent or "in the process of delivering", shall be delivered in the ED (vaginal deliveries only).
   a. A "Code Delivery" will be initiated by the ED staff.
      i. The code will include the location of the delivery
      ii. The Laborist will respond to all Code Deliveries
      iii. The LD Charge RN or designee will notify the primary OB provider of the delivery and location as appropriate.
      iv. Refer to the Standardized Procedure: Precipitous Vaginal Delivery.

6. When a patient has delivered her newborn outside of the hospital the ED staff will:
   a. Notify LD and NICU Charge RNs of expected time of arrival
   b. Assess mother and newborn immediately upon arrival to determine stability for transfer to the LD and/or NICU unit
      i. If the mother or newborn are not stable they will remain in the ED and the appropriate code will be called for additional assistance.
   c. Banding the mother and newborn will be done per PCS Procedure: Newborn Identification Banding and Electronic Alarm Device.

7. All females of child bearing age presenting to the ED will be assessed for recent birth history.
   a. If the patient has given birth in the last 8 weeks, has abnormal vital signs as outlined below and is complaining of any of the following symptoms, she will be evaluated by the ED physician immediately and an OB physician will be consulted.
      i. Vital Signs (VS): Blood Pressure (BP), Heart Rate (HR), Respiratory Rate (RR), Oxygen level (SpO2), Temperature (T), numeric pain level.
         1) Systolic BP greater than or equal to 140mmHg or Diastolic BP greater than or equal to 90mmHg, repeat in 15 minutes.
         2) HR less than 40 beats per minute or greater than 110 beats per minute
         3) RR less than 12 breaths per minute or greater than 25 breaths per minute
         4) SpO2 less than 95% on room air

5) T greater than 38°C/100.4°F

ii. Reported symptoms include:

1) Persistent headache, visual changes (floaters, spots), history of preeclampsia, shortness of breath, history of high blood pressure, chest pain, heavy bleeding, weakness, severe abdominal pain, confusion, seizures, fever or chills and swelling in hands or face.

b. If the patient is to be admitted for care, consult with the LD Charge RN or Mother Baby Charge RN for admission to unit.

C. RELATED DOCUMENT(S):

1. PCS Procedure: Identification of Newborns
2. PCS Standardized Procedure: Precipitous Vaginal Delivery

~~B. PURPOSE:~~

~~1. To provide guidelines for determining appropriate disposition and treatment of obstetrical patients at different stages of gestational ages **(less than 20 weeks or greater than 20 weeks)** who present to Labor and Delivery (L&D) **or**and the Emergency Department (ED) **with obstetrical issues or non-obstetrical issues**.~~

~~C. POLICY:~~

~~1. Obstetrical (OB) patients with gestational age (GA) of greater than or equal to 20 weeks through 40 or more weeks will be evaluated in L&D for obstetrical issues. **Patients may be transported from the ED to L&D via wheelchair or gurney avoiding supine position during transport**~~

~~a. Refer to Patient Care Services (PCS) Standardized Procedure: Medical Screening to Rule Out Labor.~~

~~b. Patients 20 weeks or greater presenting to ED for pregnancy related symptoms shall be transferred to L&D via a wheelchair or gurney avoiding supine position during transport.~~

~~c. Admission of a 16 **to** 20 week gestation**al age patient** pending loss of pregnancy will be considered on a case by case basis by the Charge Nurse/ **designee** in Labor and Delivery.~~

~~2. Pregnant patients with non-obstetrical complaints/concerns shall be evaluated and treated in the ED first. These situations may include, but are not limited to:~~

~~a. Major trauma victims.~~

~~b. Patients involved in a motor vehicle crash with cervical spine precautions in place.~~

~~c. Patients with unstable airway, difficulty breathing, or painful breathing.~~

~~d. Patients with cardiac complaints.~~

~~e. Patients needing surgical procedures.~~

~~f. Patients with orthopedic complications or ocular emergencies.~~

~~Patients with Infectious Perinatal D**d**iseases (Varicella, Parvovirus) or suspicious rash which may be contagious to other pregnant patient**s**.~~

~~g. **Patients complaining of flu-like symptoms (fever, cough, body aches etc)**~~

~~3. The ED physician may consult and involve the OB physician and L&D Charge nurse/ **designee** at any time to coordinate perinatal evaluation as indicated.~~

~~a. This can involve a trained L&D Nurse performing external fetal monitoring evaluation in the ED or the stable patient being transported to the L&D unit for monitoring.~~

~~4. Patients less than 20 weeks GA will be seen in the ED pursuant to ED protocols. OB consult shall be obtained as deemed necessary by the ED physician.~~

~~5. Patients who present to the ED whose delivery is imminent or "in the process of delivering" shall be delivered in the ED **if vaginal delivery is possible**. If the ED staff requires help from an available OB **provider** physician/Certified Nurse Midwife, the Public Branch Exchange (PBX) operator shall be notified to generate a STAT overhead page for "**Code Delivery (which will also initiate the Neonatal Team) and** any OB to the ED **STAT**, Station XX."~~

~~a. Refer to the PCS Standardized Procedure: Precipitous Vaginal Delivery**. that includes theNote the initiation of Oxytocin to the patient after delivery.To be given Intermuscular (IM) if she has no Intravenous (IV) access, or via IV fluidsinfusion if an IV is presentavailable**.~~

~~6. Patients with a gestational age less than 20 weeks, who present to L&D, will be escorted to the ED for evaluation.~~
~~a. The L&D charge nurse/designee shall notify the ED charge nurse/designee of the patient's disposition **and pertinent medical history**, including any medical information revealed by the patient or her family.~~
~~2. Evaluation of **P**patients less than 20 weeks gestation may occur **be evaluated** in L&D at the joint discretion of the **a**Attending OB Physician and the shift L&D charge nurse/designee.; **S**such conditions may include, but are not limited to:~~
~~a. Pyelonephritis~~
~~b. Diabetes~~
~~c. Uncontrolled asthma~~
~~d. Pneumonia~~
~~e. Incompetent cervix~~
~~f. Inevitable/ **a**Active miscarriage~~
~~3. When an obstetrical patient has delivered her newborn outside of the hospital and presents to ED, the ED staff shall:~~
~~a. Assess mother and newborn immediately to determine stability.~~
~~b. Notify L&D and the Neonatal Intensive Care Unit (NICU) charge nurse/designee of expected admissions.~~
~~c. Band the mother and newborn before disposition to the appropriate departments.~~
~~i. Refer to PCS Procedure: Identification of Newborns.~~
~~4. If the patient is being transported by ambulance, and both mother and newborn appear stable, based on the Paramedic/ field reports, the ED triage nurse shall:~~
~~a. Notify L&D and the NICU ANM/charge nurse/designee of the expected time of arrival for these direct admissions.~~
~~b. Care of the mother and newborn will be directed by the L&D ANM/charge nurse/designee, including responsibility to **N**notify the patients' **appropriate** OB provider or OB on "unassigned call" and Pediatrician or Pediatrician on call, if patient does not have a provider on staff.~~
~~5. If the patient**(s) are**is being transported by ambulance, and mother and/or newborn are not in stable condition, the ED triage nurse shall:~~
~~a. Notify L&D **and Neonatal Intensive Care Unit** ANM/charge nurse/designee, of the need to have the attending OB provider or OB on "unassigned call," and **the** L&D Nurse present in the ED to provide **obstetrical assistance for the mother and/or the Neonatal Team for** specialty assistance, if indicated.~~
~~**Call 66 to initiate a "Code Delivery" and for the unstable mom**~~
~~**PBX will also call for "Any OB Stat to the ED, Station XX" if the patient has not yet delivered (this will also send the message to the Neonatal Team)**~~
~~**Call 66 to** Initiate a "Code Caleb" for the **unstable** newborn~~
~~b. **(for the Neonatal Team to be notified of the need for their presence)**, per PCS Policy: Code Caleb **Response plan.** Team Mobilization. **Note this does not call for an obstetrical provider, only a Team for the newborn.**~~

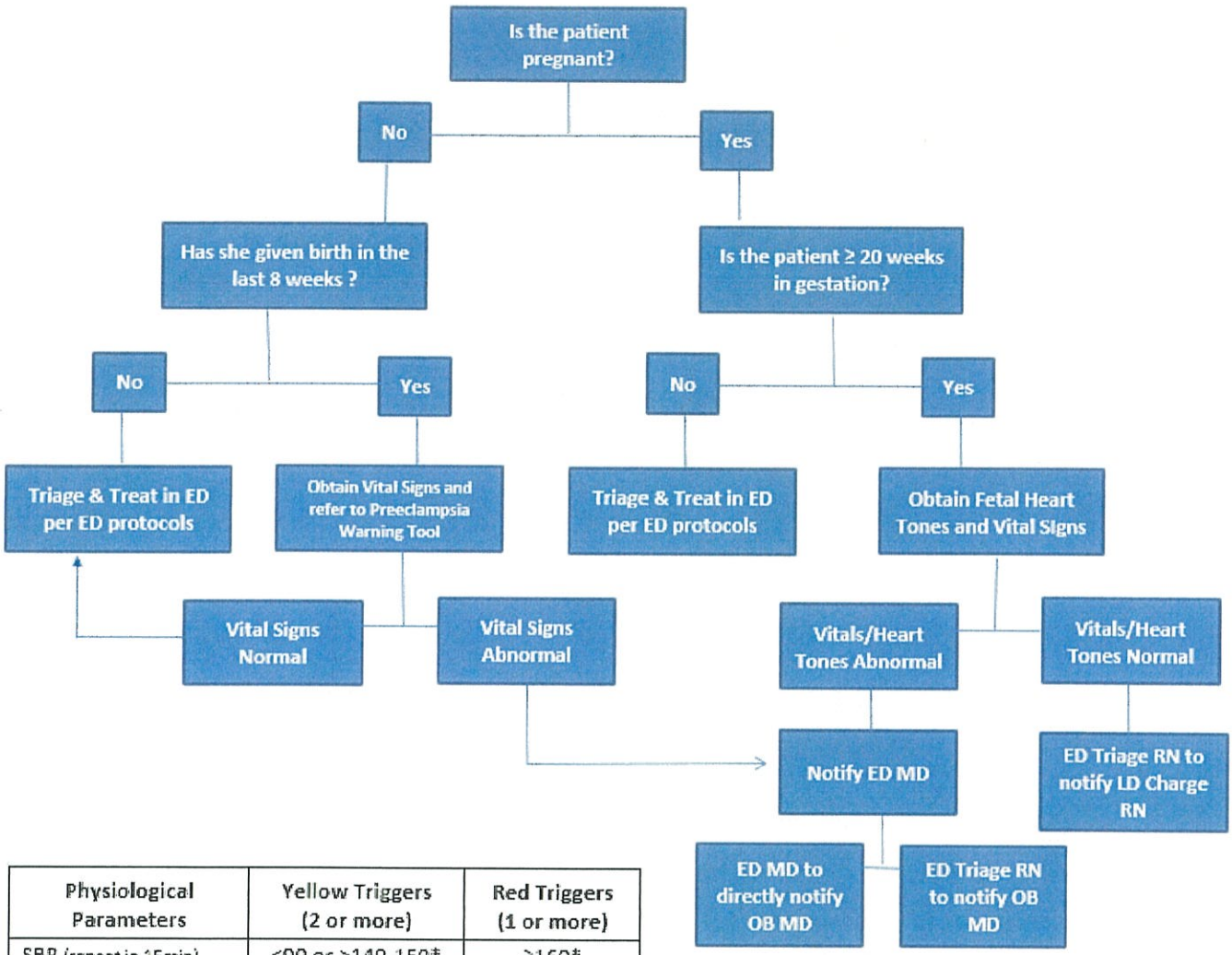
~~D. RELATED DOCUMENTS:~~
~~1. PCS Policy: Code Caleb **Response Plan** Team Mobilization~~
~~2. PCS Procedure: Identification of Newborns~~
~~3. PCS Standardized Procedure: Medical Screening to Rule Out Labor~~
~~PCS Standardized Procedure: Precipitous Vaginal Delivery~~

D. REFERENCE(S):

1. **American College of Obstetricians and Gynecologists. (2020). Committee opinion no. 667: Hospital-Based Triage of Obstetric Patients**
2. **American College of Obstetricians and Gynecologists. (2017), Obstetric Care Consensus no. 6: Periviable Birth**
3. **Emergency Nurses Association and Association of Women's Health, Obstetric and Neonatal Nurses. (2020). Consensus Statement: Emergency Care for Patients During Pregnancy and the Postpartum Period**

4. The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics. (2017) Guidelines for Perinatal Care. 8th Edition

Attachment 1: OB Triage Algorithm in the ED



4.

Physiological Parameters	Yellow Triggers (2 or more)	Red Triggers (1 or more)
SBP (repeat in 15min)	<90 or >140-159*	≥160*
DBP (repeat in 15min)	>90*	≥110*
MAP	<65 or >110	<55
HR	<40 or 110-120	>120
RR	<12 or 25-30	>30
O2 Sat on RA	<95%	<93%
Oliguria: ml/hr for ≥2 hrs	35-49	<35
Severe Red Triggers		
Altered mental status	Maternal agitation, confusion or unresponsiveness	
Neurologic	Unrelenting, severe headache unresponsive to medication	
Visual Disturbances	Blurred or impaired vision	
Physical	Shortness of breath or epigastric pain	
***If Yellow or Red BP triggers, recheck BP within 15 minutes**		

IF O2 Sat <93% or RR >24 CONSIDER PULMONARY EDEMA

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/73**	**SUBJECT:**	**Ordering Non-District Provided Services for Patients**
REVISION DATE~~(S)~~:	**05/88, 09/91, 03/00, 06/03. 09/05 08/08, 07/11, 02/15, 12/19**		

Patient Care Services Content Expert Approval:	**~~06/19~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~07/19~~10/22**
Nursing Leadership ~~Executive Council~~ Approval:	**~~09/19~~11/22**
Medical Staff Department or Division:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~10/19~~11/22**
Administration Approval:	**~~11/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **PURPOSE:**

1. To provide a means for ordering outside services which are not provided by Tri-City Healthcare District (TCHD).

B. **POLICY:**

1. Outside services such as beauticians, orthopedic appliance specialists, and any others not contracted will not be arranged by TCHD personnel.
   a. If the physician/AHP orders outside services, the written order must include which service shall be contacted. TCHD personnel may then telephone the designated service.
2. TCHD personnel may not participate in any way in selecting an outside source except as defined by department specific policy.
3. The patient may directly order outside service.
   a. The TCHD will not reimburse the provider for such services, nor will it enter into any collection activity as agent for the provider.
4. TCHD does not accept liability for any outside vendor or medical equipment/device provider contracted by the patient without a physician/AHP order.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**12/01**	**SUBJECT:**	**Physician's Admission Responsibilities**
REVISION DATE(~~S~~):	**06/03, 11/05, 12/08, 08/11, 06/15 08/19**		

Patient Care Services Content Expert Approval:	**~~04/19~~05/22**
Clinical Policies & Procedures Committee Approval:	**~~05/19~~06/22**
Nurse Executive Committee Approval:	**~~05/19~~07/22**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/19~~, 09/22**
Administration Approval:	**~~07/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **POLICY:**

1. Admitting Orders
   a. Physicians' orders must be obtained within one hour for routine elective admissions, direct admissions, and admissions from the Emergency Department (ED) to Acute Care Services, Forensic Unit, or Women and Newborn Services (WNS). ED admissions to Intensive Care Unit (ICU) and Telemetry shall arrive on the unit with orders from the physician.
   b. Minimum content for orders includes:
      i. Admit
      ii. Admitting diagnosis
      iii. Diet
      iv. Activity
      v. Lab work
      vi. Medication Orders
      vii. Admission status (observation, inpatient)
      viii. Level of care (ICU, Telemetry, Medical/Surgical)
   c. When initial admitting orders have not been received from a physician within one hour, the following chain of command is activated.
      i. ~~Assistant~~ Nurse **Leader**~~Manager (ANM)/Relief~~ Charge Nurse or Designee.
      ii. Administrative Supervisor.
      iii. Chief of Division, Department Chair, or in his/her absence, the Chief of Staff shall be notified to ensure that patient care will be provided promptly.
      iv. When no orders have been received for one hour the patient shall be admitted to the service of a physician appointed by the Chief of Division, Department Chair or in his/her absence, the Chief of Staff. In such cases, the department director/designee is to be notified as soon as possible.
2. The attending physician maintains responsibility for the direction of patient care by providing the following:
   a. Clear and legible orders.
   b. Clinical direction to healthcare professionals regarding medical plan of care.
   c. Collaboration with healthcare professionals on a regular basis pertaining to the plan of care, prognosis, and discharge planning.
   d. Collaboration with patient and family members.

e. Complete and adequate documentation per the Medical Staff Bylaws.
f. Availability to healthcare professionals when questions arise regarding specific symptoms and/or physician orders.
g. Coverage when not available.
    i. Ensure the healthcare professionals are informed when not available.
h. Participation in patient care, conferences.
i. Assistance in preventing/clarifying conflict with consultants.
j. Communication regarding patient's condition.

3. The consulting physicians collaborate with the attending physician to prevent conflicts in patient care orders or clinical direction.
4. Medical Directors, Medical Staff Officers, Department/Division Chairs/Chiefs, and Medical Staff Committees interact with the Patient Care Services Departments as follows:
    a. Work in cooperation with the Patient Care Services Departments by:
        i. Being readily available to the Management Team.
        ii. Participating as active team members in standards review.
        iii. Identifying, solving and assisting with conflict resolution as needed.
    b. The Chief Nurse Executive (CNE) will serve as the formal liaison between the Medical Staff and Patient Care Services departments either by direct participation and committee work or by designating a qualified healthcare professional.
    c. Healthcare professionals are responsible to maintain communication with physicians regarding patient's conditions.
    d. Medical Directors shall meet regularly with the clinical/operations manager of the respective departments to review quality improvement data, and refer problems for resolutions to appropriate Medical Staff Committees/Departments/Divisions, if indicated.
5. The list of current Medical Staff leaders and committees is maintained in the Medical Staff Office.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**POINT OF CARE TESTING COMPETENCY ASSESSMENT**
Purpose:	To outline the mandatory Point of Care testing personnel competency requirements.
Supportive Data:	To meet regulatory requirements, to include but not limited to College of American Pathology and Joint Commission

A. POLICY:

1. Point of Care Testing (POCT) includes analytical patient tests performed outside the clinical facilities of the main laboratory. All POCT is covered under the Laboratory's Clinical Lab Improvements Amendments license, and is subject to the same regulations. The College of American Pathologist (CAP) personnel competency requirements for POCT includes:
   a. Evidence testing personnel have adequate, specific training to ensure competence.
   b. A list delineating the specific tests each POCT personnel is authorized to perform.
   c. A documented program ensuring each person performing POCT maintains satisfactory levels of competence.
2. Joint Commission requires competency to be assessed using at least two (2) of the following methods per person per test:
   a. Performance of a test on a blind specimen.
   b. Periodic observation of routine work by the supervisor or qualified designee.
   c. Monitoring of each user's quality control performance.
   d. Use of written test specific to the test assessed.
3. Competency for waived testing shall be evaluated upon hire and annually thereafter. Competency for non-waived testing shall be evaluated upon hire, semi-annually during the first year, and annually thereafter. Competency shall be reassessed at any time when problems are identified with employee performance.
4. The records must make it possible for the Inspector to determine what skills were assessed and how those skills were measured. Some elements of competency include, but are not limited to:
   a. Direct observations of routine patient test performance, including, as applicable, patient identification and preparation; and specimen collection, handling, processing and testing.
   b. Monitoring the recording and reporting of test results, including, as applicable, reporting critical results.
   c. Review of intermediate test results or worksheets, quality control records, proficiency testing results, and preventative maintenance records.
   d. Direct observation of performance of instrument maintenance and function checks, as applicable.
   e. Assessment of test performance through testing previously analyzed specimens, internal blind testing samples or external proficiency testing samples.
   f. Evaluation of problem solving skills.
5. For non-waived (moderate-complexity) tests, all of the above six (6) elements must be assessed. For waived tests, it is not necessary to assess all elements at each assessment. Ongoing supervisory review is an acceptable method of assessing competency.
6. Personnel will not be allowed to perform POC testing without completion of the competency requirements.

B. PROCEDURE:

1. The Laboratory Medical Director authorizes personnel to perform testing. Authorization is determined by job description and is specific to nursing unit and job title. Refer to the Laboratory Point of Care Coordinator and Quality Management Manual for any clarification.
2. Evidence of training and competency shall be documented and records shall be maintained in the Employee file.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/10, 06/11, 06/14, 10/17, **07/22**	04/11, 06/14, 11/17, 06/20, **08/22**	05/11, 06/14, 12/17, 07/20, **09/22**	08/14, 04/18, 09/20, **09/22**	n/a	n/a	10/20, **12/22**	06/11, 10/14, 04/18, n/a	06/11, 11/14, 04/18, 11/20

3. Management is responsible to ensure all testing personnel within their department have completed the required competencies.
4. If an individual fails to complete competency assessment by the due date, they will not be allowed to perform POCT testing until the competency is completed.

C. FORM(S):

1. Point of Care Competency Assignments Summary – Job Description

D. REFERENCE(S):

1. College of American Pathology. (2019) Point of Care Testing Checklist.
2. e-dition.jcrinc.com WT.03.01.01. Retrieved on May 11, 2011.
3. The Joint Commission (2017). *Hospital Accreditation Standards.* Illinois: Joint Commission Resources.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 10/01 **SUBJECT: Private Duty Staff, Patient Acquired**

REVISION DATE~~(S)~~: 03/03, 06/03, 05/05, 07/06, 08/08, 03/09, 08/11, 01/15, 10/19

Patient Care Services Content Expert Approval:	~~06/19~~09/22
Clinical Policies & Procedures Committee Approval:	~~07/19~~10/22
Nursing Leadership~~ Executive Committee~~ Approval:	~~09/19~~11/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~10/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/19

A. **POLICY:**

1. Tri-City Medical Center (TCMC) allows the use of private duty nursing staff, except in **the** Intensive Care Unit (ICU) and Neonatal Intensive Care (NICU), to provide nursing care by an outside agency. The hospital remains ultimately responsible for the patient's care and welfare. The TCMC Registered Nurse (RN) is in charge of the patient and determines the care to be provided by and the supervision required by the private duty nurse.
2. Nursing staff shall notify the primary care physician/AHP of family's request for private duty staff.
3. Arrangements for all private duty nursing staff are made by the patient's family, patient, or attending physician/AHP.
4. The hospital assists families by providing outside private duty agency names and telephone numbers. Payment is made directly by the patient/family to the private duty nurse or through **the outside agency.**~~registry.~~ TCMC nursing staff are not eligible for private duty nursing while the patient is in TCMC.
5. The hospital reserves the right to notify the ~~registry~~ **outside agency** when a nurse fails to meet the standards required of them.
6. The hospital assumes no responsibility in the collection of the fee. Agency payroll time slips may be signed by the shift supervisor/designee and given to the family/significant other, if a signature is required.
7. Private duty nursing staff shall sign in at the Staffing Resource Office. Private duty staff must **check in with the Administrative Supervisor** ~~sign a log~~ prior to starting and at the completion of his/her shift.
8. Private duty staff members are only allowed to participate in patient's basic care needs.
   a. If a family/patient enlists licensed (RN/LVN) private duty personnel, he/she may not perform such tasks as dressing changes, indwelling urinary catheter insertion **or removal, blood glucose monitoring,** intravenous and medication administration, **any insertion or removal on an indwelling tube or drain,** or any other nursing duties that require proof of competency.
9. Private duty nurses will have no access to the patient's medical record.
~~9.~~**10. Basic report will be given from the TCMC nursing staff to the private duty staff on ADL's for the patient based on the physician/AHP orders and the private duty staff must adhere to those orders.**

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**01/06**	**SUBJECT:**	**Restraints Used for Non-Violent/Non-Self-Destructive Behavior**
REVISION DATE~~(S)~~:	**06/07; 08/09; 10/09; 01/11 07/11; 08/12; 01/16, 08/19**		

Patient Care Services Content Expert Approval:	**~~06/19~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~06/19~~10/22**
Nursing Leadership~~e Executive Council~~ Approval:	**~~06/19~~11/22**
Medical Staff Department or Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee	**~~07/19~~11/22**
Administration Approval:	**~~08/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **PURPOSE:**

1. To provide a consistent standardized organizational-wide policy for the use of non-violent/non-self-destructive behavior restraint.

B. **DEFINITIONS:**

1. Restraint –**"Any manual method, physical or mechanical device, or material, equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely"**

~~1. Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.~~

   a. Physical Restraint: Any **direct application of a** manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his/her arms, legs, body, or head freely.
   b. Chemical restraint or seclusion is not used for non-violent behaviors.

2. Physical Escort – A physical escort would include a "light" grasp to guide the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
3. Physician/Allied Health Professional (AHP) – any physician, dentist, or podiatrist who is a Medical Staff member and/or who exercises clinical privileges at **Tri-City Healthcare District TCHD)**~~TCMC~~ as context requires, unless otherwise expressly limited.
4. Qualified/Specially Trained Staff – Staff who are trained and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served.

C. **POLICY~~PHILOSOPHY~~:**

1. ~~Tri-City Healthcare District (~~**TCHD)** acknowledges restraint may be necessary for certain patient populations.

~~2. Restraint shall only be used when essential to protect patients from harming themselves, other patients, or staff.~~

2. **Restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time**
3. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment. In the event restraint of a patient becomes necessary, ~~Tri-City Medical Center (~~TC**HD**~~MC)~~ supports a philosophy which will protect ~~the~~ patient~~'s~~' health and safety and preserves ~~his/her~~**their** dignity, rights and well-being.
4. Restraints of any type should not be used as a punishment, retaliation, coercion, **prevent the potential falls,** or for the convenience of staff, and should be discontinued as soon as possible.
5. All patients are given information regarding patients' rights upon admission.
6. The use of restraint is not based on a patient's restraint history or behavior history.
7. Hand Mitts **– that meet the following criteria are considered a restraint:**
   - **a. The hand mitts are pinned or otherwise attached to the bed / bedding or are used in conjunction with wrist restraints and / or**
   - **b. The hand mitts are applied so tightly that the patient's hand or fingers are immobilized and / or**
   - **c. The hands mitts are so bulky that the patient's ability to use their hands is significantly reduced, and / or**
   - **d. That is, the hand mitts** ~~That~~ do not allow a patient to bend all fingers and thumb, mitts that look like boxing gloves whether tied down or not
   - **e. The hand mitts cannot be easily removed intentionally by the patient in the same manner they were applied by staff considering the patient's physical condition and ability to accomplish the objective.**
   - ~~a. That do not allow a patient to bend all fingers and thumb, mitts that look like boxing gloves whether tied down or not~~
   - ~~b. That are gloves to keep a patient from scratching when tied to a bed or chair frame~~
8. **Bed Side Rails**
   - **a. The determination as to whether raised side rails would be considered a restraint is based on multiple factors such as the method of use and whether it immobilizes or reduces (restricts) the ability of a patient or a patient's body part to move freely**
   - **b. Raised Side Rails**
     - **i. Restricting the patient's freedom from exiting the bed**
     - **ii. Prevents the patient from voluntarily getting out of bed or attempting to exit the bed**
     - **iii. Prevent the patient from exiting the bed**
   - **c.** Four (4) side rails **raised at the same time used for the following are considered a restraint:**
     - **i. To prevent a patient physically able to exit a bed**
     - ~~c.~~**ii.** ~~in the up position if the patient cannot lower the side rails and exit the bed.~~

D. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are ***not*** considered restraint:
   - a. Side rails
     - i. Used for safety or support
     - **ii.** Four (4) side rails in the up position at the same time that can be lowered by the patient to allow the patient to exit the bed
     - ~~ii.~~**iii. Four (4) side rails in the raised position at the same time are not considered a restraint for patients that are not physically able to get of bed. The raised side rails do not have an impact on the patient's freedom of movement.**
     - ~~iii.~~**iv.** During procedures for patient safety

v. Seizure precautions with padded side rails
~~iv.~~**vi. Raising side rails when a a patient is on a stretcher, recovering from anesthesia, sedated, experiencing involuntary movement, or on certain types of therapeutic beds to prevent the patient from inadvertently falling out of the bed**
~~v.~~**vii.** Patient in the Intensive Care Unit (ICU) or patient outside of the ICU placed in a bed used in the ICU

b. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure i.e., surgical positioning, intravenous (IV) arm boards, papoose, protection of surgical and treatment sites in pediatric patients.
c. Adaptive support in response to assessed patient needs i.e., orthopedic prescribed devices, postural support, table top chairs, and specialty mattress.
d. Protective equipment such as helmets.
e. Hand mitts **that look like gloves** ~~(gloves only)~~ **applied to**~~to~~ keep **patient from** ~~from~~ scratching self that are not secured (tied) to a bed frame or chair
   i. Pinning wrists down with **the hand** mitts **(gloves)** and/or hand or fingers are immobilized are -considered a restraint
f. Methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm
g. Devices that permit the patient to participate in activities without the risk of physical harm
h. Forensic and correctional restrictions imposed by correctional authorities and used solely for security purposes i.e., handcuffs shackles.

3. Safe transportation of patients on or off the unit for procedures or tests:
   a. Patients may be secured in a transport gurney or chair with a safety device (i.e. Velcro strap, side rails) upon transport on or off the unit.
   b. Patients may be secured with a safety device while obtaining a procedure or test.
   c. Patients may not be left unattended.
4. Restraint use for violent or self-destructive behavior (the restraint standards for violent or self-destructive behavior apply). See the Patient Care Services Restraints/Seclusion for Violent/Self-Destructive Behavior Policy which includes definitions for the following:
   a. Chemical Restraint
   b. Time-out
   c. Physical Escort
   d. Physical Holds
   e. Qualified/Specially Trained Staff

E. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room not under continuous observation by staff is at greater risk for self-injury or adverse occurrences.

F. **ORDERS:**

1. Restraint is used upon the order of a physician/AHP.

2. Physician/AHP orders are valid until criteria for release is met.
3. If a physician/AHP is not available to issue such an order, a Registered Nurse (RN) may initiate restraint use based on an appropriate assessment of the patient.
   a. Once placed in restraints, a physician/AHP shall be notified as soon as possible of the initiation of restraint, and a telephone or written order shall be obtained from that physician/AHP and entered in the patient's **eElectronic hHealth rRecord (EHR)**~~medical record~~.
   b. If the initiation of restraint is based on a significant change in the patient's condition, the RN shall immediately notify the physician/AHP.
4. The attending physician must be consulted as soon as possible if restraint is not ordered by the patient's attending physician.
5. A written order, based on examination of the patient by a physician/AHP is entered into the **EHR**~~medical record~~ on the initiation of restraint.
6. Orders for restraint are not written as standing orders or on an as needed basis i.e., PRN.
7. Orders for non-violent/non-self-destructive restraint must include: action justifying restraint, type of restraint, and criteria for release.
8. The RN shall assess the discontinuation of the use of restraints as soon as it is safely possible, **regardless of the length of time identified in order.** ~~.~~
9. When restraint is discontinued and/or alternatives methods are not effective and restraint must be reapplied, a new order must be obtained.
   a. Restraints may not be removed for a trial period or to identify patient's readiness for restraint discontinuation
   ~~a.~~**b. Restraints removed temporarily to provided care while staff remain in the patient room are not considered a trial.**

G. **INITIATION AND DOCUMENTATION:**

1. Alternatives must be considered and tried before using restraint. Refer to examples of alternative interventions**. See Alternatives to Restraints** ~~on Appendix A~~.
2. If alternatives are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.
3. The RN shall document initiation of restraint in the **EHR**~~medical record on the appropriate restraint electronic form or paper restraint flowsheet~~. The following shall be documented:
   a. Initiation Date and Time
   ~~a.~~**b. Behavior requiring restraint**~~Restraint Reason i.e., Non-violent/ Non-Self Destructive Behavior Restraint~~
   ~~b.~~**c.** ~~Restraint Initiation Date and Time~~
   d. Type of restraint i.e., soft limb, mittens, immobilizer (vest).
      i. A dynamic group must be initiated for each restraint type
   ~~c. Restraint Type i.e., chair with lap table, mitts that look like boxing gloves, soft ankle, soft wrist, vest~~
   ~~d.~~**e.** ~~Restraint~~ Location **of restraint** i.e., left or right upper or lower extremity, torso
   ~~e.~~**f. Alternatives implemented for non-violent restraints.** ~~Action Justifying use of Restraint~~
   ~~f. Description of other behavior requiring restraint, if applicable~~
   ~~g. Pre-restraint alternatives attempted~~
   ~~h. Effectiveness of Pre-restraint alternatives~~
   g. Education provided to patient/family education
   ~~i.~~**h. Presence of a patient safety attendant (sitter, Patient Safety Technician), if applicable**

H. **ONGOING MONITORING AND DOCUMENTATION:**

1. Patient in restraint may need more frequent monitoring because of age, physical or mental conditions or other needs/conditions based on clinical judgment and knowledge of the patient and their individual needs

2. If the patient is sleeping, the RN shall observe the patient to ensure a safe environment.
   a. Clinical judgment and knowledge of the patient and their individual needs shall be used to determine when and what items need to be evaluated.
3. Patient Care
   a. The RN or designee trained and competent in use of restraint shall address and document the following patient care needs ~~-~~approximately every 2 hours **in the EHR**~~medical record~~
      i. Range of Motion (when awake)
      ii. Elimination ~~and hygiene~~
      iii. Nutrition/Hydration
      iv. Allowance for the patient to have maximum movement
4. Assessment and Reassessment
   a. The RN shall reassess patients in restraint approximately every 2 hours or more frequently if necessary.
      ~~b.~~**i.** The patient will be assessed for the following:
         1) **Need to continue to use restraints or discontinue restraints**
         ~~i.~~**2)** Mental status and behavior
         ~~ii.~~**3)** Physical/emotional well-being
         ~~iii.~~**4)** Respiratory status
         ~~iv.~~**5)** Limb circulation
         ~~v.~~**6)** Maintenance of the patient's rights, dignity, and security
         ~~vi.~~**7)** Monitoring of the correctness of the application, removal and reapplication of restraint
         8) Skin
      ~~vii.~~**b. Vital signs per physician order or standards of care**
   c. Document assessment and reassessment findings in the **EHR**~~medical record~~.

I. **PLAN OF CARE:**

1. Ensure the appropriate Interdisciplinary Plan of Care (IPOC) is implemented with the initiation of restraint.
   a. Select the appropriate interventions and outcomes based on the behavior of the patient
   ~~a.~~**b.** Review and update per the IPOC policy~~.~~
   ~~2.~~**c.** Discontinue the restraint IPOC ~~-~~when restraint is discontinued

J. **PATIENT/FAMILY EDUCATION:**

1. The following education shall be provided to the patient/family:
   a. Clinical reason for restraint
   b. Purpose and use of restraint
   c. Monitoring and care that shall be provided
   d. Criteria necessary for termination of restraint
   e. Additional information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. Appropriate family members shall be notified when a patient is placed in restraint when it meets with the patient's wishes and/or Health Insurance Portability and Accountability Act (HIPAA) and other regulatory standards.

K. **DISCONTINUATION:**

1. Restraint shall be discontinued when criteria for release are met **or as soon as possible regardless of the length of time identified in the order**~~.~~
2. Document discontinuation of restraint in the **EHR.**~~medical record. on the appropriate restraint electronic form or paper restraint flowsheet~~.

L. **COMPETENCY AND EDUCATION:**

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the application and monitoring of restraint, and shall undergo education and training in the proper and safe use of restraint during initial orientation and annually thereafter.
2. Training requirements include but are not limited to:
   - **a. The determination of who has authority to:**
     - **i. Order restraint**
     - **ii. Initiate the use of restraint**
     - **iii. Continue or discontinue the use of restraint**
     - **iv. Circumstances under which restraint is discontinued**
   - **b. Identify patient's immediate situation requiring restraint**
   - **c. The definition of:**
     - **i. Restraints**
     - **ii. Types of restraints**
   - **d. Describes what constitutes the use of medications as a restraint**
   - **e. Knows who can assess and monitor patients in restraints**
   - **f. Time frames for assessing and monitoring patients in restraints**
   - **g. Monitoring patient's reaction(s) to restraint initiation**
   - ~~a. The determination of who has authority to order restraint~~
   - ~~b. The determination of who has authority to discontinue the use of restraint~~
   - ~~c. The determination of who can initiate the use of restraint~~
   - ~~d. The circumstances under which restraint is discontinued~~
   - ~~e. The requirement that restraint is discontinued~~
   - ~~f. A definition of restraint~~
   - ~~g. A definition or description of what constitutes the use of medications as a restraint~~
   - ~~h. A determination of who can assess and monitor patients in restraints~~
   - ~~i. Time frames for assessing and monitoring patients in restraints~~
3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring of restraint.
   a. A qualified staff member shall be assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure proper safety procedures, orders and monitoring are implemented.
4. Physicians/AHP's shall be educated in the use of restraint

M. **STAFFING:**

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, co-occurring conditions, patient acuity, age, and developmental functioning of the patient. ~~These elements are addressed in the staffing mix of the unit.~~

N. **NOTIFICATION:**

1. The hospital shall **follow** ~~report required information to~~**the** Centers for Medicare and Medicaid Services (CMS) ~~per~~ regulation**ss related to the reporting and record keeping for deaths associated with restraints.**~~.~~ See the examples below:
   a. Each death that occurs while a patient is in restraint ~~or seclusion~~
   b. Each death that occurs within 24 hours after the patient has been removed from restraint. ~~or seclusion~~ **Excluding the removal of soft wrist restraints.**
   c. Each death known to the hospital that occurs within one week after restraint or seclusion was used **as outlined by regulatory requirements.**
2. Regulatory Compliance shall document **notification of CMS** ~~i~~in the patient's **EHR**~~medical record. the date and time the death was reported to CMS~~.

O. **PERFORMANCE IMPROVEMENT:**

1. Data shall be collected on restraints and submitted to the Restraint Committee and reviewed by the Patient Safety Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement.
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce the **potential and actual** risks associated with restraint use.

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

1. Alternatives to Restraint
2. Restraint Education/Competency for Non-Violent/Non-Self-Destructive

Q. **REFERENCE(S):**

1. California Code of Regulations. -Title XXII **§77103.**
2. Department of Health and Human Services. **Code of Federal Regulations 42 482.13** ~~*Federal registry part IV.*~~ *Centers for Medicare and Medicaid Services (CMS)* ***Conditions of Participation:Patient Rights (September 2022)*** ~~*42CFR part 482.*~~
3. Joint Commission (201~~5~~**22**). *Hospital accreditation standards.* Retrieved from http://www.jointcommission.org

Tri-City Medical Center
Oceanside, California

ALTERNATIVES TO RESTRAINT

A. Alternatives to restraints should include less restrictive interventions that may prevent the us of restraint.
B. Document in the medical record all alternatives to restraints implemented or attempted prior to the application of restraint.
C. Categories of Alternatives to Restraint and Seclusion interventions or activities include but are not limited to the following:
    - Change or eliminate treatment
    - Toileting/ Nutrition
    - Decrease line(s) and tube(s) visibility
    - Diversional activities
    - Environmental changes
    - Manage pain
    - Place patient in a room close proximity to nursing statin
    - 1-on- companionship (Sitter)
    - Medications that will not restrict patient's ability to participate in their care or restrict their ability to move
D. Detail examples of alternatives to restraints include but are not limited to the following:

Psychosocial Alternatives	Environmental Alternatives	Physiological Alternatives
Watching or listen to the TV, soothing music,	Commode at bedside	Toileting, frequently offer assistance with toileting needs
Family interaction	Decrease noise	Address hygiene needs and comfort measures
Orientation today, time and place	Music/ TV	Fluids / nutrition / snack
Pastoral visit	Night light	Positional devices
Reassurance	Room close to nurses' station	Pain intervention
Reading – books, newspaper,	Call light within reach	Assisted ambulation
Relaxation techniques	Place personal items within reach	Re-positioning
Interpreter services	Keep bed in low position and locked in place	Rest / sleep; decrease interruptions, allow patient to nap
Quiet area	Sensory aids available (glasses, hearing aid)	Providing assistance with ADLs
One-on-one discussion	Decrease stimulation	Additional warmth, provide blankets
Encourage verbalization of feelings	Providing quiet area	Room temperature at comfort level
Validate patient's feelings	Physical activity	Check lab values
Respect patient's need for personal space	Orientation to surroundings	Pharmacy consult
Decreased stimulation		Encourage patient to participate in care
Change in environment		
Re-establishing communication		
Setting limits		
Use de-escalation and verbal		

redirection techniques		

A. Psychosocial Alternatives

- Diversion activities such as: TV, soothing music, books, or folding washcloths
- Family interaction
- Orientation today, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values

Pharmacy consult

Tri-City Medical Center
Oceanside, California

Restraint Education/Competency
Based Upon Scope of Practice
Non-Violent, Self-Destructive Restraints

	Registered Nurse	**Licensed Vocational Nurse**	CNA/ NA ACT/MHW/ET/PST	Rad. Tech	Transporter ~~Lift Team~~	Physical Therapist/ RCP	Occupational Therapist	Security	Patient Safety Technician	Regulatory
Initiation	✓									
Orders	✓									
Pre-Restraint Alternatives	✓	✓	✓							
Ongoing Monitoring	✓	✓	✓							
Observation	✓	✓	✓							
Patient Care	✓	✓	✓							
Assessment/Reassessment	✓									
Discontinuation	✓									
Documentation **of Assessment / Reassessment**	✓		✓	✓		✓	✓			
Documentation Reapplication and Removal to Perform Patient Care	✓	✓		✓		✓	✓	✓		
Release and/or Re-secure	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Report restraint related death to CMS										✓
Document CMS notification in Patient's medical record										✓

~~✓= Required for scope of practice~~

✓= Required for scope of practice
ACT = Advanced Care Technician
CNA = Certified Nurse Assistant
MHW = Mental Health Worker
NA = Nurses Assistant
PST = Patient Safety Technician
RCP = Respiratory Care Practitioner
RT = Respiratory Therapist

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 01/06

SUBJECT: Restraints/Seclusion for Violent/Self-Destructive Behavior

REVISION DATE~~(S)~~: 06/07, 08/09, 10/09, 09/10, 12/11, 02/12, 07/15, 08/19

Patient Care Services Department Approval:	~~04/19~~09/22
Clinical Policies & Procedures Committee Approval:	~~05/19~~10/22
Nursing Leadership ~~Executive Committee~~ Approval:	~~05/19~~11/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~06/19~~11/22
Administration Approval:	~~07/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/19

A. **PURPOSE:**

1. To provide a consistent standardized organizational-wide policy for the use of violent/self-destructive behavior restraint and/or seclusion.

B. **PHILOSOPHY:**

1. Tri-City Healthcare District **(TCHD)** acknowledges restraint may be necessary for certain patient **situations** ~~populations.~~
2. Restraint or seclusion ~~is~~ **may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.**
3. ~~1.~~ **Restraint or seclusion should be** limited to emergencies in which there is an imminent risk of patient physically harming ~~himself~~**their self** ~~/herself~~ or others and **when less restrictive interventions are ineffective.** ~~nonphysical interventions would not be effective~~.
4. The ultimate goal is to minimize the use of restraints and achieve a restraint-free environment.
5. In the event seclusion or restraint of a patient becomes necessary, T**CHD**~~ri-City Medical Center (TCMC)~~ supports a philosophy, which will protect the patient's health and safety and preserves **their**~~his/her~~ dignity, rights and well-being.
6. -Restraints of any type sh**all**~~ould~~ not be used as a punishment, retaliation, coercion, or for the convenience of staff, **or as a substitute for more effective programming** and should be discontinued ~~as soon as possible.~~**at the earliest possible time.**
7. ~~2.~~ All patients are given information regarding patients' rights upon admission.
8. The type of physical intervention selected considers information learned from the patient's initial assessment, which outlines interventions that have helped **them**r~~him/her~~ in crisis situations in the past which could minimize the use of restraint or seclusion.
9. ~~3.~~ -The use of restraint or seclusion is not based on a patient's restraint or seclusion history or solely on history of dangerous behavior.

C. **POLICY:**

1. **The use of restraint or seclusion must be in accordance with the order of a physician or an Allied Health Professionals (AHP) who is responsible for the care of the patient and authorized to order restraint or seclusion.**

2. **Behavioral restraint and seclusion shall only be used upon a physician's or clinical psychologist's written or verbal order, except under emergency circumstances.**
3. **Under emergency circumstances behavior restraint may be applied and then an order obtained within one hour.**
4. **Patients in restraint must be continuously monitored by trained staff without interruptions. This can be face-to-face or both video and audio in close proximity to patient.**

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

1. Restraint – **"Any manual method, physical or mechanical device, or material, equipment that immobilizes or reduces the ability of a patient to move their arms, legs, body, or head freely.** ~~Direct application of physical force to a patient, with or without the patient's permission, to restrict his or her freedom of movement. The force may be human, mechanical devised or a combination thereof.~~
   a. Physical Restraint: Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move ~~his~~**their** arms, legs, body, or head freely.
   b. Chemical Restraint: A drug or medication used as a restriction to manage the patient's violent/aggressive behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition. A**n as needed** -(PRN) order does not determine the use of that drug as a restraint. Criteria for "standard treatment or dosage" are treating a specific patient's clinical condition of symptoms, not behaviors, which enable the patient to function more effective and appropriately (not a restraint) rather than reduce that patient's ability to interact with the world around them (restraint).
      i. Emergency Medication: It may be necessary to use psychotropic agents to control severe agitation. Medications ordered and taken voluntarily on a PRN basis as indicated for the psychiatric condition being treated are not considered chemical restraint. Emergency medication given against a patient's will is not considered a chemical restraint if it is for the treatment of acute symptoms of a psychiatric illness.
2. Seclusion – The involuntary confinement of a patient *alone* in a room or area from which the patient is physically prevented from leaving. Seclusion ~~is a form of restraint that~~ may **only be** ~~be~~ used ~~only~~ for the management of violent or ~~self destructive~~**self-destructive** behavior.
3. Time-out - A strategy which directs **a** patient from the general milieu to a quiet area to provide a less stimulating environment. A responsible **Registered Nurse** (RN) implements time-out based on assessed need when time-out is documented as an intervention on the patient's plan of care. Time-out is voluntary; it is designed as a least restrictive behavior management technique. Time-out becomes a form of physical restraint if the patient is prevented from leaving the time-out area.
4. Physical Escort – A physical escort would include a "light" grasp to guide the patient to a desired location. If the patient can easily remove or escape the grasp, this would not be considered physical restraint. However, if the patient cannot easily remove or escape the grasp, this would be considered physical restraint.
5. Physical Holds – The regulation permits the physical holding of a patient for the purpose of conducting routine physical examinations or tests. However, patients do have the right to refuse treatment. This includes the right to refuse physical examinations or tests. Holding a patient for being violent or ~~self destructive~~**self-destructive** or to force psychotropic medications is considered restraint, but if patient consents to injection then it is permitted to hold patient if patient allows.
6. Practitioner –~~A~~ **a**ny physician, dentist, or podiatrist who is a Medical Staff member and/or who exercises clinical privileges at TC**HD**~~MC~~ as context requires, unless otherwise expressly limited.
7. Qualified/Specially Trained Staff – Staff who are **provided education (e.g.,** trained) and who have demonstrated competency in the use of restraint and/or seclusion in accordance with their scope of licensure and patient population served. The Qualified/Specially trained RN has

additional training and demonstrates competency in the First Hour assessment and documentation process.

~~D.~~E. **EXCLUSIONS:**

1. The specific device used to restrain a patient does not in itself determine whether the restraint standards apply. Rather, it is the device's intended use (such as physical restriction), its involuntary application, and/or the identified patient need that determines whether use of the device triggers the implementation of the restraint policy.
2. For the purposes of this policy, the following are not considered restraint:
   a. Standard practices that include limitations of mobility or temporary immobilization during medical, dental, diagnostic, or surgical procedures, and the immediate post-procedure care processes when these practices are considered an inherent part of the procedure ~~(~~i.e., surgical positioning, **intravenous (**IV) arm boards, papoose, protection of surgical and treatment sites in pediatric patients~~).~~
   b. Adaptive support in response to assessed patient needs (i.e., orthopedic prescribed devices, postural support, table top chairs).
   c. Protective equipment such as helmets.
   d. Hand mitts (gloves only) to keep from scratching self (if pinning wrists down with mitts, hand or fingers are immobilized, this is considered a restraint).
   e. Devices that permit the patient to participate in activities without the risk of physical harm.
   f. **Justice Involved** ~~Forensic~~ and correctional restrictions imposed by correctional authorities and used solely for security purposes (i.e., handcuffs, shackles).
   ~~g. Restraint use for non-violent/non-self-destructive behavior to which the restraint standards for non-violent/non-self-destructive behavior apply.~~

~~E.~~F. **PRECAUTIONS:**

1. Restraint of patients with deformities may preclude proper application of restraining devices.
2. Restraining of patient in the prone position may predispose the patient to suffocation. Prone restraint is prohibited.
3. Certain vulnerable patient populations are at a greater risk of experiencing adverse effects from restraint use including but not limited to those who are cognitively impaired, physically impaired, elderly and/or those with a history of sexual or physical abuse that would place them at greater psychological risk.
4. Patients at risk for entrapment, including physical, mental and behavioral or medication impairment.
5. A patient in a room that is not under continuous observation by staff is at greater risk for self – injury or adverse occurrences.

G. **FACE-TO-FACE EVALUATIONS:**

1. **When restraint or seclusion is used to manage behavior that jeopardizes the immediate physical safety of or the patient, a staff member, or others, the patient must be seen face-to-face within 1 (one) hour after the initiation of the intervention by a:**
   a. Physician or AHP
   b. RN (qualified) to evaluate the patients:
      i. Immediate situation
      ii. Reaction to the interventions
      iii. Medical and behavioral conduct
      iv. Need to continue or terminate the restraint or seclusion
2. **The RN must consult the attending physician or AHP who is responsible for the care of patient as soon as possible after the completion of the 1-hour face-to-face evaluation**
3. **If the First hour face-to-face evaluation is conducted by a qualified PA, the attending practitioner who is responsible for the care of the patient shall be consulted within one hour after completion of the evaluation.**

H. SIMULTANEOUS RESTRAINT AND SECLUSION USE:

1. **Simultaneous use of restraint and seclusion use is only permitted if the patient is continually monitored face-to-face by an assigned trained staff member or by trained staff using both video and audio equipment.**
   a. **Video and audio equipment must be in close proximity to the patient**

~~F.~~**I. ORDERS:**

1. **Orders must never be written as a standing order or PRN**
2. All restraint and seclusion are applied and continued pursuant to an order by the practitioner who is primarily responsible for the patient's ongoing care, or his or her designee.
   a. **The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion**
3. **Each order used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:**
   a. **4 hours for adults 18 years of age or older;**
   b. **2 hours for children and adolescents 9 to 17 years of age; or**
   c. **1 hour for children under age 9 years of age**
4. **After 24 hours, before writing a new order for restraint or seclusion**
   a. **A physician or AHP who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient**
5. **When restraint or seclusion is discontinued before the order expires, the original order cannot be used to reapply the restraint or seclusion if the patient is at imminent risk or physically harming themselves or others, and non-physical interventions are not effective.**
   a. **Each application of restraint must be considered a separate episode in which all assessment and documentation procedures are applied.**
6. **If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the physician primarily responsible for the patient's ongoing care, treatment, and services, or their designee.**
7. **Orders for violent/self-destructive restraint and/or seclusion must include: restraint and/or seclusion start and end time, action justifying restraint, type of restraint, criteria for release, and location of restraints.**

~~2.~~**8.** In the case of emergency, a patient may be placed in restraint/seclusion at the discretion of the ~~Registered Nurse (~~RN~~)~~
   a. As soon as possible but no longer than one hour after the initiation of restraint or seclusion by a RN, **the RN must~~, he or she~~:**
      i. Notifi~~y es~~ and obtain~~s~~ an order (telephone or written) from the practitioner
      ii. Consult~~s~~ with the practitioner about the patient's physical and psychological condition
      iii. Supplies staff with guidance in identifying ways to help the patient regain control so that restraint or seclusion can be discontinued as soon as safely possible.

~~3.~~**9.** The **Physician or AHP responsibilities include but are not limited to:**~~practitioner does the following:~~
   a. Reviews with the staff the physical and psychological status of the patient
   b. Determines whether restraint or seclusion should be continued
   c. The patients' ongoing care, treatment, and services which includes evaluating the patient in person within 1 hour of the initiation of restraint or seclusion.
   d. At the time of the in-person evaluation, the practitioner/ AHP shall complete the following:
      i. Work with the patient and staff to identify ways to help the patient regain control

ii. **Reviews and revises (if required) the patient's plan of care, treatment, and services as needed**

iii. **If necessary, the practitioner provides a new written order and documents**

1. **The immediate situation**
2. **The patient's reaction to the intervention**
3. **Patient's medical and behavioral condition**
4. **Need to continue or discontinue the restraint or seclusion**

~~If the First hour face-to-face evaluation is conducted by a qualified PA, the attending practitioner who is responsible for the care of the patient shall be consulted within one hour after completion of the evaluation.~~

e. **If a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the Physician or AHP responsible for the care of the patient must see and assess the patient before writing a new order for the continued use of restraint or seclusion.**

~~b.~~

~~4. Telephone and written orders for restraint and seclusion are limited to the following:~~
~~a. 4 hours for patients ages 18 and older~~
~~b. 2 hours for children and youth ages 9 to 17~~
~~c. 1 hour for children under age 9~~

~~5. Orders for restraint or seclusion are not written as a standing order or on an as needed basis (that is, PRN).~~

~~6. When restraint or seclusion is terminated before the time-limited order expires, the original order cannot be used to reapply the restraint or seclusion if the patient is at imminent risk or physically harming themselves or others, and non-physical interventions are not effective.~~
~~a. Each application of restraint must be considered a separate episode in which all assessment and documentation procedures are applied.~~

~~7. If restraint or seclusion needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee.~~

~~8. Orders for violent/self-destructive restraint and/or seclusion must include: restraint and/or seclusion start and end time, action justifying restraint, type of restraint, criteria for release, and location of restraints.~~

~~G.~~J. INITIATION and DOCUMENTATION:

~~1. The practitioner primarily responsible for the patient's ongoing care, treatment, and services, or his or her designee or a qualified Physician's Assistant (PA), evaluates the patient in person within 1 hour of the initiation of restraint or seclusion.~~

~~2. At the time of the in-person evaluation, the practitioner/ PA does the following:~~
~~a. Works with the patient and staff to identify ways to help the patient regain control~~
~~b. Revises the patient's plan of care, treatment, and services as needed~~
~~i. If necessary, the practitioner provides a new written order and documents~~
~~ii. The immediate situation~~
~~iii. The patient's reaction to the intervention~~
~~iv. The patient's medical and behavioral condition~~
~~v. The need to continue or discontinue the restraint or seclusion.~~
~~c. If the First hour face-to-face evaluation is conducted by a qualified PA, the attending practitioner who is responsible for the care of the patient shall be consulted within one hour after completion of the evaluation.~~
~~d. Another one-hour face-to-face patient evaluation is not required when the original order is renewed.~~

~~3.~~1. Alternatives and nonphysical interventions including redirecting the patient's focus or employing verbal de-escalation should be attempted prior to initiating restraints/seclusion. Refer to **The Alternatives to Restraints.** ~~examples of alternative interventions on Appendix A.~~

~~4.~~2. If alternatives and non-physical interventions are not effective, the least restrictive restraint shall be used in order from least to most restrictive based on the assessment of the RN.

3. The RN is responsible for assessing the patient before restraint **or seclusion** use is initiated. **The assessment shall include but is not limited to monitoring:**
   - a. **The physical and psychological well-being of the patient (this information may be obtained from reviewing the patient's history)**
   - b. **Respiratory and circulatory status**
   - c. **Skin integrity**
   - d. **Vital signs**
   - ~~a.~~e. **Hospital policies, procedures, and/or practices associated with the 1-hour face-to-face evaluation**

~~5.~~4. The RN shall document initiation of restraint in the **electronic health record EHR** ~~medical record on the appropriate restraint electronic form~~. The following shall be documented:
   - a. **Initiation Date and Time**
   - b. **Behavior requiring restraint**
   - c. **Type of restraint i.e., leather limb, chemical , seclusion, immobilizer (vest) etc.**
     - i. **A dynamic group must be initiated for each restraint type**
   - d. **Location of restraint i.e., left or right upper or lower extremity, torso**
   - e. **Alternatives implemented for violent restraints**
   - f. **Education provided to patient/family education**
   - g. **Presence of a patient safety attendant (sitter, Patient Safety Technician), if applicable**
   - h. **Restraint Discontinue (DC) Readiness Attempts**
   - i. **Restraint Debriefing with Patient**
   - ~~a. Restraint reason i.e., Violent/Self-Destructive Behavior Restraint~~
   - ~~b. Restraint Initiation Date and Time~~
   - ~~c. Type of Restraint: Locked device/Hard Restraints, Physical Hold~~
   - ~~d. Restraint Location: i.e. left or right upper or lower extremity~~
   - ~~e. Action justifying use of Restraint~~
   - ~~f. Description of other behavior requiring restraint~~
   - ~~g. Pre-restraint alternatives attempted~~
   - ~~h. Effectiveness of Pre-restraint alternatives~~
   - ~~i. Education provided to patient/family education~~
   - ~~j. Patient's rights denied~~

~~H.~~K. ONGOING MONITORING and DOCUMENTATION:

~~1. Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:~~
   - ~~a. 4 hours for adults 18 years of age or older;~~
   - ~~b. 2 hours for children and adolescents 9 to 17 years of age; or~~
   - ~~c. 1 hour for children under 9 years of age~~

~~2. If a patient remains in restraint or seclusion for the management of violent or self-destructive behavior 24 hours after the original order, the practitioner who is responsible for the care of the patient must conduct a face-to-face patient evaluation before writing a new order for the continued use of restraint or seclusion.~~

~~3. If the patient's practitioner, or his or her designee, is not the practitioner who gives the order, the patient's practitioner is notified of the patient's status if the restraint or seclusion is continued. Patients in restraint and seclusion shall be monitored continuously by in-person observation by an assigned staff member who is competent and trained.~~

~~4. An individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the patient's condition or wishes.~~

1. A trained and competent RN **must** assess ~~es~~ the patient every 15 minutes while the patient is in restraint or seclusion for:

a. ~~s~~**S**igns of any injury associated with applying restraint or seclusion
b. ~~,n~~**N**utrition and hydration
c. ~~,s~~**S**kin **and** /circulation
d. ~~and r~~**R**ange of motion **(ROM)** in extremities (release one restraint at a time, beginning with the ankles)
i. Regular ROM exercise of at least ten (10) minutes every two (2) hours shall be provided to restrained patients. When ROM is contraindicated, a physician or a psychologist shall document the reason in the patient's record
e. ~~,h~~**H**ygiene and elimination
f. ~~,p~~**P**hysical and psychological status
g. ~~and c~~**C**omfort
h. ~~and r~~**R**eadiness for discontinuation of restraint to ensure the release at the earliest possible time.
~~a.~~**i.** -Vital signs will be monitored every 15 minutes~~,~~ or as clinically indicated. ~~The RN documents the assessment in the medical record on the appropriate restraint electronic form or paper restraint flowsheet.~~
i. **When** ~~In some cases,~~ vital signs taken every 15 minutes ~~may be excessive or~~ **are** disruptive to patient care, ~~,d~~**D**ocument a valid rationale for the decision regarding vital signs not assessed every 15 minutes **in the EHR** ~~**medical record.**~~

2. The staff helps patients meet behavioral criteria for discontinuing restraint or seclusion.
~~5.~~**3. Document every 15-minute assessments and vital signs in the EHR**~~**medical record.**~~

~~I.~~L. DEBRIEFING:

1. The patient and, if appropriate, the patient's family shall participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion. The debriefing shall:
   a. Occur as soon as possible and appropriate but no longer than 24 hours after the episode.
   b. Identify what led to the incident.
   c. Ascertain that the patient's physical well-being, psychological comfort, and right to privacy were addressed.
   d. Counsel the patient for any trauma that may have resulted from the incident.
   e. Result in modification of the patient's plan of care, treatment, and services if indicated.
   ~~e.~~**f. Document the debriefing in the EHR**~~**medical record.**~~

~~J.~~M. COMPETENCY AND EDUCATION:

1. All direct patient care staff in keeping with their scope of practice, shall be assessed for competence before participating in the application and monitoring of behavioral restraint/seclusion, and shall undergo education and training in the proper and safe use of restraint/seclusion during initial orientation and annually thereafter.
2. Training requirements include but are not limited to:
   a. The determination of -who has authority to:
   i. ~~o~~**O**rder restraint and seclusion
   ii. Initiate the use of restraint or seclusion
   ~~ii.~~**iii.** ~~The determination of who has authority to d~~**Continue or d**iscontinue the use of restraint or seclusion
   ~~iii.~~**iv. Circumstances under which restraint or seclusion is discontinued** ~~The determination of who can initiate the use of restraint or seclusion~~
   b. Identify patient's immediate situation requiring restraint or seclusion
   ~~The circumstances under which restraint or seclusion is discontinued~~
   ~~b. The requirement that restraint or seclusion is discontinued~~
   c. ~~A.~~**The** definition of:

i. ~~r~~Restraints
ii. ~~A definition of s~~Seclusion
iii. **Use of nonphysical interventions: choosing least restrictive interventions based on individualized assessment of patient's medical or behavioral status/condition**
~~ii.~~**iv. Types of restraints**

d. Safe application and use of all types of restraint/seclusion
e. How to recognize and respond to signs of distress
f. Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
~~e.~~**g.** ~~A definition or description~~**Describes** ~~of~~ what constitutes the use of medications as a restraint
~~d.~~**h.** **Knows**~~A determination of~~ who can assess and monitor patients in restraints or seclusion
i. Time frames for assessing and monitoring patients in restraints or seclusion
~~e.~~**j. Monitoring patient's reaction(s) to restraint or seclusion initiation**

3. Agency or other temporary staff who work in direct patient care roles shall be given a self-learning module to complete before participating in the application or monitoring process of restraint or seclusion.

~~3.~~**4.** In addition, there shall be a qualified staff member assigned as a resource, when the initiation of restraint is necessary on an assigned patient to ensure that the proper safety procedures, orders and monitoring are implemented. **Clinical identification of specific behavioral changes that indicate restraint/seclusion is no longer necessary.**

~~4. Practitioners shall be educated in the use of restraint.~~

~~K.~~N. STAFFING:

1. Staff assignments shall be based on qualifications, physical design of the environment, patient diagnosis, concurrent conditions, patient acuity, age, and developmental functioning of the patient. ~~These elements shall be addressed in the staffing mix of the unit.~~

~~L.~~O. DISCONTINUATION/DOCUMENTATION:

1. As early as feasible in the restraint or seclusion process, the patient is made aware of the rationale for restraint or seclusion and the behavioral criteria for discontinuation.
2. When the patient meets **their** ~~his or her~~ behavioral criteria for restraint discontinuation, all ~~four~~ restraints shall be released at the same time.
3. Restraint or seclusion is discontinued ~~at~~**s the earliest possible time, regardless of the length of time identified in the order.**
~~3.~~**4. Staff will use identified** ~~soon as the~~ **behavioral criteria to assist with determining when** ~~patient meets his or her~~ behavioral criteria **is met.**~~.~~
~~4.~~**5.** Document discontinuation of restraint in the **EHR**~~medical record~~ on the appropriate restraint electronic form or paper restraint flowsheet.
~~5.~~**6.** Document **the patient was re-educated on their rights and the plan of care.** ~~patient's rights restored~~

~~M.~~P. PATIENT/FAMILY EDUCATION:

1. The following education shall be provided to the patient and his/her family (with patient consent):
   a. Clinical reason for restraint
   b. Purpose and use of restraint
   c. Monitoring and care that shall be provided to patient
   d. Criteria necessary for termination of restraint
   e. Any other information necessary to assure the safety and comfort, dignity, preservation of rights and well-being of the patient
2. Document education provided in the EHR~~medical record~~

~~2.~~**3.** In cases in which the patient has consented to have the family kept informed about his or her care, treatment, and services and the family has agreed to be notified, staff attempts to contact the family promptly to notify them of the restraint or seclusion episode. **Document the attempts and the notification in the EHR~~medical record~~.**

~~N.~~**Q. PLAN OF CARE:**

1. The plan of care will be modified according to the use and discontinuation of restraints.

~~O.~~**R. NOTIFICATION:**

1. The hospital shall report required information to Centers for Medicare and Medicaid Services (CMS) per **regulations related to the reporting and record keeping for deaths associated with restraints or seclusion** ~~regulations.~~ See the examples below:
   a. Each death that occurs while a patient is in restraint or seclusion
   b. Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion. **Excluding the removal of soft wrist restraints**
   c. Each death known to the hospital that occurs within one week after restraint or seclusion was used.
2. Regulatory Compliance shall document **notification of CMS** in the patient's **EHR**~~medical record the date and time the death was reported to CMS~~.

~~P.~~**S. PERFORMANCE IMPROVEMENT:**

1. Data shall be collected on all occurrences of restraints and seclusion and submitted to the Restraint Committee and reviewed by the Regulatory Compliance Committee to identify opportunities to maintain patient safety, reduce restraint use and to identify opportunities for performance improvement
2. Performance improvement seeks to identify opportunities to introduce preventive strategies, alternatives to use, and process improvements that reduce ~~the~~ **potential and actual** risks associated with restraint use.

~~Q.~~**T. RELATED DOCUMENT(S):**

1. Alternatives to Restraint
2. Restraint Education/Competency for Violent/Self-Destructive Behavior

~~R.~~**U. REFERENCE(S):**

1. California Code of Regulations. Title XXII.**§77103**
2. Department of Health and Human Services. ~~Federal~~ **Code of Federal Regulations 42**~~registry~~ **482.13** ~~part IV.~~ Centers for Medicare and Medicaid Services (CMS) **Conditions of Participation: Patient Rights**~~42CFR part 482~~. **(September 2022)**
3. Joint Commission (20**22)**~~15)~~. Hospital accreditation standards. Retrieved from http://www.jointcommission.org

Tri-City Medical Center
Oceanside, California

ALTERNATIVES TO RESTRAINT

A. Alternatives to restraints should include less restrictive interventions that may prevent the us of restraint.
B. Document in the medical record all alternatives to restraints implemented or attempted prior to the application of restraint.
C. Categories of Alternatives to Restraint and Seclusion interventions or activities include but are not limited to the following:
    - Change or eliminate treatment
    - Toileting/ Nutrition
    - Decrease line(s) and tube(s) visibility
    - Diversional activities
    - Environmental changes
    - Manage pain
    - Place patient in a room close proximity to nursing statin
    - 1-on- companionship (Sitter)
    - Medications that will not restrict patient's ability to participate in their care or restrict their ability to move
D. Detail examples of alternatives to restraints include but are not limited to the following:

Psychosocial Alternatives	Environmental Alternatives	Physiological Alternatives
Watching or listen to the TV, soothing music,	Commode at bedside	Toileting, frequently offer assistance with toileting needs
Family interaction	Decrease noise	Address hygiene needs and comfort measures
Orientation today, time and place	Music/ TV	Fluids / nutrition / snack
Pastoral visit	Night light	Positional devices
Reassurance	Room close to nurses' station	Pain intervention
Reading – books, newspaper,	Call light within reach	Assisted ambulation
Relaxation techniques	Place personal items within reach	Re-positioning
Interpreter services	Keep bed in low position and locked in place	Rest / sleep; decrease interruptions, allow patient to nap
Quiet area	Sensory aids available (glasses, hearing aid)	Providing assistance with ADLs
One-on-one discussion	Decrease stimulation	Additional warmth, provide blankets
Encourage verbalization of feelings	Providing quiet area	Room temperature at comfort level
Validate patient's feelings	Physical activity	Check lab values
Respect patient's need for personal space	Orientation to surroundings	Pharmacy consult
Decreased stimulation		Encourage patient to participate in care
Change in environment		
Re-establishing communication		
Setting limits		
Use de-escalation and verbal		

redirection techniques		

A. Psychosocial Alternatives

- Diversion activities such as: TV, soothing music, books, or folding washcloths
- Family interaction
- Orientation today, time and place
- Pastoral visit
- Reassurance
- Reading
- Relaxation techniques
- Interpreter services
- Quiet area
- One-on-one discussion
- Encourage verbalization of feelings
- Validate patient's feelings
- Respect patient's need for personal space
- Decreased stimulation
- Change in environment
- Re-establishing communication
- Setting limits
- Use de-escalation and verbal redirection techniques
- Sitter

B. Environmental Alternatives

- Commode at bedside
- Decreased noise
- Music/ TV
- Night light
- Room close to nursing station
- Call light within reach
- Place personal items within reach
- Keep in low position and locked in place
- Sensory aids available (glasses, hearing aid)
- Decreases stimulation
- Providing quiet area
- Physical activity
- Orientation to surroundings

C. Physiological Alternatives

- Toileting
- Address hygiene needs and comfort measures
- Fluids/nutrition/snack
- Positional devices
- Pain intervention
- Assisted ambulation
- Re-positioning
- Rest/sleep
- Providing assistance
- Additional warmth
- Room temperature at comfort level
- Check lab values

Pharmacy consult

Tri-City Medical Center
Oceanside, California

Restraint Education/ Competency
Based Upon Scope of Practice

	Restraints for Violent/Self-Destructive Behavior						
	Registered Nurse (RN)	Licensed Vocational Nurse	CNA / NA / ACT / ~~MHW~~ MHW / RT / PST	Security	Behavioral Health Liaison	Qualified / ~~s~~Specially Trained RN ~~trained RN~~	Regulatory
Pre-Restraint Alternatives	✓	✓	✓			✓	
Initiation	✓					✓	
Orders	✓					✓	
Ongoing Monitoring	✓	✓	✓			✓	
Observation	✓	✓	✓	✓	✓	✓	
Patient Care	✓	✓	✓			✓	
Vital Signs	✓	✓	✓ (except PST)			✓	
Assessment/Reassessment	✓					✓	
Discontinuation	✓					✓	
Documentation (PIRP, Careplan)	✓					✓	
Release and/or Re-secure	✓	✓	✓	✓		✓	
Complete ~~1 hour~~**1-hour** face-to-face evaluation						✓	
Debriefing	✓			✓	✓	✓	
Report restraint related death to CMS							✓
Document CMS notification in Patient's medical record							✓

✓= Required for scope of practice
ACT = Advanced Care Technician
CNA = Certified Nurse Assistant
MHW = Mental Health Worker
NA = Nurses Assistant
PST = Patient Safety Technician
RT = Respiratory Therapy

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**SIEMENS RAPIDPOINT ® 500**
Purpose:	The analysis of blood gases, electrolytes, ionized calcium, glucose, and hematocrit.
Supportive Data:	Siemens RAPIDPoint ® 500 Operator's Guide
Equipment:	RAPIDPoint ® 500 Analyzer
Authorized to Perform Procedure:	Registered Nurse (RN), Respiratory Care Practitioner (RCP), Perfusionist, Anesthesia Technician, Clinical Laboratory Scientist (CLS)
NOTE:	For more detailed information regarding technology, reagents, calibration points, etc., please refer to the laboratory and/or manufacturer's user manual.

A. **PRINCIPLE:**

1. The RAPIDPoint ® 500 system uses potentiometry, amperometry, and conductance to measure the concentration of analyte in the sample. An electrochemical interaction between the analyte of interest and the sensor generates an electrochemical signal that is proportional to the amount of analyte in the sample. Potentiometry is the technology that measures the difference/ potential between two electrodes in a solution without applied current. Amperometry involves applying voltage to an electrode and then measuring the current generated. Conductance is the readiness with which a conducting substance transmits electrical current.

B. **CLINICAL SIGNIFICANCE:**

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
SODIUM	Dehydration Diabetes insipidus Salt poisoning Skin losses Hyperaldosteronism CNS disorders	Dilutional hyponatremia (cirrhosis) Depletional hyponatremia Syndrome of inappropriate ADH
POTASSIUM	Renal glomerular disease Adrenocortical insufficiency Diabetic Ketoacidosis (DKA) Sepsis In vitro hemolysis	Renal tubular disease Hyperaldosteronism Treatment of DKA Hyperinsulinism Metabolic alkalosis Diuretic therapy
CHLORIDE	Prolonged diarrhea Renal tubular disease Hyperparathyroidism Dehydration	Prolonged vomiting Burns Salt-losing renal disease Overhydration Thiazide therapy
IONIZED CALCIUM	Dehydration Hyperparathyroidism Malignancies Immobilization Thiazide diuretics Vitamin D intoxication	Hypoparathyroidism Early neonatal hypocalcemia Chronic renal disease Pancreatitis Massive blood transfusions Severe malnutrition
GLUCOSE	Diabetes mellitus Pancreatitis	Insulinoma Adrenocortical insufficiency Hypopituitarism

Patient Care Services Content Review	Clinical Policies & Procedures Committee	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/09, 05/15, 04/18, 06/20, **07/22**	07/11, 05/15, 05/18, 07/20, **08/22**	08/11, 05/15, 05/18, 08/20, **09/22**	03/16, 06/18, 09/20, **09/22**	n/a	10/11, 04/16, 06/18, 09/20, **10/22**	10/20, **12/22**	11/11, 05/16, 07/18, n/a	11/11, 05/16, 07/18, 11/20

ANALYTE	Some Causes of Increased Values	Some Causes of Decreased Values
GLUCOSE	Endocrine disorders (e.g. Cushing's syndrome) Drugs (e.g. steroids, thyrotoxicosis) Chronic renal failure Stress IV glucose infusion	Liver disease Ethanol ingestion Reactive hypoglycemia Glycogen storage disease
pH	Respiratory alkalosis Metabolic alkalosis	Respiratory acidosis Metabolic acidosis
PCO_2	Acute Respiratory Acidosis: • Depression of respiratory center • Suppressed neuromuscular system • Pulmonary disorders • Inadequate mechanical ventilation Chronic respiratory acidosis • Decreased alveolar ventilation • Hypoventilation Compensation in metabolic alkalosis	Respiratory alkalosis: • Increased stimulation of respiratory center • Hypermetabolic states • Mechanical hyperventilation Compensation in metabolic acidosis
PO_2	Breathing oxygen-enriched air	Carbon-monoxide exposure Pulmonary disorders Myocardial infarction Congestive heart failure
HCO_3	Primary metabolic alkalosis Compensation in respiratory acidosis	Primary metabolic acidosis Compensation in respiratory alkalosis
HEMATOCRIT	Dehydration Burns Impaired ventilation Renal disorders	Hemolytic anemias Iron deficiency Marrow depression Blood loss

C. **SPECIMEN:**

1. Specimen Type:

Sample Type	Collection Device	Minimum Fill Volume	Preparation
Arterial blood	Syringe	200 microliters for 1.0 mL syringe 800 microliters for 3.0 mL syringe 1.5 mL for 5.0 ml syringe	Expel air from the syringe and cap it immediately after obtaining the sample.
Venous blood			
Capillary blood	Capillary tube	175 microliters balanced heparin tubes (Minimum is 100 microliters)	Fill the tube completely and cap it securely.

a. For whole blood samples, use syringe or capillary tube. For whole blood venous specimens submitted to the laboratory, use lithium heparin. If staff are analyzing samples for ionized calcium lithium heparin can be used.

b. Other anticoagulants, such as benzalkonium heparin, EDTA, citrate, oxalate, and fluoride significantly affect blood pH, sodium, potassium, chloride, and ionized calcium results.
c. Antimicrobial compounds such as silver sulfadiazine and chlorhexidine, which are found in some central venous catheters, significantly affect sodium results and may affect subsequent sample analyses. Do not collect venous samples for electrolytes analysis from a central venous catheter that contains silver sulfadiazine or chlorhexidine.
d. Staff can introduce samples into the RAPIDPoint ® 500 system using the sample collection devices listed in the previous table.

2. Specimen Handling:
a. Position any labels toward the back of the syringe barrel near the plunger so the label does not block the syringe from entering the system and cause it to fall off.
b. Cap the sample device immediately after collection to avoid room air contamination.
c. Analyze the sample as soon as possible to minimize oxygen consumption.
d. Before analysis, roll the syringe or capillary tube between palms and gently invert it several times to mix the sample thoroughly. Blood cells settle during storage, and if the sample is not well mixed before analysis, the Hematocrit results obtained can be falsely decreased or increased. Mix all samples using a consistent technique. Ensure there are no air bubbles in the syringe after mixing.
e. Dispose of used sample devices in a biohazard contamination bag.

3. Known Interfering Substances:
a. Always select the mixed venous sample button to analyze mixed venous samples. Samples collected from some pulmonary artery catheters can contain the benzalkonium ion that interferes with analysis and affects results.

Analyte	Interfering Substance	Concentration Tested	Level of Interference
Ionized Calcium	Salicylic Acid	50 mg/dL 30 mg/dL	.098 mM (6%) .046 mM (3%)
Sodium	Dobutamine Benzalkonium Heparin Heparin Leo	5 mg/dL n/a 800-850 U/mL	6 mmol/L >50 mM -12.6 mM
Chloride	Salicylic Acid	50 mg/dL 20 mg/dL	9.5 mmol/L 1.8 mmol/L
Hematocrit	Dextran Leukocytes Protein Protein	3 g/dL 60,000 WBC cu/mm 12% 4%	5% 10% 4.9% -1.3%
Potassium	Benzalkonium Heparin		>0.15 mM

D. **REAGENTS/SUPPLIES:**
1. RAPIDPoint® 405/500 Systems Measurement Cartridge
2. RAPIDPoint® 405/500 Systems Wash/Waste Cartridge
3. RAPIDSystems™ AutomaticQC Cartridge
4. Syringe/ Capillary Tube

E. **CALIBRATION:**
5. The system performs calibrations automatically at prescribed intervals and with each sample if necessary.
6. The system automatically calibrates the sensors as follows:

a. One-point calibrations are scheduled to occur regularly at 30-minute intervals between calibrations.
b. Every fourth scheduled calibration is a two-point calibration.

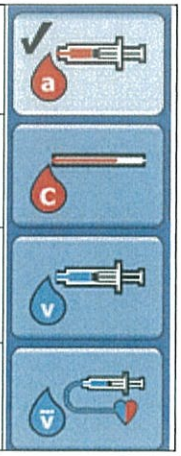
7. No operator action is required for calibration. If necessary, the system can defer a calibration to analyze a sample. In this case the message informing staff that the system is busy contains a STAT button that lets staff interrupt the calibration. However, if the maximum time between automatic calibrations has elapsed, the system must complete the calibration before allowing sample analysis.
8. During calibration, if the system detects a problem for a parameter, the system repeats the calibration for as many as two times. The Additional Cal Required message appears on the printed report and in the events log. If the calibrations are not successful, the system turns the parameter off. Staff can continue to obtain results for the other parameters. However, staff must wait for the parameter to pass the next calibration to obtain results for the parameter the system turned off.
9. The system performs additional calibrations during sample analysis for the first four hours after staff installs a new measurement cartridge. These calibrations ensure that the cartridge is ready for sample analysis. When these additional calibrations are required, sample results do not update during analysis, analysis time is prolonged due to additional calibration.

F. **QUALITY CONTROL:**

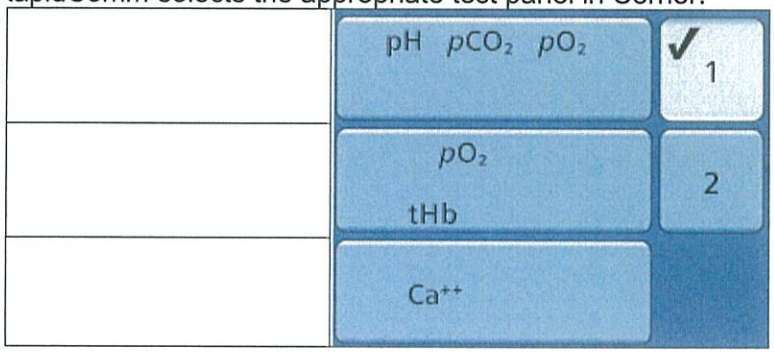
1. The Automatic QC (AQC) analysis option performs quality control analysis at the scheduled time and for the scheduled level. The cartridge contains all the levels of QC material needed to monitor system performance without operator intervention.
10. During AQC analysis, the system compares the results to the ranges for each parameter and identifies any results that are out of range. Any parameters that fail QC are turned off. The system repeats QC analysis if the first attempt fails and turns on any failed parameters that pass. Any parameters that fail the second QC analysis are turned off.
11. The system allows staff to analyze a sample from the AQC cartridge in addition to the scheduled AQC. When staff analyze an AQC sample, the results can affect parameter status. The system turns failed parameters on that pass QC analysis for the failed level and turns parameters off that do not pass QC analysis.
12. The system automatically sends the QC results to the RapidComm data management system. This is to be reviewed periodically by approved Laboratory personnel.
13. Staff can interrupt AQC between levels if an urgent patient sample needs to be analyzed. Touch STAT on the AQC Results screen to delay analysis of the next level of QC material. When the system is ready, analyze the patient sample. The system analyzes any remaining levels of QC after staff finish.

G. **PROCEDURE:**

14. Analyzing Patient Samples:
    a. Roll the syringe or the capillary tube between palms and gently invert it several times to mix the sample thoroughly.
    b. Touch the button for the patient SAMPLE TYPE. A checkmark indicates the button is selected. (Default is arterial syringe).

i.	Arterial (syringe)	
ii.	Capillary (175 microliters Cap tube)	
iii.	Venous (syringe)	
iv.	Mixed venous blood (this will only do a pO2)	

c. Touch (select) the panel of choice to perform testing. This is important so that RapidComm selects the appropriate test panel in Cerner.



d. Introduce the sample device into the sample port and touch the START button. The system aspirates the sample.
   i. Arterial or Venous: Place the syringe into the sample port.
   ii. Capillary: Insert the Capillary tube into the sample port until it clicks into place.
e. When prompted, remove the sample device from the sample port and touch the CONTINUE button.
f. When prompted, enter the following demographic information.
   i. Touch the Patient ID field and key in the patient's FIN number (performed in ICU, ED, NICU, PACU and OR) or the patient's accession number (performed in Lab).
   ii. Touch the Patient Name field and key in the patient Last Name.
   iii. Touch the Temperature field and key in the patient's temperature
g. Touch the CONTINUE button.
h. View the results.
i. Touch the CONTINUE button when finished viewing results. The instrument will wash and prepare for the next sampling.

15. Recalling Patient Results: Use this procedure to view and print results for patient samples that have already been analyzed.
   a. Touch the Recall button. The recall button is the "File Folder" icon located in the upper right hand corner of the screen.
      i. Touch Patients: The list of patient samples appears.
      ii. Touch the desired sample to view.
      iii. Use the arrow keys to view additional samples. Select the sample.
      iv. Touch the Results button to view the results.
         1) Edit sample demographics by pressing the Edit button (for example, to change the temperature). If changed this will not be corrected in Cerner.

The results have already been filed. To correct this in the computer, notify the laboratory.

2) To reprint results, touch the Print icon.

v. Staff may search for a sample by patient by pressing the Search button.

1) Enter in the Accession or FIN number and touch the CONTINUE button.

16. Result Symbols:

↑	The result is above the patient range.
↓	The result is below the patient range.
-----↑	The result is above the reporting range. Send to Laboratory for analysis.
-----↓	The result is below the reporting range. Send to Laboratory for analysis.
-----?	The system has an atypical response when measuring this parameter and cannot report the result. Analyze the sample again. When this symbol appears for the HCT, it may indicate that the HCT result was not reported because Na failed Required QC or it was not performed
u	The HCT was not corrected for Na or K because the sensor is out of calibration, turned off, or beyond the reporting range. The system uses a default value of 140 mmol/L for Na or a value of 4 mmol/L for K to determine the HCT result.

H. **PROCEDURE NOTES:**

1. Status of Parameter Buttons:

✓pH	Parameters with checkmarks are selected (Touch to deselect test)
pH	This parameter is available but not selected.
~~pH~~	This parameter is not available because the sensor is out of calibration.
~~pH~~	This parameter is not available because the sensor is out of calibration and is unlikely to become available with further calibrations.
	YELLOW BUTTON: not available because the sensor has failed QC.
	PURPLE BUTTON: not available because Required QC was not performed.

2. Send specimen to the laboratory if staff has any questions concerning the operation or results of the RAPIDPoint ® 500.
3. Troubleshooting
   a. The system messages can appear as follows:
      i. Messages can appear in a message box over the Analysis screen or over the Status screen.
      ii. Messages can appear in the events log at the Status screen or in the events log that staff access from the Recall menu. For example, after staff replaces a depleted wash/waste cartridge, the message about the cartridge no longer appears at the Status screen but remains in the events log that staff access from the Recall menu.
      iii. Refer to the Troubleshooting Section of the Siemens RAPIDPoint ® 500 Operator's Guide for the list of system diagnostic messages, its probable cause

and corresponding corrective action to be performed. If further help is required, call POC Coordinator or the lab.

17. Maintenance
    a. Cleaning and Disinfecting the Screen: Clean the touch screen as needed to remove dust, dirt, or splatters from the screen and disinfect the screen surface.
        i. Materials:
            1) Hospital-approved disinfectant wipe
            2) Lint-free cloth
        ii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
        iii. Touch the Status button and then touch Clean Screen. The Clean screen appears for 20 seconds. This allows staff to wipe the screen without activating any buttons. While the Clean Screen is displayed, wipe the screen with the wet wipe and then thoroughly dry the screen with the lint-free cloth to remove chemicals that may damage the screen.
        iv. Touch the Continue button to return to the Analysis screen.
    b. Cleaning and Disinfecting the Exterior Surfaces: Clean the exterior surfaces as needed to remove dust, dirt, and splatter from the surfaces, and disinfect the surfaces.
        i. Materials:
            1) Bleach disinfectant wipe
            2) Alcohol Pad
        ii. Caution: Do not wet the sample port or the sensor contacts for the measurement and Automatic QC cartridges. When cleaning surfaces do not spray cleaning solution or other fluids into or on the sample port or the area behind the cartridges. The sensor contacts, which are located behind the cartridges, may be damaged if they get wet. Sensors inside the cartridge may be damaged if cleaning solution enters the sample port.
        iii. If necessary, wring any excess liquid from the wipe so it is wet but not dripping.
        iv. To disinfect the exterior surfaces: wipe, let remain wet for two minutes, then dry with a lint-free cloth.
    c. Replacing the Printer Paper: Replace the printer paper when a pink stripe appears on the edge of the paper.
        i. Material:
            1) Printer paper
        ii. Grasp the latch on top of the touch screen and move the screen forward to expose the printer compartment.
        iii. Remove the old roll of paper:
            1) Open the printer compartment.
            2) If paper remains in the printer, tear off the paper below the printer. Caution: Do not pull the torn paper back through the printer. This can damage the printing mechanism.
            3) Turn the paper-advance knob clockwise to move the torn paper through the printer.
            4) Remove the old roll of paper.
            5) Save the spindle for use with the new roll of paper.
        iv. Install a new roll of paper:
            1) Note: When advancing the paper, watch the paper move through the printer to ensure that it exits the printer correctly.
            2) Get a new roll of paper and remove the outer wrapper.
            3) Insert the spindle through the roll of paper and place the paper in the printer compartment. Ensure that the paper is tightly wound and the ends of the spindle fit into the grooves on the sides of the compartment.
            4) Insert the paper from the bottom of the roll through the back of the printer. The system advances the paper automatically if the previous roll of paper was empty.

5) Turn the paper-advance knob clockwise to move 2-3 inches of paper through the top of the printer.
6) Note: When closing the printer compartment, ensure that the edge of the printer paper extends beyond the top of the printer.
7) Close the printer compartment.
8) Note: The first report printed after installing a new roll of paper does not have the Rapidpoint 500 name printed at the top.
9) Adjust the position of the screen for viewing.

d. Replacing the Air Filter
   i. Pull the air filter carrier out of the instrument (located on the bottom back right of the instrument).
   ii. Remove the filter from the carrier.
   iii. Install a new air filter in the carrier.
   iv. Reinstall the air filter carrier in the instrument.

G. **DOWNTIME**: N/A

H. **CALCULATIONS:**

1. The RAPIDPoint ® 500 analyzer contains a microprocessor that performs all calculations required for reporting results.

I. **AMR, CRR, REFERENCE RANGES, AND CRITICAL VALUES:**

1. Refer to Patient Care Services POC Quick Reference for AMR and Reference Ranges
2. Refer to Critical Tests and Critical Results Quick Reference Guide for Critical Results

J. **REPORTING OF RESULTS:**

1. Results coming from OR and PACU are automatically posted to Cerner thru RapidComm
2. Other location requires verification in RapidComm (Refer to RapidComm Instructions procedure)
   a. Open the RapidComm software to enter additional values (i.e. Draw Date & Time, Sample Site, Order Name, PCOM, FiO2/LPM, and Allen's Test).
   b. If there are critical results, results will be displayed in red font and the Notified and Read Back field should be completed with the person receiving the results and credentials (i.e. Jane D, RN or Dr. Doe, MD); the Notified and Confirmed by field should be completed with the operator giving the results and credentials (i.e. J Doe, RCP); and the Notified Time field should be completed.
   c. Once the results are reviewed, select OK for the results to record in Cerner.

K. **TECHNICAL NOTES:**

1. Refer to Appendix F: Principles of System Operation

L. **LIMITATIONS:**

1. Refer to Appendix E: Specifications section of the Siemens RAPIDPoint ® 500 Operator's Guide for the limitation of the system and each analytes.

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

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

1. **Laboratory Point of Care Procedure:** RapidComm Instructions ~~Procedure~~
2. **Laboratory Point of Care:** Patient Care Services POC Quick Reference

3. **Laboraotory General / Quality Assurance:** Critical Tests and Critical Results Quick Reference Guide
4. **Laboratory Point of Care:** Siemens RAPIDPoint ® 500 Operator's Guide

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

P. **REFERENCE(S):**

1. Siemens RAPIDPoint® 500 System Operator's Guide 10631336 Rev. C, 2019-10

CRITICAL TESTS AND CRITICAL RESULTS QUICK REFERENCE GUIDE

Critical Tests 1
Chemistry 1
Infectious Diseases 2
Hematology/Coagulation/Urinalysis 2
Point of Care 2
Microbiology 3

Critical Tests

Fetal Fibronectin (FFN)
Frozen Section
Protime and PTT (Stroke Code)
STAT Gram Stain for ED

Chemistry

CHEMISTRY	Units	Low	High
Acetaminophen	mcg/mL	--	>100
Amikacin, Trough	mcg/mL	--	>10
Amikacin, Rn & Peak	mcg/mL	--	>35
Bilirubin, Direct (0-5 dys)	mg/dL	--	>1.8
Bilirubin, Total (0-15 hrs)	mg/dL	--	>7.0
Bilirubin, Total (15-19 hrs)	mg/dL	--	>7.2
Bilirubin, Total (19-23 hrs)	mg/dL	--	>7.4
Bilirubin, Total (23-27 hrs)	mg/dL	--	>7.7
Bilirubin, Total (27-31 hrs)	mg/dL	--	>9.0
Bilirubin, Total (31-35 hrs)	mg/dL	--	>10.0
Bilirubin, Total (35-39 hrs)	mg/dL	--	>11.0
Bilirubin, Total (39-43 hrs)	mg/dL	--	>12.2
Bilirubin, Total (43-47 hrs)	mg/dL	--	>12.5
Bilirubin, Total (47-51 hrs)	mg/dL	--	>13.1
Bilirubin, Total (51-55 hrs)	mg/dL	--	>13.8
Bilirubin, Total (55-59 hrs)	mg/dL	--	>14.5
Bilirubin, Total (59-63 hrs)	mg/dL	--	>15.2
Bilirubin, Total (63-67 hrs)	mg/dL	--	>15.4
Bilirubin, Total (67-71 hrs)	mg/dL	--	>15.7
Bilirubin, Total (71hrs–4d)	mg/dL	--	>16.0
Calcium (0-30 days old)	mg/dL	<8.0	>12.9
Calcium (>30 days old)	mg/dL	<6.1	>12.9
Carbamazepine	mcg/mL	--	>15.0
CO_2	mmol/L	<16	>44
Digoxin	mcg/mL	--	>2.0

CHEMISTRY	Units	Low	High
Ethanol Level	mg/dL	--	>300
Fetal Fibronectin	N/A	Negative	Positive
Gentamicin, Trough	mcg/mL	--	>2.0
Gentamicin, Rn & Peak	mcg/mL	--	>12.0
Glucose (age 0–2 days)	mg/dL	<30	>450
Glucose (age >2 days)	mg/dL	<40	>450
Glucose, CSF	mg/dL	<26	>449
Iron	mcg/dL	--	>300
Lactic Acid	mEq/L	--	>3.9
Lithium	mEq/L	--	>1.5
Magnesium	mg/dL	<1.1	>4.6
Magnesium (OB only)	mg/dL	<1.1	>6.9
Osmolarity, Serum	mOsm/kg	<250	>323
Phenytoin	mcg/mL	--	>25
Phosphate	mg/dL	<1.1	>9.9
Potassium (0days-6mo)	mEq/L	<2.9	>6.5
Potassium (>6 mo)	mEq/L	<2.9	>6.1
Salicylate	mg/dL	--	>50
Sodium	mEq/L	<121	>164
Troponin	ng/mL	--	>0.04
Valproic Acid	mcg/mL	--	>120
Vancomycin Tr (<30 days)	mcg/mL	--	>10
Vancomycin Tr (>30 days)	mcg/mL	--	>20
Vancomycin Rn & Peak	mcg/mL	--	>40

Infectious Diseases

INFECTIOUS DISEASE	Result
HIV 1/2 Antibody	Confirmed Reactive
Hepatitis B Surface Ag	Confirmed Reactive
Hepatitis B Core Ab IgM	Reactive
Hepatitis B Core Total Ab	Reactive
Hepatitis A Ab, IgM	Reactive
Hepatitis C Ab	Positive
RPR/Syphilis	Positive

Hematology/Coagulation/Urinalysis

HEMATOLOGY	Units	Low	High
Fibrinogen	mg/dL	<100	--
Hematocrit (0-9 yr)	%	<20	>64.5
Hematocrit (>10yr M)	%	<20	>63.5
Hematocrit (>10yr F)	%	<20	>60.0
Hemoglobin (0-24 mo)	g/dL	<7.0	>24.0
Hemoglobin (>25 mo)	g/dL	<7.0	>20.0
Platelet	$x10^3/\mu L$	<20	>1000
Protime	sec.	--	>42.9
PTT on Heparin	sec.	--	>199
PTT no Heparin	sec.	--	>80
Thrombin Time	sec.	--	>90
WBC	$x10^3/\mu L$	<2.0	>30.0

Differential Blood Smear	Result
Blasts on Blood Smear	Positive
Sickle Cells	Positive
Malaria Parasites or Other Blood Protozoans	Positive

Clinical Microscopy	Result
Pathogenic Crystals (Cysteine, Leucine, or Tyrosine) in Urine	Positive

Point of Care

RapidComm	Units	Low	High
VBG Calcium, Ionized	mg/dL	<3.1	>6.2
VBG CarboxyHgb	%	--	>14.0
VBG Chloride	mEq/L	<80	>120
VBG Glucose	mg/dL	<40	>450
VBG Potassium	mEq/L	<2.9	>6.5
VBG HCO_3	mEq/L	<12	>32
VBG Hct	%	<20	>60
VBG MetHgb	%	--	>3.0
VBG O_2 Sat	%	<70	--
VBG pCO_2	mmol/L	--	>56
VBG pH	--	<7.29	>7.56
VBG pO2	mmHg		
VBG Sodium	mEq/L	<125	>160
VBG THgb	g/dL	<7.0	>21.0

Arterial Blood Gas ADULTS	Units	Low	High
PaO2 mmHg	mmol/L	<55	--
PaCO2 mmHg	mmol/L	--	>56
pH	--	<7.29	>7.56
MetHb	%	--	>3.0
Carboxy Hgb	%	--	>14.0
Arterial Blood Gas NEONATAL / PEDIATRICS	**Units**	**Low**	**High**
PaO2 mmHg, arterial only	mmol/L	<50	--
PCO2 mmHg, arterial or capillary	mmol/L	<25	>65
pH, arterial or capillary	--	<7.25	>7.50

Microbiology

Cultures and Stains	Critical Result
Covid-19 Antigen (for pre-operative patients only)	Positive
Covid-19 Viral by PCR (for pre-operative patients only)	Positive
Gram Stain	STAT and ER Results
CSF, Blood Culture, Sterile Body Fluid, Tissue	Positive Gram Stain or Positive Culture
India Ink prep	Positive
Serum or CSF Cryptococcal antigen	Positive
Acid Fast Stain or Culture	Positive
Stool Culture	Positive for *Salmonella, Shigella, E. coli* 0157:H7, or *Camphylobacter*
Culture	Positive for *Neisseria Gonorrhoeae, Streptococcus* Group A
Culture	*Streptococcus* Group B isolated from women of childbearing age, pregnant women, and OB-GYN patients
Malaria smear	Positive
RSV, *Rotavirus, Chlamydia Legionella*	Positive
Amoebae from CSF direct wet mount	Positive
Clostridium difficile PCR	Positive
Organisms that would require the patient to be in isolation or under certain precautions	Positive for; i.e. Salmonella spp., Shigella spp., Vancomycin-resistant *Enterococcus faecalis* or *Enterococcus faecium*, methicillin-resistant *Staphylococcus aureus.* For all other organisms, only the Nursing Unit is notified.

Pharmacy: Extension 3012
Administrative Supervisor: Extension 7765 or 760-644-6968

PATIENT CARE SERVICES POC QUICK REFERENCE

Blood Gas – Siemens Rapidpoint 500

Analyte	Unit	Reference Range		Reportable Range	QC Range	CVM Range
		Arterial	Venous		Changes lot-to-lot are minor	
pH	--	7.35 - 7.45	7.31 – 7.41	6.50 – 7.80	7.12-7.49	6.68-7.73
PCO_2	mm/Hg	35 – 45	41 – 51	5-200	25-75	11-188
PO_2	mm/Hg	81 – 100		10 – 700	38-145	64-600
HCO_3	mmol/L	22 – 26	23 – 29			
BE	mmol/L	-2 – 3				
$ctCO_2$	mmol/L	24 – 31				
sO_2	%	94 – 100	55 – 85			
ctO_2	mL/dL	15 – 23				
MetHb	%	<1.4				
COHb	%	<2.9				
Sodium	mmol/L	135 – 153		100–200	119-162	105-180
Potassium	mmol/L	3.5 – 5.3		0.5-15.0	3.2-7.2	1.1-12.6
Chloride	mmol/L	98 – 107		65 – 140	78-121	65-137
Glucose	mg/dL	70 – 110		20 – 750	51-205	20-750
Ion-Calcium	mg/dL	4.5 – 4.9		0.80 – 20.0	3.2-6.7	1.8-13.0
Hb	g/dL	11 – 17		2 – 25	7.8-17.7	4.2-21.8
Hct	%	33 – 52				

A. Contact Info:
   1. Technical Support: 1-877-229-3711 #12 #2
   2. Customer Service: 1-800-255-3232 (Account number: 617988)

B. Cartridge Credit. Measurement and Automatic QC cartridges that fail prematurely can be submitted to Siemens for a full or partial refund.
   1. Measurement Cartridge:
      a. Emails are automatically sent to Siemens from the instrument each time the cartridge is replaced.
      b. Siemens will evaluate the trace log and process a cartridge replacement if needed. A cartridge replacement summary will be sent to the email programmed into the rapidpoint.
      c. Rapidpoint settings:
         i. Setup > Printers and Devices > Email Setup
         ii. Message to: cartcredit.healthcare@siemens.com
         iii. Message from: ortizrc@tcmc.com (or current POCC email address)
         iv. SMTP port: 25
         v. Autosend: checked
   2. Automatic QC Cartridge:
      a. Call Technical Support. Have the serial numbers ready. Relay the issues experienced. They will process the request and ship out a replacement

Urine Dipstik Clinitek Status+ Connect

Test	Abbreviation	Units	REFERENCE RANGES:	
			Normal	Abnormal
Glucose	GLU	mg/dL	Negative	100 500 250 ≥1000
Bilirubin	BIL		Negative	Small Moderate Large
Ketone	KET	mg/dL	Negative	Trace 80 15 ≥160 40
Specific Gravity	SG		≤ 1.005 1.020 1.010 1.025 1.015 1.030 ≥ 1.035	N/A
Blood	BLO		Negative	Trace Moderate Small Large
pH	pH		5.0 6.5 8.0 5.5 7.0 8.5 6.0 7.5 ≥9.0	N/A
Protein	PRO	mg/dL	Negative	Trace, 30, 100, ≥ 300
Urobilinogen	URO	E.U./dL	0.2 1.0	2.0 4.0 > 8.0
Nitrite	NIT		Negative	Positive
Leukocytes	LEU		Negative	Trace Moderate Small Large

A. Technical Assistance:
1. Siemens HealthCare Technical Care Center: 1-877-229-3711 Option 13; option 2

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

A. **POLICY:**

1. A Stroke Code shall be initiated if a patient presents to the Emergency Department (ED) experiencing "stroke-like" symptoms of less than twenty-four (24) hours duration.

B. **PROCEDURE:**

1. Stroke Code Activation:
   a. Patient with "stroke-like" symptoms who are in route to Tri-City Medical Center (TCMC) by Emergency Medical Service (EMS) providers will have a Stroke Code activated by the Mobile Intensive Care Nurse (MICN) prior to arrival by dialing 66 and notifying the operator.
      i. The MICN will notify the ANM/Charge RN as well as the ED Physician.
   b. Patients with "stroke-like" symptoms who present through triage should be immediately ~~placed in an emergency department bed~~**taken to the Pit Stop** and notify the ED ANM/Charge RN and ED physician.
      i. The Registered Nurse or Unit Secretary will activate a Stroke Code at the direction of the ED Physician by dialing 66 and notifying the operator.
   c. The operator will page the Stroke Team consisting of:
      i. Computed Tomography (CT) Technologist
      ii. Lab Phlebotomist
      iii. Stroke Coordinator
      iv. Radiology Technologist
      v. Lab Technologist
2. Notification of Neurologist:
   a. The Neurologist on call will be notified by the ED physician.
3. Initial Care of the Stroke Patient per physician orders:
   a. Initial care of the stroke patient should include immediate stabilization of the airway, breathing, and circulation (ABC's). This is quickly followed by an assessment using the National Institute Health Stroke Scale (NIHSS).
   b. The ED Physician serves as the Stroke Team Leader and is responsible for initial evaluation and stabilizing treatment, as well as determining eligibility for thrombolytics in collaboration with the Neurologist.
   c. Determine time of symptom onset.
      i. This is defined as when the patient was at his or her previous baseline or symptom-free state. For patients unable to provide this information or who awaken with stroke symptoms, the time of onset is defined as when the patient was last awake and symptom-free or known to be "normal".
   d. Obtain finger stick blood glucose.
      i. Notify ED physician of result.
   e. Initiate continuous cardiac monitoring

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

f. Monitor blood pressure every 15 minutes until thrombolytic eligibility is determined.
g. Obtain vital signs including: heart rate, blood pressure, respiratory rate, oxygen saturation, and estimated weight.
h. Obtain 12 lead Electrocardiogram (ECG).
i. Obtain Intravenous (IV) access.
   i. Place 18 or 20 gauge IV in antecubital (AC) or forearm.
j. Initiate supplemental oxygen as ordered.
k. Perform NIHSS assessment and Swallow Screen prior to any oral intake.
   i. Notify ED physician of results.

4. Time Parameter goal is to maintain the best practice times listed below per physician orders:
   a. Draw STAT labs to include prothrombin time (PT)/international normalized ratio (INR), partial thromboplastin time (PTT), Glucose, and Creatinine –complete within 45 minutes of arrival but not to delay **thrombolytic**~~tPA~~ administration.
      i. Draw labs prior to CT scan.
   b. Obtain STAT CT scan – completed within 25 minutes of arrival.
      i. The Emergency Department RN accompanies all Stroke Code patients to CT scan.
      ii. CT Technologist will notify Radiologist of the Stroke Code CT for STAT read.
      iii. Radiologist will notify the Emergency Department Physician of CT results within 20 minutes of completion.
   c. Obtain portable chest x-ray and ECG – complete within 45 minutes of arrival but not to delay Patients **thrombolytics**~~tPA~~ administration.
5. Care of the patients eligible for thrombolytics per physician orders:
   a. Continuous cardiac monitoring
   b. Place second peripheral IV.
   c. Place Foley Catheter prior to **thrombolytic**~~tPA~~ administration if ordered by the ED Physician.
   d. Monitor blood pressure Q 15 minutes.
      i. Acceptable blood pressure obtained prior to administration of tPA is a systolic blood pressure less than (<) 185 and diastolic blood pressure of less than (<) 110.
   e. If patient is eligible for **thrombolytic**~~tPA~~ treatment informed consent will be obtained by ED Physician and/or Neurologist.
      i. Signed consent is not required for administration of **thrombolytics**~~tPA~~.
6. Administer **thrombolytics**~~tPA~~ per physician order**, see Throbmolytic Administration Guidelines**:
   ~~a. Recommended TOTAL dose of tPA is 0.9 mg/kg, not to exceed 90 mg.~~
   ~~b. Reconstitute and administer tPA as follows:~~
      ~~i. Reconstitute tPA with 100 mL of sterile water for injection utilizing the transfer device to create a solution with a concentration of 1 mg/mL.~~
      ~~ii. With a second Registered Nurse, calculate the weight based dose of tPA.~~
      ~~iii. Remove from the vial any quantity drug in excess of that specified for patient treatment. , calculate the excess dose and discard 10 mL less than that dose. This will allow for the complete dose of tPA to be infused.~~
      ~~iv. Withdraw the bolus amount (bolus dose is 10% of total dose) and administer IVP over 1 minute.~~
      ~~Program the infusion pump to deliver the remaining dose over 60 minutes.~~
      ~~v. **Once the chamber is near empty, hang 50 ml normal saline and infuse at the same rate to ensure the patient receives the complete dose.**~~
      ~~vi. tPA must be double checked by two Registered Nurses and documented in the Medication Administration Record.~~
7. Monitoring During and Post Thrombolytic Administration:
   a. Continuous cardiac monitoring.
   b. Monitor blood pressure:

i. Every 15 minutes for 2 hours
ii. Then every 30 minutes for 6 hours
iii. Then every 1 hour for 16 hours.
iv. Notify ED Physician immediately for systolic blood pressure greater than (>) ~~185~~ **180** and/or diastolic blood pressure greater than (>) ~~110~~**105**.

c. Monitor neurological status every:
i. 15 minutes for 2 hours
ii. Then every 30 minutes for 6 hours
iii. Then every 1 hour for 16 hours.
iv. Neurological assessment should include: level of consciousness, orientation, response to commands, motor scoring of upper and lower extremities, language, dysarthria~~, and pupillary response.~~.
v. If the patient develops a severe headache, acute hypertension, nausea, vomiting or has worsening neurological examination notify ED Physician immediately.
vi. Monitor temperature and maintain normothermia.
vii. Monitor blood sugar and maintain euglycemia.

d. Continue monitoring patient upon transport and during diagnostic tests. If unable to perform assessment/vital signs during test, document reason and resume assessment/vital signs as soon as test is completed.
i. Note: most diagnostic areas have vital sign monitoring capability but staff may not be able to perform assessment during test

8. Care of the patients eligible for thrombectomy
a. Neurology and/ or ED Physician will discuss case with on call Interventional Radiologist
b. The Registered Nurse (RN), Unit Secretary, or designee will activate a Code Thrombectomy at the direction of the Interventional Radiologist and/or ED Physician by dialing 66 and notifying the operator.
c. The operator will page the Code Thrombectomy Team consisting of:
i. Administrative Supervisor
ii. Intensive Care Unit (ICU) Charge Nurse
iii. Stroke Coordinator
d. The operator will also call 5400 and notify Operating Room (OR) desk to gather their team (Anesthesiologist, Anesthesia Tech and OR RN). The OR desk will return a call to the private branch exchange (PBX) with OR team names and call response.
e. The operator will call the Interventional Radiology Team (RN, scrub tech, rad tech) as per the on-call schedule

9. Disposition of Stroke Patient:
a. Monitoring Post Thrombectomy without thrombolytics ~~(tPA)~~:
i. Continuous cardiac monitoring, vitals and groin checks:
1) Every fifteen (15) minutes for one (1) hour
2) Then every half (½) hour for (1) hour
3) Then every one (1) hour for four (4) hours
4) Then routine.
ii. NIHSS every one (1) hour for six (6) hours

b. Monitoring Post Thrombectomy with thrombolytics ~~(tPA)~~
i. Continuous cardiac monitoring
ii. Monitor blood pressure, VS and NIHSS:
1) Every fifteen (15) minutes for two (2) hours
2) Then every thirty (30) minutes for six (6) hours
3) Then every one (1) hour times sixteen (16) hours

c. Stroke patients who have received thrombolytics and/or Thrombectomy are admitted to the Intensive Care Unit
d. Stroke patients who do not meet the criteria for admission to the Intensive Care Unit should be admitted to 4 Pavilion or Telemetry.

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

1. **Thrombolytic Administration Guidelines**

~~C.~~D. **FORM(S):**

~~1. 24 hour tPA Flow Sheet. Form # 6010-1010 - Sample~~

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

1. ~~Guidelines for the early management of patients with acute ischemic stroke: a guideline for healthcare professionals from the American Heart Association/American Stroke Association. Stroke. Volume 49 (2018)~~ **Guidelines for the Early Management of Patients With Acute Ischemic Stroke: 2019 Update to the 2018 Guidelines for the Early Management of Acute Ischemic Stroke: A Guideline for Healthcare Professionals From the American Heart Association/American Stroke Association Powers, WJ, Rabinstein AA, Ackerson, T, Adeoye, OM et al. Originally published30 Oct 2019Stroke. 2019;50:e344–e418**
2. Thrombectomy 6 to 24 Hours after Stroke with a Mismatch between Deficit and Infarct. engl j med 378;1 nejm.org January 4, 2018

Thrombolytic Administration Guidelines

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

~~1.~~

24 hour tPA Flow Sheet. Form # 6010-1010 - SAMPLE

Score Table

Level of Consciousness
0=Alert 2=Obtunded
1=Drowsy 3=Coma/Unresponsive

Orientation Questions "What month"/"How old"
0=Answers both correctly
1=Answers one correctly
2=Answers neither correctly

Response to Commands
Open/Close eyes/makes fist
0=Performs both tasks correctly
1=Performs one tasks correctly
2=Performs neither task correctly

Language
0=Normal, no aphasia
1=Mild to moderate aphasia
2=Severe aphasia 3=Coma, mute

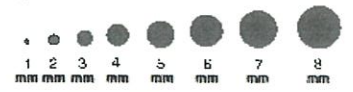
Motor Score-10 sec-arms, 5 sec-legs
0=No Drift 1=Drift
2=Some effort against gravity
3=No effort against gravity
4=No movement

Pupil Reaction
N-Non Reactive S-Sluggish
B-Brisk

Dysarthria
0=Normal articulation
1=Mild to moderate dysarthria
2=Severe dysarthria, coma

Pupil Assessment
Reaction to light: B=Brisk
F=Fixed S=Sluggish

Pupil size:



Abbreviated NIHSS	t-PA Start	15 min	30 min	45 min	1 hr	1 1/4 hr	1 1/2 hr	1 3/4 hr	2 hr	2 1/2 hr	3 hr	3 1/2 hr	4 hr	4 1/2 hr	5 hr	5 1/2 hr	6 hr	6 1/2 hr	7 hr	7 1/2 hr	8 hr	9 hr	10 hr	11 hr	12 hr	13 hr	14 hr	15 hr	16 hr	17 hr	18 hr	19 hr	20 hr	21 hr	22 hr	23 hr	24 hr
Time																																					
Systolic Blood Pressure																																					
Diastolic Blood Pressure																																					
Heart Rate																																					
Pupil Size: Right																																					
Pupil Size: Left																																					
Pupil Reaction: Right																																					
Pupil Reaction: Left																																					
Level of Consciousness																																					
Orientation Questions																																					
Response to Commands																																					
Motor Score Right Arm																																					
Left Arm																																					
Motor Score Right Leg																																					
Left Leg																																					
Language																																					
Dysarthria																																					
TOTAL SCORE																																					
*Groin site ✓ R/L/NA																																					
Initials																																					

DELETE

Affix Patient Label

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

Neuro checks and Vital Signs to be completed:
- 15 Minutes X 2 Hours
- 30 Minutes X 6 Hours
- 1 Hour X 16 Hours

6010-1010
(Rev 08/15)

24 Hour t-PA Flow Sheet

Permanent part of the record

Signature Date/Time Signature Date/Time

Signature Date/Time Signature Date/Time

Document any site abnormalities in the EHR

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**07/93**	**SUBJECT:**	**Swallowing, Food and Nutrition Considerations for Patients with Oro-Pharyngeal Dysphagia**
REVISION DATE~~(S)~~:	**06/03, 08/05, 07/07, 05/10, 05/13 01/17, 04/19**		

Patient Care Services Content Expert Approval:	**~~08/16~~08/22**
Clinical Policies & Procedures Committee Approval:	**~~02/19~~09/22**
Nursinge Leadership~~Executive Committee~~ Approval:	**~~03/19~~10/22**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/19~~10/22**
Administration Approval:	**~~04/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **POLICY:**

1. An order for thick liquids, thickened liquids, or no thin liquids shall be interpreted by Food and Nutrition Services staff as meals with no thin liquids until further clarification or orders are received from physician.
   a. When an order for no thin liquids is received, meals sent to the patient shall be without thin liquids. Thin liquids are defined as: water, coffee, tea, iced tea, milk, all fruit juices~~(~~), and broth, broth-based soups, soft drinks, Boost, hot chocolate, ice cream, jello and milkshakes.
   b. Thickened milk and thickened juices are available and may be added to the menu.
   c. Thick liquids shall be offered, including nectar thick liquids, honey thick liquids and pudding thick liquids as determined by speech pathology recommendations.
   d. Foods of mixed consistencies where one consistency is thin liquid (i.e. fruit cocktail, dry cereal with milk, vegetable soup, and pineapple chunks) shall not be included unless otherwise ordered by the physician.
   e. In cases when speech therapy is involved in the patient's care, the speech pathologist may assess the patient's tolerance of liquids and may consult with the dietician, as appropriate.
      i. Recommendations for changes to diet will be made to the physician.
   f. The dietitian shall assess the patient's status per routine assessment and evaluation. The dietitian shall update the diet order in the electronic health record as appropriate.

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: NEW **SUBJECT: Team NICU Response Plan**

REVISION: DATE:

Patient Care Services Content Expert Approval:	**06/22**
Clinical Policies & Procedures Committee Approval:	**07/22**
Nursing Leadership Approval:	**~~08/22~~10/22**
Perinatal Collaborative Practice Approval:	**09/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**11/22**
Administration Approval:	**12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify the members of the neonatal resuscitation team and circumstances under which the team will be called to attend to deliveries and emergencies in Women and Newborn Units.

B. **DEFINITION(S):**

1. Team **Neonatal Intensive Care Unit** (NICU):
   a. A neonatal resuscitation team with a designated leader that attends high-risk deliveries.
   b. Team members will be competent in the current guidelines of the Neonatal Resuscitation Program (NRP).
   c. Team members will consist of a neonatologist, a respiratory therapist (RCP/RRT), and a **NICU** registered nurse (RN).
      i. A neonatologist and at least one other qualified team members will be present when perinatal risk factors are present.
      ii. At least one member of the team will be skilled in intubation.
      iii. Additional personnel may be included depending on the neonatal condition.

C. **POLICY:**

1. The team will be immediately available at all times to perform a complete neonatal resuscitation.
2. The team will be activated when there are perinatal high-risk factors. Risks may include **but are not limited to**:
   ~~a. Pre-term, post-term, multiple gestations.~~
   ~~b. Nonreassuring fetal heart rate, umbilical cord prolapse.~~
   ~~c. Fetal anomalies, known or suspected (e.g. pulmonary hypoplasia, diaphragmatic hernia, hydrops fetalis).~~
   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)
   ~~d.~~**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
   ~~e.~~**f.** Emergency cesarean ~~section~~**delivery** or general anesthesia.
   g. ~~Instrument assisted~~**Operative vaginal** delivery~~, macrosomia,~~ **(e.g. vacuum assist, forceps)**
   h. Prolapse of the umbilical cord

i. **Suspected hydrops**
~~f.~~**j. Macrosomic fetus and/or potential for** shoulder dystocia~~.~~

3. A Team NICU alert is not a "code". It is to be used whenever the neonatal team is needed.
4. Team NICU is used exclusively in the Women and Newborn Services (WNS) environment.
   a. Labor & Delivery (L&D) unit: The Obstetrician (OB), Certified Nurse Midwife (CNM), Anesthesiologist ~~OR~~**or** L&D RN may initiate a Team NICU at any delivery.
   b. Postpartum unit: In the event of a neonatal emergency, any staff member may ~~call~~**initiate** a Team NICU.
   c. For neonatal/newborn (≤ 30 days of life) emergencies outside of WNS, a Code CALEB (overhead announcement) will be activated and the neonatal team will respond (see Code CALEB Policy).

D. **PROCEDURE:**
1. Team NICU response is triggered by dialing 66 and activating a "Team NICU".
   a. The caller will request a Team NICU and provide the location and reason for request.
   b. If it is an emergency, ~~the reason~~ can be **indicated by adding** "911" or "STAT"
   c. Hospital PBX will text message to Team NICU cell phones.
      i. Text message will appear with location ~~and reason~~.
         1) e.g. "Team NICU L&D RM 7 ~~FETAL INTOLERANCE~~"
         2) e.g. "Team NICU OR 1 **STAT**"
         ~~3) e.g. "Team NICU LD Rm 1 VACCUUM~~
2. Resuscitation supplies will be readily available prior to team's arrival.
3. L&D personnel will communicate the following information to the team.
   a. NRP 8th Edition "Four pre-birth questions"
      i. Gestational age
      ii. Amniotic fluid color.
      iii. Additional risk factors.
      iv. Umbilical cord management plan
   b. Any other pertinent maternal/neonate medical history.

E. **DOCUMENATION:**
1. Neonatologist will document according to protocols.

F. **RELATED DOCUMENT(S):**
1. Women and Newborn Services Policy: Neonatal Delivery Room Attendance
2. Patient Care Service Policy: Code Caleb Response Plan

G. **REFERENCE(S):**
1. Beauman, S. S., & Bowles, S. (Eds.). (2019). Policies, procedures, and competencies for neonatal nursing care (6th ed.), Code Blue Chicago, IL: National Association of Neonatal Nurses.
2. Chang C., Perlman P., 2019. Anticipation and preparation for delivery room emergencies. Seminars in Fetal and Neonatal Medicine, 24(6). doi.org/10.1016/j.siny.2019.101031.
3. Sawyer T, Lee H. C., Aziz K., 2018. Anticipation and preparation for every delivery room resuscitation. *Seminars in Fetal and Neonatal Medicine*, 23(5), doi.org/10.1016/j.siny.2018.06.004.
4. Weiner, G.M~~., Zaichkin, J., & Kattwinkel, J. (Eds.). (2016).~~. **(Ed). (2021).** *Textbook of neonatal resuscitation (~~7th~~8th ed.)*. ~~Elk Grove Village, IL:~~ American Academy of Pediatrics.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTICK ANALYSIS, MANUAL READ PROCEDURE**
Purpose:	To outline nursing responsibilities for testing urine using dipsticks.
Supportive Data:	A Registered Nurse (RN) may perform this procedure. Testing using a urine dipstick is under the direction, authority, jurisdiction and responsibility of the Laboratory Director. Urine dipstick testing is considered definitive for the purpose of care and diagnosis.
Equipment:	Timer Paper Towel

A. **POLICY:**

1. Urine dipsticks are inert plastic strips which have attached different reagent papers for measuring urine chemistries. The dipstick provides a rapid, simple method for measuring pH, leukocytes, nitrite, protein, glucose, ketones, urobilinogen, bilirubin, blood, and hemoglobin in urine specimens. Testing is considered definitive for the purposes of care and diagnosis

B. **PROCEDURE:**

1. Verify Quality Control (QC) has been completed within at least 24 hours.
   a. Quality Control: Two levels of quality control (QC) must be tested daily before performing patient tests and when opening a new vial of test strips.
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well prior to testing
   b. Complete QC and record in log.
2. Collect voided urine in a clean container. A first-morning specimen is preferred, but random collections are acceptable.
   a. Test the urine within two hours (test immediately if testing for bilirubin or urobilinogen). If unable to test within two hours, refrigerate the specimen immediately and bring to room temperature before testing.
   b. Label the sample if the test is not performed at the bedside and in the presence of the patient.
   c. Mix well before testing.
3. Immerse the test strip into the container of urine and remove immediately.
   a. Make sure the reagent pads are totally immersed.
4. Draw the edge of the strip along the rim of the container to remove excess urine.
5. Turn the test strip on its side and tap once on an absorbent paper towel to remove excess urine.
   a. This also prevents the possible mixing of reagent chemicals which can produce reading difficulties.
6. Wait the appropriate time (per manufacturer's recommendation) and read the test. Accurate timing is essential.
   a. Color changes that occur after 2 minutes are of no clinical value.
   b. Match the test strip to the color and record results.
      i. Be sure the strip is properly oriented to the color chart on the test strip container.
      ii. Color changes that occur only along the edges of the pads should be ignored. Careful removal of excess urine will eliminate this effect.
7. Storage:
   a. Store all unused strips in the original bottle.
   b. Store at room temperature.
   c. Do not remove desiccant from bottle.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/03,04/04,11/06,07/09,08/11, 04/15, 06/18, 01/20, 06/20, 07/22	09/11, 05/15, 07/18, 03/20, 07/20, 08/22	10/11, 05/15, 07/18, 04/20, 08/20, 09/22	03/16, 08/18, 09/20, 09/22	n/a	11/11, 04/16, 08/18, 05/20, 09/20, 10/22	09/18, 10/20, 12/22	1/12, 05/16, n/a	01/12, 05/16, 09/18, 11/20

d. Do not store in direct sunlight.
e. Do not use strips after their expiration date.
f. Once opened, strips are good until the expiration date listed on the bottle or six months after the open date, whichever is sooner.

B. **REFERENCE RANGES:**

Test:	Glucose	Bilirubin	Ketones	Specific Gravity	Blood	pH	Protein	Urobilinogen	Nitrite	Leukocytes
Normal:	Neg	Neg	Neg	1.010–1.035	Neg	4.6-8.0	Neg	Neg	Neg	Neg

C. **LIMITATIONS:**

1. Protein: A visibly bloody urine may cause elevated results.
2. Blood: Capoten (captopril) may reduce sensitivity. Certain oxidizing contaminates, such as hypochlorite, may produce false positive results. Microbal peroxidase associated with urinary tract infection (UTI) may cause false positive reaction.
3. Leukocytes: Elevated glucose, (greater than or equal to [≥] 3g/dL), may cause decreased test results. The presence of cephalexin, cephalothin, or high concentration of oxalic acid may cause decreased test results. Tetracycline may cause decreased reactivity and high levels of the drug may cause a false negative reaction. Positive results may occasionally be due to contamination of specimen by vaginal discharge.
4. Nitrite: Pink spots or pink edges should not be interpreted as a positive result. A negative result does not rule out significant bacteriuria. False negative results may occur with shortened bladder incubation of the urine, absence of dietary nitrate, or the presence of nonreductive pathological microbes.
5. Glucose: Ketone bodies reduce the sensitivity of the test; a moderately high ketone levels (40mg/dL) may cause false negatives for specimens containing a small amount of glucose (75-125mg/dL) but the combination of such ketone levels and low glucose levels is metabolically improbable in screening.
6. Ketones: False trace results may occur with highly pigmented urine specimens or those containing large amounts of levodopa metabolites. Compounds such as mesna that contain sulfhydryl groups may cause false positive or an atypical color reaction.
7. pH: Bacterial growth by certain organisms may cause a marked alkaline shift (pH >8), usually because of the urea conversion to ammonia.
8. Specific Gravity: Highly buffered alkaline urines may cause low readings, while the presence of moderate quantities of protein (100-750 mg/dL) may cause elevated readings.
9. Bilirubin: Atypical colors (colors that are unlike the negative or positive color blocks shown on the color chart) may indicate that bilirubin-derived bile pigments are present in the urine sample and may be masking the bilirubin reaction. These colors may indicate bile pigment abnormalities and the urine specimen should be tested further (send to lab).
10. Urobilogen: Atypical color reactions may be obtained in the presence of high concentration of p-amino benzoic acid. False negative results may be obtained if formalin is present. Strip reactivity increases with temperature.

D. **DOCUMENTATION:**

1. Document the results in electronic health record.
2. Document QC results on the Point of Care Quality Control Log - Urine Dipstick Manual Read

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

1. Point of Care Quality Control Log - Urine Dipstick Manual Read

F. **REFERENCE(S):**

1. Siemens Healthcare Multistix 10 SG Package Insert. TN30516A. 06/2010.

Point of Care Quality Control Log - Urine Dipstick Manual Read

Unit:	Lab Review:

Quality Control			
Name of QC:		Lot #:	
QC Level:		Expiration:	

Reagent Strips	
Lot#:	
Expiration:	

Date of Testing	GLUCOSE	BILIRUBIN	KETONES	SG	BLOOD	pH	PROTIEIN	UROBILIN-OGEN	NITRITE	LEUKOCTE ESTERASE	Pass/ Failed	Initial

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**URINE DIPSTICK ANALYSIS USING SIEMENS CLINITEK STATUS + CONNECT**
Purpose:	To provide an accurate and reliable method for reading urine dipstick results. Test results may provide information regarding the status of carbohydrate metabolism, kidney and liver function, acid-base balance, and urinary tract infection.
Supportive Data:	A Registered Nurse (RN) may perform this procedure. Testing is under the direction, authority, jurisdiction, and responsibility of the Laboratory Director.

A. **PRINCIPLE:**

1. The Clinitek Status analyzer is for in vitro diagnostic use in the semi-quantitative detection of bilirubin, blood (occult), glucose, ketone (acetoacetic acid), leukocytes, nitrite, pH, protein, specific gravity, and urobilinogen in urine samples.
   a. The Clinitek Status+ Analyzer provides more regulatory control than the previous Clinitek Status model, including connectivity options and **Quality Control** (QC) lockout functions.

B. **SPECIMEN:**

1. First-morning void specimen is preferred. If not available, use a specimen that has incubated in the bladder for at least 4 hours. A random-void specimen is acceptable, but may not register positive nitrite results.
2. Collect in a clean dry container.
3. Label with patient identification.
4. Test within one hour of collection or refrigerate for up to 24 hours and bring to room temperature before testing. (Bilirubin and urobilinogen decrease with time).

C. **REAGENTS/ SUPPLIES:**

1. Siemens Multistix® 10 SG Reagent strips for urinalysis
   a. Storage: 15 – 30°C (59 – 86°F)
   b. Keep away from sunlight
2. Quality Controls (2 levels)
   a. Storage:
      i. Unopened bottle: 2 – 8°C stable until expiration
      ii. Opened bottle: 20 - 25°C stable for 30 days

D. **QUALITY CONTROL:**

1. Quality Control: Two levels of Quality Control (QC) must be tested under the following conditions:
   a. Daily before performing patient tests
   b. Opening a new vial of test strips
   c. Training of new users
2. QC Procedure:
   a. Store QC vials in the refrigerator when not in use and bring to room temperature before use (10-15 minutes). An open vial of QC is good for 30 days at room temperature. Mix well.
   b. If QC needs to be performed, the "Strip Test" button will not be available, and the QC button will say "QC Test Due".
   c. Select the QC button.
   d. Select "QC Strip Test"

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
05/13, 05/15, 06/18, 06/20, **07/22**	**06**/13, 05/15, 07/18, 07/20, **08/22**	6/13, 05/15, 07/18, 08/20, **09/22**	03/16, 08/18, 09/20, **09/22**	n/a	**07/13**, 04/16, 08/18, 09/20, **10/22**	09/18, 10/20, **12/22**	09/13, 05/16, n/a	09/13, 05/16, 09/18, 11/20

e. Operator: Select "Enter New Operator Name". Enter operator 'name' by
   i. Scanning badge barcode or
   ii. Toggle to numeric and type numeric – Employee ID
f. Control: Select "Enter Lot and Expiration Date".
   i. Scan the barcode for the QC lot number.
   ii. Adjust the year and month of the expiration date.
g. Strip: Select "Enter new lot and expiration date".
   i. Scan the barcode assigned to the vial of strips in use.
   ii. Adjust the year and month of the expiration date.
h. Prepare Test:
   i. Mix the QC Vial well. Press "Start". You have 8 seconds to complete the following steps:
      1) Wet each pad of the strip with control material.
      2) Tap the edge of the strip onto a paper towel to remove excess liquid.
      3) Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
      4) At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read. The instrument will compare the results obtained with pre-programmed expected results and determine a PASS or FAIL.
      5) Dispose of the strip and wipe clean the test strip holder.
      6) Repeat any levels of Failed QC as necessary.
      7) Verify reagent strips and QC has been stored properly and are not expired.
      8) Re-mix sample well.
      9) Clean the test-table insert.
      10) Refer to additional troubleshooting steps at the end of this procedure.
      11) Contact the lab for support.
i. QC results are automatically log into the middleware.

E. **PROCEDURE FOR PATIENT TEST**:

1. Select "Strip Test"
2. Operator: Select "Enter New Operator Name". Enter operator 'name' by
   a. Scanning badge barcode or
   b. Toggle to numeric and type numeric- Employee ID
3. Patient Information: Select "Enter New Patient"
   a. Enter the Patient's Last Name
   b. Enter the Patient's ID
4. Strip: Select "Enter new lot and expiration date".
   a. If available, select "use last lot" OR
   b. Scan the barcode assigned to the vial of strips in use.
   c. Adjust the year and month of the expiration date.
5. Prepare Test:
   a. Mix the sample well. Press "Start". You have 8 seconds to complete the following steps:
   b. Fully immerse the dipstick into the urine. Tilt slightly to the side ensuring all strip pads are wet. Slowly pull the strip out, dragging the edge of the strip along the rim of the vial to catch excess liquid.
   c. Place the strip in the test strip holder with the test pads facing up. Slide the strip to the end of the holder.
   d. At the end of the 8 second countdown, the test strip holder will pull into the instrument and the strip will be read.
   e. The analyzer automatically performs a calibration each time a strip is read. Do not push or

pull the test table or bump the instrument while it is calibrating.)

f. While the strip is reading, select the color and clarity of the urine.

g. Dispose of the strip and wipe clean the test strip holder.

6. Recall Results:
   a. From the main Select screen, touch the Recall Results button.
   b. Select to review Patient or Quality Control tests.
   c. Test results are listed chronologically, with the most recent being at the top. Use the up and down arrows to scroll and highlight the result you would like to recall. Touch Select to view.
   d. You may print. Touch done when finished.

F. **REFERENCE RANGES AND CRITICAL VALUES:**

1. Critical Values
   a. Glucose greater than or equal to 1000 mg/dL shall be reported to patient's licensed health care provider (RN or MD)
2. Reference Ranges
   a. Refer to Patient Care Services POC Quick Reference

G. **LIMITATIONS:**

1. Interfering substances may cause false positive or false negative results.
   a. Refer to Urine Dipstick Analysis Using Siemens Clinitek Status Procedure - Substances Conditions Affecting Test Results.

H. **METER MAINTENANCE AND CLEANING:**

1. The test table is to be kept clean if the analyzer is to operate properly.
2. Nursing shall be responsible for the daily cleaning of the test table insert and weekly cleaning of the meter.
   a. To clean the Test Table Insert:
      i. Remove the insert and thoroughly clean with a hospital approved disinfectant.
      ii. Rinse both sides under running water
      iii. Dry and replace insert
   b. To clean the Meter:
      i. Turn analyzer off
      ii. Wipe the outside with a damp (not wet) cloth and mild detergent
         1) May use a hospital approved disinfectant after wringing out excess liquid
         2) Avoid liquid from enter the printer compartment and under touch display
3. Lab shall perform other cleaning and maintenance to include cleaning of test table and white calibration bar monthly.
   a. To clean the Calibration Bar:
      i. Remove the insert from the test table.
      ii. Remove the test table by pulling it slowly out of the analyzer.
      iii. Drain the drip tray, if necessary.
      iv. Examine the white calibration bar on the test table for dirt or discoloration under good lighting. If it appears dirty or discolored, wet a cotton-tipped stick or lint free cloth with distilled water and gently wipe and clean the calibration bar.
      v. Do not scratch, touch or mark the Calibration bar.
      vi. Allow the calibration bar to air dry.
      vii. Insert the test table and table insert back.
4. Troubleshooting
   a. If the movement of the test table is irregular or slow, this may be due to:
      i. Heavy buildup of dried urine on the test table—clean the test table
      ii. Low battery power—replace the batteries or use the power supply.

b. Refer to Siemens Clinitek Status®+Operators Guide for other troubleshooting procedures.

5. Complete the Point of Care Quality Control Log – Urine Clinitek.

I. **FORM(S):**

1. Point of Care Quality Control Log – Urine Clinitek

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

1. Urine Dipstick Analysis Using Siemens Clinitek Status Procedure - Substances/Conditions Affecting Test Results
2. Siemens Clinitek Status®+Operators Guide

K. **REFERENCE(S):**

1. Siemens Healthcare Multistix® 10SG Reagent Strips Package Insert. 11306391 Rev. A 07-2017
2. Siemens Clinitek Status®+Operators Guide 10490853 Rev. C, 2011-12

POINT OF CARE QUALITY CONTROL LOG - URINE CLINITEK

UNIT:	Instructions: 1. Indicate Lot #s. Verify Reagents and Controls are not expired. 2. Indicate Corrective Actions if QC fails at the bottom of the form. 3. If no testing performed, indicate "No Patient Tests" 4. Questions: Point of Care Coordinator x7974 5. Completed Log is stored in the Lab.
MONTH: _____ YEAR: _____	
LAB REVIEW POCC INITIALS: _____ DATE: _____	**Monthly Calibration bar inspection/cleaning** Date _____ Initials _____

URINE MULTISTIX®	Lot #: _____ Exp: _____			Maintenance of test table, insert, & meter	QC Pass?	Temp (°C)	Humidity (%)	Operator Initials
LOT	QC Reagent	LEVEL 1 Lot #: _____ Exp: _____ ✓	LEVEL 2 Lot #: _____ Exp: _____ ✓	*Cleaned and Disinfected* ✓	*QC/Reagents not expired* ✓	*Acceptable Range* 18-30 °C	*Acceptable Range* 18-80%	
DAY OF THE MONTH	1.							
	2.							
	3.							
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QC FAIL? CORRECTIVE ACTIONS: (Indicate below: e.g. Check exp. dates, repeat, try new reagent / QC. Contact lab with repeated fails)

_____

_____

_____

_____

Rev 09/19 RO, 01/20 RO, 7/20 RO

156

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**VENTRICULAR ASSIST DEVICE: IMPELLA NURSING CARE OF THE PATIENT**
Purpose:	To provide guidelines for the safe nursing care and monitoring of the patient with an Impella device in place outside of the Cath Lab (CCL) or Operating Room (OR).
Supportive Data:	ABIOMED Impella Protocol and Tools
Equipment:	Impella_2.5/CP_5.0/LD_RP

A. **DEFINITION(S):**

1. Left Sided Impella: Impella 2.5,CP,5.0/LD
   a. The Impella 2.5/CP/5.0 are percutaneously inserted temporary ventricular assist devices (VAD) which provides hemodynamic support by using a small microaxial blood pump housed inside a catheter to pull blood from the left ventricle into the aorta, unloading up to five liters of blood. This action effectively decreases left ventricular preload, increases mean arterial pressure and forward flow, increases end-organ perfusion and protects the myocardium by decreasing oxygen demand and increasing oxygen supply. They are recommended for short-term use (Impella 2.5 and Impella CP < 4 days and Impella 5.0 <6 days or per MD order)
   b. Impella 2.5 is inserted percutaneously via an introducer sheath and ~~i~~is capable of unloading up to 2.5 liters of blood per minute.
   c. Impella CP is inserted percutaneously via an introducer sheath and is capable of unloading 2.5-3.5 liters of blood.
   d. Impella 5.0/LD assist device is inserted peripherally via arterial cut down and is capable of unloading up to 5.0 liters of blood per minute.
2. Right Sided Impella: Impella RP System
   a. The Impella RP System is a percutaneously inserted temporary ventricular assist device (VAD) with an intracardiac microaxial blood pump that supports a patient's pulmonary circulation. It is inserted percutaneously through the femoral vein and into the pulmonary artery (PA). It delivers blood from the inlet area which sits in the inferior vena cava (IVC), through the cannula, to the outlet in the pulmonary artery.

B. **POLICY:**

1. The Impella device will be placed in the Cardiac Catheterization Lab (CCL) or Operating Room (OR) and may or may not be removed prior to leaving the CCL or OR.
2. The patient with an Impella device in place outside of CCL or OR must be cared for in the Intensive Care Unit (ICU) by an Impella-trained Registered Nurse (RN).
3. Nurse to patient ratio will be at least 1:1
4. Left Sided Impella: Impella 2.5,CP,5.0/LD
   a. The Left-sided Impella device provides left heart support. Monitor patient for signs of right heart failure and assess need for bi-ventricular implantable cardiac defibrillator (BIVICD) if necessary. Signs of right heart failure may include:
      i. Reduced output from Impella.
      ii. Suction alarms on Impella console.
      iii. Elevated CVP.
      iv. Signs of liver failure
      v. Elevated PA pressures.
   b. Indications:
      i. Stable ~~P~~patients with high-risk coronary disease scheduled for revascularization.
      ii. Cardiogenic shock patients in need of left ventricular support.
      iii. Patients with reduced ventricular function, e.g., post-cardiotomy, low output syndrome, post-MI, and peri/post percutaneous coronary intervention (PCI).

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11/18, **09/21**	12/18, **06/22**	12/18, **07/22**	11/18, **08/22**	01/19, **10/22**	02/19, **11/22**	03/19, **12/22**	n/a	03/19

c. Contraindications:
   i. Mural Thrombus in the left ventricle
   ii. Presence of mechanical aortic valve or heart constrictive device
   iii. Aortic valve stenosis/calcification (equivalent to an orifice area of 0.6cm2 or less)
   iv. Moderate to severe aortic insufficiency (echocardiographic assessment graded as > +2)
   v. Severe peripheral arterial disease precluding placement of the Impella system
   vi. Significant right heart failure
   vii. Combined cardiorespiratory failure
   viii. Presence of an atrial or ventricular septal defect (including post-infarct VSD)
   ix. Left ventricular rupture
   x. Cardiac Tamponade (Cardiogenic shock indication only)

5. Right-Sided Impella - Impella RP
   a. Indications:
      i. The Right-Sided Impella device provides right heart support for patients such as those who develop acute right heart failure or decompensation following left ventricular assist device implantation, myocardial infarction, heart transplant or open-heart surgery.
   b. Contraindications:
      i. Disorders of the pulmonary artery wall that would preclude placement or correct position**ing** of the Impella RP device
      ii. Mechanical valves
      iii. Severe valvular stenosis or regurgitation of the tricuspid valve (TV) or pulmonary valve (PV)
      iv. Mural thrombus of the right atrium (RA) or vena cava
      v. Anatomic conditions precluding insertion of the pump
      vi. Presence of a vena cava filter or caval interruption device.

C. **PROCEDURE**:
1. General considerations:
   a. Ensure the Impella console is always plugged in; device can function for one hour without AC power. It may take up to 10 hours to fully re-charge the Impella.
   b. Do not raise HOB greater than 30 degrees if patient is temporally cannulated.
   c. Obtain order for knee immobilizer if patient **is** unable to maintain straight-leg position and is femorally cannulated.
   d. Perform dressing changes to insertion site per hospital policy or as needed (prn) using aseptic technique and transparent dressing.
   e. Refer to the infection prevention guidelines in relation to hand hygiene and possible person protection equipment (PPE) when applicable.
   f. Assess insertion site every one hour for bleeding, hematoma or infection.
   g. Monitor pedal pulses every 15 minutes times 4, every 30 minutes times 4, then assess for limb ischemia every one hour.
   h. Turn patient according to implanting cardiologist/cardiac surgeon's order. Patient positioning order must be reviewed daily with implanting cardiologist/cardiac surgeon.
   i. Use care when turning, repositioning, or performing bed-to-gu**rn**~~me~~y or bed-to-bed transfers to ensure the device is not pulled on or pulled out.
   j. Do not allow red Impella plug (left-sided Impella) or blue Impella plug (right- sided Impella) to hang freely from catheter and avoid bending catheter near red (or blue) Impella plug to avoid kinking.
   k. Impella may cause ECG interference~~,~~. ~~s~~**S**et ~~B~~**b**edside monitor to "filter" status for ECG interference.
   l. Patient will be anticoagulated with a heparin infusion~~,~~. ~~m~~**M**onitor PTT per physician orders for Pharmacy to dose. ~~(Goal: PTT 65-87sec)~~

m. Obtain daily transthoracic echocardiogra~~mphy~~ or portable chest X-ray to determine Impella catheter placement per physician order. Implanting cardiologist/**cardiac surgeon** to review Impella catheter placement daily with the nurse.
n. The catheter of the Impella 2.5, CP, 5.0/LD, and RP is to be removed only by a Physician or Physician Assistant.
o. The performance level indicates the performance level at which the catheter is operating (how much it is unloading) and is determined by physician order and is set to achieve desired hemodynamics.
p. If the patient with an Impella device in place needs CPR, place performance level at "P2" and perform CPR with device in place and running.
q. Change NS arterial flush/tubing daily for 2.5 and CP devices. For 5.0/LD or RP device no arterial flush is required.
r. Purge fluid and purge tubing change per hospital's protocol on fluid and tubing change.
s. Wean per physician orders.

2. On Admission to critical care:
   a. Order echocardiogram (left-sided Impella) or Chest X-ray (right-sided Impella) to verify placement on arrival to critical care unit as soon as possible.
   b. Verify that Tuohy-Borst valve on Impella catheter is locked to prevent catheter migration.
   c. Switch to P-level mode and disable P-level suction control.
   d. If the purge system has not been transferred to the standard configuration, follow the steps below:
      i. Press "PURGE SYSTEM" to select "Transfer to Standard Configuration" from the menu.
      ii. Do not use saline. Use Heparin/Dextrose purge solution as **ordered by the physician**~~recommended by pharmacy~~
      iii. Select OK to deliver a bolus to the pressure reservoir so that the reservoir can maintain purge pressure during the change. A progress bar shows the progress of the bolus. After the bolus is delivered, the controller automatically proceeds to the next screen.
      iv. Disconnect the yellow luer from the Impella ~~C~~catheter and remove the used purge cassette.
      v. Insert the new purge cassette into the controller. Be sure to slide the purge pressure transmitter into place and extend the purge tubing through the gap in the purge cassette door when you close the door.
      vi. The system automatically primes the purge cassette. A progress bar shows the progress of the priming. Once the priming is complete, you are prompted to connect the purge tubing to the Impella catheter.
      vii. Connect the yellow luer on the end of the purge tubing to the yellow luer on the Impella catheter.
      viii. Purge system change is complete. Enter the purge fluid information and select OK.
         1) To select the default purge fluid values displayed on the screen, scroll to and select OK. This will select those values and automatically advance to the next screen.
         2) To change the purge fluid information, scroll to the appropriate item and push the selector knob to select it. Then scroll through the values and push the selector knob to make a new selection.
   e. Assess and chart the centimeter marker on the Impella catheter closest to the sheath.
   f. Ensure roller clamp is completely open on the line to the pressure bag.
   g. Verify that the pressure bag is inflated to 300-350 mmHg.

h. It is recommended that central venous pressure (CVP) be monitored and that a level of 12 mmHg be maintained.

3. Monitoring of catheter position:
   a. The position of the Impella device is monitored by the RN continuously via placement signal and motor current displays and the placement monitoring illustration display on the Impella console.
   b. Obtain physician order for daily transthoracic echocardiography or portable chest x-ray to monitor position.
   c. The ideal position of the Impella catheter is:
      i. For Impella 2.5,CP,5.0/LD, the catheter inlet lies in the left ventricle and the catheter outlet in the aorta, the placement signal and motor current displays will be pulsatile and the Impella catheter icon will be displayed with the valve symbol in the middle of the catheter.
      ii. For Impella RP, the catheter inlet lies in the inferior vena cava (at the level of the diaphragm or apex of the heart away from RA and TV) and the catheter outlet in the PA (bifurcation of the right and left PA branch), the placement signal and motor current displays will be similar to a PA waveform.
   d. Note and document catheter position markings after placement and hourly.
   e. Ensure device is secured to leg with tape.
   f. If the device migrates, the following warnings will appear on the Impella console: "Impella position wrong" or "Impella in Ventricle"
      i. If the pump console alarms that the device is not positioned properly, reduce performance level to "P2" and notify the physician immediately- only a physician may reposition the device. The physician may request echocardiography or fluoroscopy for guidance.
   g. Low native heart pulsatility: In a patient with poor native ventricular function, the placement signal may remain pulsatile. ~~h~~However, the amplitude will be dampened
   h. If the device is out of position, the patient may be at risk for hemolysis. Monitor the patient for and notify physician of signs of hemolysis including:
      i. Decreased hemoglobin level.
      ii. Dark or blood-colored urine.
      iii. Acute renal failure.
   i. For "Placement Signal Lumen Blocked" alarm
      i. Ensure roller clamp on pressure bag is fully open
      ii. Check pressure in the pressure bag (300-350mmHg)
      iii. Close roller clamp and disconnect IV from the red luer, do not grip the white flush valve when trying to disconnect IV from luer
      iv. Attach 20 cc syringe to red luer, squeeze white flush valve, and aspirate 1-2 cc of blood into syringe
      v. Remove syringe and open roller clamp
      vi. Hold the clear luer upright and flood with saline from the pressurized bag
      vii. Reconnect IV to the red iluer and ensure roller clamp **is** still open
      viii. Squeeze or pinch white flush valve side-to-side and flush the aspirated blood from the lumen
      ix. If still unable to get placement signal, notify MD and utilize motor current waveform to ensure positioning across the aortic valve.

4. Normal saline (NS) arterial flush solution (2.5 and CP devices only):
   a. Change flush solution daily and p**rn** ~~m~~
   b. Perform hand hygiene and don gloves.
   c. Prime the new NS flush solution set-up and close the roller clamp.
   d. Place the NS bag in a pressure bag and inflate to between 350-400 mmHg.
   e. Close the roller clamp and disconnect the old flush solution connected at the red sidearm port.
   f. Open the roller clamp on the new flush solution set-up to start a slow drip.

g. Position the male luer connector over the female luer connector and fill to overflow, displacing any air.
h. Connect and secure luer fittings.
i. Open the roller clamp all the way and squeeze the white wings for 5 to 10 seconds to complete the internal prime- the final prime should eliminate any risk of lost or dampened pressure caused by blood tracking into the pressure lumen during the pressure tubing change.
j. To maintain a good pressure signal: periodically fast-flush catheter lumen for 15-20 seconds, maintain pressure bag at 350-400 mmHg.
k. Remove gloves and perform hand hygiene.

5. Suction Alarm:
   a. Suction alarm may occur if the circulating blood volume is inadequate or if blood return is restricted.
   b. Suction will limit the amount of support the device can provide and will result in decreased blood pressure, cardiac output, and dysrhythmia.
   c. Suction can cause hemolysis by damaging the red blood cells.
   d. Suction can be caused by:
      i. Left-sided Impella:
         1) Right ventricular failure - consider RV support
         2) Improper catheter position - check catheter position
         3) Hypovolemia - correct volume deficits
      ii. Right-sided Impella
         1) Inadequate preload - correct volume deficits
         2) Malposition - check device position (Chest X-ray, fluoroscopy, or echo)
   e. Assess for and correct the above conditions if a suction alarm occurs.
   f. While running in auto-mode if the controller detects suction it will alarm "Impella Flow Reduced" and will automatically reduce motor speed to reduce the flow rate.
   g. While running in P-Level mode, if the controller detects suction it will alarm "Suction".
   h. Recommended actions:
      i. Impella 2.5/CP:
         1) Check the device position
         2) Confirm RV function by assessing CVP or right side function with echocardiography or fluoroscopy. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
         3) Assess patient's fluid intake and output to confirm adequate volume status.
         4) Return P-level to pre-alarm setting.
      ii. Impella 5.0/LD Catheter:
         1) Reduce P-level by 1 or 2 levels to reduce the effects of suction.
         2) Check the device position
         3) Assess patient's fluid intake and output to confirm adequate volume status.
         4) Confirm RV function by assessing CVP or right side function with echocardiography. If CVP is not an option, check the pulmonary artery diastolic pressure (if PA is present) to assess the patient volume status.
         5) Return the P-level to pre-alarm setting Q.
      iii. Impella RP:
         1) If suction is an issue, the flow displayed on the controller maybe higher than the actual Impella RP flow rate.
         2) If the suction alarm appears on the controller when the Impella RP is running at P-levels between P7 and P9, decrease the P-level to P6, or to P5, or to P4 as needed, to resolve suction. If suction alarm continues

when P- level is between P4 and P6, momentarily stop the Impella RP to resolve the suction issue and then restart it immediately.
3) Evaluate patient volume status; maintain a positive CVP
4) Check device position
5) Return to previous P-level when suction alarm is resolved when appropriate

6. Differential pressure sensor:
   a. Impella 2.5 & CP
      i. Not Applicable
   b. Impella 5.0/LD or RP
      i. The Impella 5.0LD, RP has an electronic differential pressure sensor at the proximal end of the cannula which generates the placement signal, the placement signal is equal to the difference. The sensor generates an electrical signal proportional to the difference between the pressure outside the inlet area and the pressure inside the cannula. This signal is displayed on the Automated Impella Controller as the placement signal.
      ii. If the waveform shifts up or down on the y-axis or if the flow rate does not match the performance level setting, the differential pressure sensor is experiencing "drift" and may require zeroing.
         1) Press the MENU key and select "Start Manual Zero."
         2) Select OK to confirm the decrease in P-level 3.
         3) The controller displays "Wait until the new P-level is reached" and then "Calculation is running".
         4) Select OK to accept the new setting when the controller displays the "Placement Signal Offset Adjust finished!" message.
         5) The Impella will automatically be reset to the previous P- level.
7. Purge pressure management:
   a. The purge system prevents blood from entering the microaxial motor by providing a pressure barrier via the flow of purge fluid through the motor in the opposite direction of the blood flow.
   b. Purge pressure must be greater than the patient's peak blood pressure.
   c. Increasing the flow of the purge fluid will increase the **purge** pressure, decreasing the flow of purge fluid will decrease the purge pressure
   d. The AIC console that accompanies the Impella device is used to adjust the purge fluid flow rate.
   e. Purge pressure is displayed on the Impella console.
   f. Purge fluid flow rate is not to be less **than**~~and~~ 2 m**L**/hour or greater than 30 ml/hour.
   g. Purge fluid and purge tubing change per hospital policy
      i. Perform hand hygiene and don gloves.
      ii. Open PURGE SYSTEM menu and select "Change Purge Cassette"
      iii. Follow the instructions on the screen to change the purge cassette.
   h. Standard Purge Solution: The Heparin/Dextrose solution provided by the pharmacy is Heparin 25,000 units in Dextrose 5%, 500 ml (concentration 50units/ml) and is for intra-arterial flush. The amount of heparin and dextrose in purge fluid may be changed per physician order. Note: for Impella RP, the Heparin/Dextrose solution is started in Cardiovascular Lab rather than in the critical care unit.
   i. "Low Purge Pressure" alarm (purge pressure less than 300 mmHg and purge flow greater than or equal to 30 mL/hr.:
      i. Check for leaks and loose connections in or on the purge cassette, yellow luer connection to the clear sidearm, the clear sidearm and the red luer connection (if the Y connector **is** being used)
      ii. Change purge cassette if leaking or every 72 hours.
      iii. If there are no leaks, change to a purge fluid with a higher dextrose

concentration. To do this, open the Purge System menu and select "Change Purge Fluid." Follow the instructions on the screen.

iv. If the pressure stabilizes, no other action is required.

v. If the purge pressure is not stable and the low purge pressure alarm remains unresolved for more than 20 minutes, there may be a problem with the purge cassette. Replace the purge cassette. (Follow the instructions on the screen "Change Purge Cassette".)

vi. If the low purge pressure alarm still remains unresolved for more than 20 minutes, this may be a sign of Impella catheter damage. Inform MD.

j. High purge pressure will result in one of two alarms- "Purge Flow Low" or "Purge System Blocked"

k. For high purge pressure (purge pressure greater than or equal to 1100 mmHg and purge flow less than 2 ml/hour):

i. Check for kinks in the purge tubing, clear sidearm, catheter shaft and Y connector (if being used)

ii. Ensure plastic clip on pressure reservoir of the clear sidearm is snapped into connector cable

iii. Decrease dextrose concentration (must obtain physician order)

iv. Monitor motor currents and note any upward trend, consider replacing catheter if a rise in motor current is seen.

l. For in-depth troubleshooting of purge pressure alarms, refer to Impella user manual located on the unit.

D. **DOCUMENTATION AND ASSESSMENT:**

1. In electronic health record (EHR) document:

a. Vital signs per standards of care.

b. Intake and output (I&O) every hour.

c. Daily weights.

d. Positioning/repositioning as ordered.

e. Dressing change per hospital policy.

f. Head of bed elevation hourly.

g. If femorally cannulated, assessment of pulses and signs of limb ischemia hourly.

h. If femorally cannulated, perform neurovascular checks of the extremity with the Impella device every hour and **prn** ~~pm~~ Notify the physician immediately if signs and symptoms are present (6Ps - pain, pallor, paresthesia, paralysis, pulselessness, poikilothermia).

i. Subjective patient complaints:

i. Deep throbbing feeling of pressure in affected extremity.

ii. Calf pain with dorsal flexion of foot. (~~h~~**H**oman's sign).

iii. Loss of lower leg sensation or function.

j. Objective finding (for unconscious patient or patient unable to communicate):

i. Ankle/arm index: Ankle systolic divided by brachial systolic, (radial/brachial arterial line systolic okay).

ii. Normal ankle/arm index value = 0.8 - 1.2.

iii. Post insertion ankle/arm index < 0.8 have 8 times the risk of limb ischemia.

k. Assessment of access site hourly.

l. Monitor and document upon arrival, every hour and with repositioning:

i. Pump performance (P Level)(P0-P8 or Auto)

ii. Flow (L/min)(0.0-5.0)

iii. Placement Signal (mmHg) [(2.5/CP = Sys/Dia) (5.0: (30-60/+15)]

iv. Purge Pressure (300-1100mmHg)

v. Motor Current

vi. Purge Fluid Infusion Rate (mL/hr)

vii. Power AC Battery (60 minute battery life)

viii. Distal Pulses

E. **TROUBLESHOOTING:**

1. For an in-depth description of troubleshooting and operation and description of all possible alarms, refer to Impella reference guide and user manual located on unit.
2. Impella 24-hour support 1-800-422-8666.

F. **REFERENCE(S):**

1. Abiomed Corporation (2016). Impella 5.0 with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation (2016). Impella 2.5/CP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Abiomed Corporation (2016). Impella RP with the Impella automated controller: Instructions for use & clinical reference manual. Danvers, MA Hoag Hospital Cath Lab Policy 3.1. (2008). Abiomed Impella 2.5 Percutaneous Cardiac Assist Device.
2. McCulloch,B. (2011) Use of the Impella 2.5 in High-risk Percuataneous Coronary Intervention. Critical Care Nurse, 31(1), e1-e16.
3. Wiegang, D.L. (2011) AACN procedure manual for critical care. Saunders Elsevier. St. Louis: MO.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**WHOLE BLOOD PT/INR USING THE ROCHE COAGUCHEK XS PLUS METER**
Purpose:	To provide an accurate and reliable method to monitor oral anticoagulant therapy in the point of care setting.
Supportive Data:	Point of Care The CoaguChek XS Plus is a CLIA waived system. Roche Technical Support: 1-800-428-4674. www.coaguchek.com
Equipment:	CoaguChek XS Plus meter CoaguChek XS PT test strips CoaguChek XS PT test strip code chip (from same box as test strip) CoaguChek XS Plus Liquid Controls CoaguChek XS Plus Liquid Control code chip Lancet (at least 1.8mm depth) Alcohol wipe or soap and water Gauze or tissue Bandages
Authorized to Perform:	Registered Nurse (RN), License Vocational Nurse (LVN), Medical Assistant (MA)

A. **INTRODUCTION/PRINCIPLE:**

1. Prothrombin Time (PT) is a test of the blood's ability to clot. Blood clots form in response to vessel injury to prevent excessive loss of blood. If blood clots form inappropriately and lodge in the vascular system of important organs, serious consequences such as stroke can result. In certain medical conditions (i.e. atrial fibrillation or mechanical heart valves) blood clots are more likely to form, and there is increased risk of stroke. Oral anticoagulants are used to prevent clots in these conditions.
2. Oral anticoagulants have a narrow therapeutic range and the response to a standard dose varies widely both between patients and within a patient over time. Patients undergoing oral anticoagulant therapy must have their level of anticoagulation monitored often. Dosage adjustments should be made as needed to ensure maximum safety and efficacy.
3. The PT test is the principle assay used to monitor oral anticoagulant therapy. The dosage of oral anticoagulant is adjusted based on the PT test results to recommended therapeutic ranges. The PT can be reported in seconds or as an International Normalized Ratio (INR). The INR is a mathematical conversion that compensates for differences between PT methods.
4. The CoaguChek XS Plus test strip and meter will provide an electrochemical measurement of Prothrombin time following activation of blood coagulation with human recombinant thromboplastin. In simple terms, blood works with the chemicals in the test strip to make a small electric current in the test strip that measures blood-clotting time.

B. **SPECIMEN:**

1. Requirements:
   a. Fresh capillary whole blood or fresh venous whole blood drawn in an anticoagulant-free plastic syringe.
   b. The blood sample must be applied to the test strip within 10 minutes of removing the strip from its container.
   c. Capillary sample must be applied to the strip within 15 seconds of the fingerstick.
   d. Minimum sample size is 10 uL of blood.
2. Criteria for rejecting specimens:
   a. Plasma or serum cannot be used.
   b. Sample size cannot be less than 10 uL.
   c. Additional blood sample must not be added to the test strip once testing has begun.

Department Review	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
05/13, 11/17, 05/20, 07/22	06/13, 12/17, 06/20, 08/22	06/13, 01/18, 07/20, 09/22	04/18, 09/20, 09/22	n/a	07/13, 04/18, 09/20, 10/22	10/20, 12/22	08/13, 05/18, n/a	08/13, 05/18, 11/20

d. Meter will beep to indicate that sufficient flood has been applied and that testing has begun.
e. Venous sample cannot be collected in a syringe containing anticoagulant, or into a glass tube or syringe.
f. Sample must be used immediately after collection.
g. Do not collect from an arm receiving an infusion line for intravenous (IV) therapy.

3. Collecting a Fingerstick Sample:
   a. Prepare lancet device according to manufacturer's instructions. Set it aside until finger puncture is needed.
   b. Warm the hand by having the patient hold it under their arm, using a hand warmer, or washing with warm water.
   c. If possible, have the patient hold his or her arm down to the side, so the hand is below the waist, for about 30 seconds to increase blood flow.
   d. Massage the finger from its base.
   e. Clean the selected finger with alcohol wipe or use soap and warm water. Allow to air dry completely.
   f. Prepare the meter.
   g. When the meter displays the flashing test strip and blood drop symbols, with the hand still down, stick the side of the finger with a lancet. Do not wipe away the first drop of blood. Do not puncture the finger until the flashing test strip and blood drop symbol appears on the meter screen.
   h. Gently squeeze and release the finger from the base to develop a hanging drop of blood.
   i. Blood should be applied within 15 seconds of the puncture. Do not touch the strip with the finger. Do not apply a second drop or disturb the strip while testing.
   j. While the flashing test strip and drop of blood symbols are flashing on the display, apply the first drop of blood as outlined in Performing a Test Procedure.

C. **STORAGE AND STABILITY:**
1. Store test strips in their container, with the cap closed.
2. Store test strips at room temperature or in the refrigerator (2-30 °C or 36-86 °F).
3. When stored properly, the test strips can be used until the expiration date printed on the test strip container.
4. Store test strips in a cooler with an ice pack when transporting in a car.
5. Dispose of strips past their "use by" date.
6. Use the test strip within 10-minutes after removing it from the container.
7. Do not open a vial of test strips or touch a test strip with wet hands or gloves. This may damage the test strips.
8. Close the container tightly.
9. A blue color on the back of the test strip indicated storage conditions have been maintained. A lavender or purple color indicates that storage conditions have been exceeded. Do not use and dispose of any test strips with a lavender or purple color on the back.

D. **OPERATING CONDITIONS**
1. Temperature: Use between 59°F and 90°F (15°C and 32°C). Relative Humidity: Use between 10-85%.
2. Use only fingertips on touchscreen.
3. Place on level, vibration-free surface while testing.
4. Do not use near strong magnetic fields.

E. **METER SET-UP (CHANGES FROM DEFAULT SETTINGS)**
1. Lockouts > QC > New Code > YES

F. **QUALITY CONTROL:**
1. The CoaguChek XS System has quality control functions integrated into the meter and test

strips; two levels of QC are automatically run with every patient test. If the QC results are acceptable, the patient results will display.

2. Liquid controls must be performed on each new shipment and lot of test strips. Record results on the Quality Control Log.

G. **PROCEDURE:**

1. Before Testing:
   a. A code chip is required for each lot of test strips. The XS Plus meter will store data from 60 code chips.
   b. Leave the code chip in the meter to protect the electrical contacts.
   c. Inserting the Code Chip:
      i. Be certain the meter is Off.
      ii. Remove the old code chip and throw it away.
      iii. Make sure the 3-number code on the new test strip container matches the 3-number code on the new code chip.
      iv. Insert the code chip into the code chip slot on the meter with the printed side facing up it snaps into place.
2. Performing a test:
   a. Use hand hygiene.
   b. Prepare the lancet device according to manufacturer's instructions.
   c. Place meter on a flat surface, free of vibrations, or hold it so it is roughly horizontal.
   d. Turn the meter on using the power button.
   e. The main menu will be displayed. Check the battery level (if there are no bars left in the battery symbol, it is not possible to perform any more tests). Check that the date and time are correct.
   f. Select 'Patient Test'.
   g. Enter the patient ID, then press OK. Select the patient from the list, or select 'New Patient' and enter a patient ID.
   h. The test strip symbol prompts staff to enter a test strip. Remove a test strip from the container and close the container tightly. Hold the strip so the print is facing upward. Slide the strip into the test strip guide in the direction indicated by the arrows. Slide it in as far as it will go. A beep tone indicates the meter has detected the strip.
      i. If this is a new lot of test strip, it is necessary to run liquid QC first. Refer to Performing Liquid Quality Control procedure.
   i. An hourglass symbol shows that the meter is warming (approximately 30 seconds).
   j. When the meter is ready, the flashing test strip and blood drop symbols appear. The meter begins a countdown, staff have 120 seconds to apply blood to the test strip. Do not obtain sample until the flashing test strip and drop of blood appear on the display. Strip must be used within 10 minutes of removing it from the container.
   k. Identify the sample target area on the test strip.
   l. Collect the fingerstick blood sample as outlined in "Specimen":
   m. Do not wipe away the first drop of blood.
   n. Apply the first drop of blood to the top or side of the target area within 15 seconds of puncture. Do not touch the strip with the finger.
      i. Note: dose the target area by bringing the patient's finger to the top of the test strip, or keeping the meter level, by bringing the meter to the patient's finger so that the side of the test strip touches the blood drop. Do not apply a second drop. Do not touch strip while a test is in progress.
      ii. Be certain that blood covers the sample target area completely.
      iii. The meter beeps when it detects the drop. The flashing blood drop symbol disappears. Do not add more sample. Do not touch the test strip or move the meter until the result is displayed.
   o. Wait for results—this takes about one minute.
   p. If retest is necessary, use a new fingerstick from the opposite hand and a new test strip.

q. Read and record results. Remove the test strip.
r. Turn the meter Off.
s. Dispose of materials in biohazard or sharps container.

3. Performing Liquid Quality Control:
   a. Remove control vials from the fridge.
   b. Open the lid of the control bottle and remove the rubber cap.
   c. Hold the dropper with the sealed dropper neck pointing upward, then cut off the end of the cap with scissors. Ensure dropper is away from face to prevent contamination. Do not squeeze the bulb of the dropper while cutting the tip.
   d. Apply gentle pressure to the reservoir to transfer the entire contents of the dropper to the bottle. Make sure the dropper does not come in contact with the dried control plasma.
   e. Close the bottle. Keep the dropper at hand.
   f. Swirl the bottle using a circular motion to completely dissolve all the control plasma inside. Do not shake the bottle or turn it on its side. The solution is not ready to be applied to the test strip. (Controls may be used up to 30 minutes after reconstitution.)
   g. Turn the meter on. Check the battery level, date, and time.
   h. Select QC Test.
   i. Remove a test strip from the container, close the container, and insert the test strip into the meter.
      i. If using a new test strip lot and have not inserted the test strip code chip, do so now.
      ii. If using a new control lot, insert the code chip that came with the control solution.
   j. Select the code already stored for control or select New Code to use a new control solution.
   k. Select the level for this measurement.
   l. The hourglass will appear while the strip is warming.
   m. When the strip and dropper symbol display, apply the sample. Staff has120 seconds to complete this step.
      i. Using the dropper, draw up the dissolved contents of the vial.
      ii. Apply a single drop of solution to the test strip. Enough sample is applied when the meter beeps.
   n. The result will be displayed and saved to memory.
   o. If liquid QC test fails, an arrow will be displayed and flash. Repeat first with the same control and a new test strip. If the control still fails, repeat with a new vial of control. If control continues to fail, contact the laboratory.
   p. Remove the test strip and turn the meter off.

4. Recalling Results:
   a. From the main menu, select 'Memory'.
   b. Select 'Patient Result' or 'QC Result'.
   c. Scroll through the data using the up and down arrows. The most recent test is listed at the top.
   d. Select a result. The patient ID, test result, date and time of test, and strip code is displayed.
   e. If the 'individual' symbol is selected, only results for this patient will be displayed.

5. Cleaning the Meter:
   a. Use only 70% isopropyl alcohol or 10% bleach to clean the meter housing:
      i. With the meter turned OFF, ensure the blue test strip guide cover remains tightly closed while cleaning the housing.
      ii. Make sure no liquid enters the meter or accumulates near any opening.
      iii. Let the disinfectant sit on the meter for at least two minutes for alcohol wipes and five minutes for bleach wipes.
      iv. Wipe away residual moisture and fluids after cleaning the housing.
      v. Allow wiped areas to dry for at least 15 minutes before performing a test.
   b. Use only 70% isopropyl alcohol or 10% bleach to clean the test strip guide upon opening

a new bottle of test strips. Use of any other cleaning solutions can result in damage to the meter or incorrect patient results.

c. With the meter turned off, open the cover of the test strip guide by pressing its front edge upward.

d. Move the cover safely away from the meter. Then rinse the cover with water or wipe it clean.

e. Hold the meter upright with the test strip guide facing down. (This will help prevent fluid from entering the meter.) Clean the easily accessible areas of the test strip guide with a cotton-tipped swab. Ensure the swab is only damp, not wet. Caution: do not insert any objects into the test strip guide. Doing so could damage the electrical contacts behind the test strip guide. Wipe the test strip guide area. Let the cleaning solution sit for at least one minute.

f. Wipe away any residual moisture and fluids. Let the inside of the test strip guide dry for at least 15 minutes with the cover off.

g. Close the cover. Make sure it snaps into place.

6. Troubleshooting:
   a. If the meter displays a message other than a result, refer to the Error Messages section of the CoaguChek XS Plus System User Manual.
7. Calculations: n/a
8. Expected values/reference range/critical values:
   a. Normal Range:
      i. The CoaguChek XS meter displays results in units equivalent to those used for the laboratory plasma measurements.
      ii. Normal, healthy, warfarin free individuals: 0.9 – 1.0 INR
   b. Therapeutic Range: must be determined by the physician/Allied Health Professional (AHP) for each patient based on the reason for anticoagulation therapy and how each patient responds to treatment.
      i. Less intense 2.0-3.0 INR
      ii. More intense 2.5-3.5 INR (mechanical heart valves, etc)
   c. Reportable range:
      i. The meter will display results 0.8 – 8.0 INR.
      ii. Any INR greater than or equal to 3.1 must be verified by the laboratory.
   d. Unexpected results:
      i. If the meter displays an unusual test result, check the strip code, date, and time programmed into the meter.
      ii. Repeat the test with a new fingerstick and test strip. If the result is still unexpected, draw a sample for the laboratory.
   e. Limitations:
      i. This method should not be used for patients being treated with Hirudin.
      ii. Hematocrit ranges between 25-55% do not significantly affect test results.
      iii. The presence of anti-phospholipid antibodies (such as lupus Ab) can lead to prolonged clotting times. Test using a lab APA-insensitive method.
      iv. Do not use the meter near strong electromagnetic fields.
      v. Results are unaffected by heparin levels up to 0.8U/mL and low molecular weight heparin levels up to 2 IU anti-factor Xa activity/mL.
      vi. Failure to follow cleaning procedures correctly can lead to a falsely elevated result.
   f. Reporting results:
      i. Record the result in the patient's chart.
      ii. Record the result on the XS Plus Patient Test Log (for regulatory requirements).

H. **REFERENCE(S):**

1. Roche Diagnostics. CoaguChek XS PT Test Product Insert. 7/2010. 05967716001 (02).
2. Roche Diagnostics. CoaguChek XS Plus System Policies and Procedures. 2007. 05021499001-

00-0807.
3. Roche Diagnostics. CoaguChek XS Plus System User Manual. 05021464001 (02) 2009-11 USA.
4. Roche Diagnostics. CoaguChek XS Plus System Policy and Procedure manual CD 2012.

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 12/14 **SUBJECT:** 340B Outpatient Drug Pricing Program

REVISION DATE: **POLICY NUMBER:** 8610-295

Administrative District Operations Content Expert Approval:	**11/21**
Administrative Policies & Procedures Committee Approval:	**12/21**
Pharmacy & Therapeutics Committee Approval:	**~~05/19~~03/22**
Organizational Compliance Committee Approval:	**~~05/1906/22~~10/22**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/19**

A. **PURPOSE:**

1. To define the processes that allows Tri-City Medical Center (TCMC) to purchase pharmaceuticals at discounted prices for its qualified outpatients that is consistent with the Human Resources Services Administration (HRSA) 340B Drug Discount Purchasing Program as defined by the enactment Section 340B of the Public Health Service Act.

B. **BACKGROUND:**

1. Section 340B of the Public Health Service Act (1992) requires drug manufacturers participating in the Medicaid Drug Rebate Program to sign an agreement with the Secretary of Health and Human Services. This agreement limits the price manufacturers may charge certain covered entities for covered outpatient drugs. The resulting program is called the 340B Program. The program is administered by the Office of Pharmacy Affairs (OPA), a part of the federal Health Resources and Services Administration/Department of Health and Human Services.
2. Upon registration on the OPA database as a participant in the 340B Program, entities agree to abide by specific statutory requirements and prohibitions.

C. **DEFINITIONS:**

1. 340B Eligible Covered Entity: The statutory name for facilities and programs eligible to purchase discounted drugs through the Public Health Service's 340B Drug Pricing Program
2. Covered Outpatient Drugs: The category of drugs for which manufacturers must pay rebates to state Medicaid agencies under the Medicaid rebate program and give 340B discounts to covered entities under the 340B program. The 340B statute defines "covered outpatient drug" by referencing the definition found in the Medicaid rebate statute at 42 USC §1396r-8(k) (2). As of November 2012, OPA explained on its website that the 340B program generally covers the following outpatient drugs:
   a. Prescription drugs approved by the Food and Drug Administration (FDA)
   b. Over-the-counter (OTC) drugs dispensed pursuant to a prescription
   c. Biological products that can be dispensed only by prescription (other than vaccines)
   d. FDA-approved insulin
3. Non-covered outpatient drugs: These include vaccines, plain large volume parenterals, anesthetic gases, saline flushes, contrast agents, compounding supplies, bundled items, floor stock and outsourced sterile products.

4. Inpatient status: TCMC determines that patients have an inpatient status according to Admission Discharge and Transfer (ADT) data.
5. Outpatient status: TCMC determines that patients have an outpatient status according to ADT data.

D. **340B POLICY STATEMENTS:**

1. Tri-City Medical Center will comply with all applicable requirements of the 340B drug discount program as set forth in these policies and procedures.
2. TCMC meets all 340B Program eligibility requirements.
   a. TCMC's OPA Database covered entity listing is complete, accurate, and correct.
   b. TCMC is a public non-profit corporation which is formally granted governmental powers by a unit of State or local government
   c. For the most recent cost reporting period that ended before the calendar quarter involved, TCMC had a disproportionate share adjustment percentage greater than 11.75 percent
   d. TCMC does not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement, except in accordance with group purchasing organization (GPO) Policy Release
   e. TCMC uses 340B only in outpatient clinics that are registered on the OPA database (or within the four walls of the parent), fully integrated into the Disproportionate Share Hospital (DSH), and reimbursable on the most recently filed cost report
3. TCMC complies with all requirements and restrictions of Section 340B of the Public Health Service Act and any accompanying regulations or guidelines including, but not limited to, the prohibition against duplicate discounts/rebates under Medicaid, and the prohibition against transferring drugs purchased under 340B to anyone other than a patient of the entity.
4. TCMC maintains auditable records demonstrating compliance with the 340B requirement described in the preceding bullet.
   a. Prescriber is on the hospital's eligible prescriber list as employed by the entity, or under contractual or other arrangements with the entity, and the individual receives a health care service from this professional such that the responsibility for care remains with the entity.
   b. 340B drugs are used in outpatient facilities that appear as reimbursable on the most recently filed Centers for Medicare and Medicaid Services (CMS) cost report and are registered on the OPA database (or within the four walls of the parent).
   c. TCMC maintains records of the individual's health care.
   d. Patient is an outpatient at the time medication is administered/dispensed.
   e. TCMC does not purchase covered outpatient drugs using a GPO (as described above)
   f. TCMC has elected to carve in Medicaid. TCMC bills Medicaid per Medicaid reimbursement requirements, and as TCMC has reflected its information on the OPA website/Medicaid Exclusion File
      i. TCMC informs OPA immediately of any changes to its information on the OPA website/Medicaid Exclusion File
      ii. Medicaid reimburses for 340B drugs per state policy and does not collect rebates on claims from TCMC.
   g. TCMC has systems/mechanisms and internal controls in place to reasonably ensure ongoing compliance with all 340B requirements.
   h. TCMC has an internal audit plan adapted by the Internal Chief Compliance Officer and conducted annually.
   i. TCMC acknowledges its responsibility to contact OPA as soon as reasonably possible if there is any change in 340B eligibility or material breach greater than 5% by the hospital of any of the foregoing policies.
   j. TCMC acknowledges that if there is a breach of the 340B requirements, TCMC may be liable to the manufacturer of the covered outpatient drug that is the subject of the

violation, and depending upon the circumstances, may be subject to the payment of interest and/or removal from the list of eligible 340B entities.

k. TCMC elects to receive information about the 340B Program from trusted sources.

E. **RESPONSIBLE STAFF, COMPETENCY:**

1. TCMC 340B Compliance Committee is tasked with oversight for 340B program integrity in alignment with HRSA/OPA (Health Resources and Services Administration/Office of Pharmacy Affairs) policy for the covered entity.
2. Members of the 340B Committee include:
   a. Chief Financial Officer (CFO)
      i. Responsible as the principal officer and authorizing official in charge for compliance and administration of the program
      ii. Responsible for attesting to the compliance of the program in form of recertification
   b. Director of Pharmacy
      i. Accountable agent for 340B compliance
      ii. Agent of the CFO and primary contact responsible to administer the 340B program to fully implement and optimize appropriate savings and ensure current policy statements and procedures are in place to maintain program compliance
      iii. Must maintain knowledge of the policy changes that impact the 340B program which includes, but not limited to, HRSA/OPA rules and Medicaid changes
      iv. Must coordinate constant knowledge of any change in clinic eligibility/information
      v. Responsible for documentation of policy and procedures
      vi. Assure compliance with 340B program requirements of qualified patients, drugs, providers, vendors, payors and locations
   c. Pharmacy 340B Coordinator/Pharmacy Buyer
      i. Day to day manager of the program
      ii. Maintain system databases to reflect changes in the drug formulary or product specifications
      iii. Manage purchasing, receiving and inventory control processes
      iv. Continuously monitor product min/max levels to effectively balance product availability and cost efficient inventory control
      v. Assure appropriate safeguards and system integrity
      vi. Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping, and inventory processes
      vii. Responsible for establishing three distribution accounts and maintaining those accounts; i.e., non-GPO account, 340B account, and GPO account
      viii. Responsible for establishing and maintaining direct accounts for GPO ("own use") class of trade as well as direct 340B accounts
      ix. Responsible for ordering all drugs from the specific accounts as specified by the process employed
   d. Chief Compliance Officer or designee
   e. Director of Revenue Cycle Operations
      i. Responsible for communication of all changes to the Medicare Cost report regarding clinics or revenue centers of the cost report
      ii. Responsible for communication of all changes to Medicaid reimbursement for pharmacy services/products that impact 340B status
      iii. Responsible for modeling all managed care contracts (with/without 340B)
   f. Pharmacy Informaticist/Analyst
      i. Define process and access to data for compliant identification of outpatient utilization for eligible patients
      ii. Archive the data so as to be available to auditors when audited.
      iii. Review charges from billing software to split-billing software to help identify and resolve data exchange issues

g. Clinical Pharmacy Manager
   i. Be aware of products covered by 340B and Prime Vendor Program pricing
   ii. Work with the Medical Staff to use effective therapeutic classes that optimize savings with good clinical outcomes

F. **340B ENROLLMENT, RECERTIFICATION, CHANGE REQUESTS:**

1. Recertification Procedure
   a. OPA requires entities to recertify their information as listed in the OPA database annually. TCMC Authorizing Official (AO) and Primary Contact (PC) annually recertifies TCMC's information by following the directions in the recertification email sent from the OPA to TCMC's AO by the requested deadline. Specific recertification questions should be sent to: 340b.recertification@hrsa.gov
2. Enrollment Procedure: New Clinic Sites
   a. The 340B Committee evaluates a new service area or facility to determine if the location is eligible for participation in the 340B Program. The criteria used include:
      i. Service area must be fully integrated into DSH
      ii. Appear as a reimbursable clinic on the most recently filed cost report
      iii. Have outpatient drug use
      iv. Have patients that meet the 340B patient definition.
   b. If a new clinic meets these criteria, the TCMC AO completes the online registration process during the registration window (January 1–January 15 for an effective start date of April 1; April 1– April 15 for an effective start date of July 1; July 1–July 15 for an effective start date of October 1; and October 1– October 15 for an effective start date of January 1). This includes submitting cost report information, as required by OPA. http://www.hrsa.gov/opa/eligibilityandregistration/index.html
3. Changes to TCMC Information in OPA Database Procedure
   a. It is TCMC's ongoing responsibility to immediately inform OPA of any changes to its information or eligibility. As soon as TCMC is aware that it loses eligibility, it will notify OPA immediately and stop purchasing (or may be required to repay manufacturers).
   b. An online change request will be submitted to OPA by the AO for changes to TCMC's information outside of the annual recertification timeframe. Change form will be submitted to OPA as soon as the entity is aware of the need to make a change to its database entry. The entity will expect changes to be reflected within about 2 weeks of submission of the changes/requests.

G. **340B PROCUREMENT, INVENTORY MANAGEMENT, DISPENSING:**

1. 340B inventory is procured and managed in the following settings:
   a. Hospital, Mixed-use
   b. Oceanside Infusion Center
2. TCMC will participate in the 340B prime vendor program; providing price protection in the Wholesale Acquisition Cost (WAC) account, and sub-ceiling prices.
3. Oceanside Infusion Center Separate Physical Inventory
   a. TCMC uses physically separate 340B inventory as well as non-GPO/WAC inventory. Pharmacists and technicians only dispense 340B drugs to eligible patients.
   b. TCMC Staff places 340B orders from Cardinal through daily inventory reviews
   c. TCMC Staff checks in 340B inventory by examining the wholesaler invoice against the order, and reports inaccuracies to the wholesaler.
   d. TCMC Staff maintains records of 340B related transactions for a period of 6 years in a readily retrievable and auditable format located in the main pharmacy
   e. 340B inventory is stored in the outpatient pharmacy maintained with a security system. Only pharmacy employees have access to the pharmacy
4. Hospital Mixed-Use Processes:



1. Purchase mixed-use inventory (according to eligible accumulations).
2. Administer/dispense drugs to patients.
3. Accumulator accumulates drug on an 11-digit NDC match until unit of use is met, prepares order, uses patient/clinic/prescriber information to determine the appropriate contract for ordering.

GPO	Non-GPO/WAC	340B
GPO/Inpatient class of trade: Inpatient status determined by hospital at the date/time of administration GPO/Outpatient class of trade: Offsite/unregistered outpatient clinics	Products that do not have an 11 digit NDC match on the 340B contract but are otherwise eligible for 340B purchase Non-340B eligible outpatients, i.e.: • Administration or dispensing occurred at a clinic within 4 walls of parent, but not 340B eligible • In-house pharmacy open to public	Patients met 340B patient definition and received services on an outpatient basis in a 340B registered/participating hospital clinic

4. Replenishment drug order(s) are placed according to eligible accumulations.

5. Transfer Processes
   a. From non-340B to 340B
      i. Transfers between non-340B and 340B inventory are only in rare circumstances, and according to the following procedure:
         1) TCMC Staff records the transaction on a borrow/loan transaction log.
         2) TCMC Staff reconciles the process by transfer back to the separated non-340B inventory area through a purchase on the borrowing area's 340B account of the same National Drug Code (NDC) and quantity that was borrowed.
   b. From 340B to non-340B
      i. Only in the case of an emergency medical situation will drugs be transferred from a 340B inventory to a non-340B inventory. In the case this happens, the following procedures will be used:
         1) TCMC Staff records the transaction on a borrow/loan transaction log.
         2) TCMC Staff reconciles the process by transfer back to the separated 340B inventory area through a purchase on the borrowing area's non-340B account (non-GPO/WAC account) of the same NDC and quantity

that was borrowed. Reconciliation is completed within [interval] of the original loan date.

H. **MONITORING AND REPORTING:**

1. Reporting 340B-Non-Compliance
   a. TCMC defines a material breach of compliance that would require self-disclosure as a violation(s) that exceeds 5% of total 340B purchases or impact to any one manufacturer
   b. The 340B committee will assess the violation, determine the actions and communicate the information to the appropriate parties. Violations identified through internal self-audits, independent external audits, or otherwise that meet or exceed this threshold will be immediately reported to HRSA and applicable manufacturers using the following self-disclosure report template: https://docs.340bpvp.com/documents/public/resourcecenter/ALL_Entities_Self_Reporting_340B_NonCompliance.pdf
   c. The 340B committee will maintain records of materiality assessments and of violations that led to manufacturer resolutions, correspondence and or formal self-disclosure process through HRSA
   d. Address the types of non-compliance that warrant a report to OPA/manufacturer, records kept, documentation, and plan for corrective action

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 09/19

SUBJECT: Conducting Examinations of Patient or Visitor Belongings and/or Room

REVISION DATE~~(S)~~:

POLICY NUMBER: 8610-208

Administrative District Operations Content Expert Approval:	**~~05/19~~03/22**
Administrative Policies & Procedures Committee Approval:	**~~05/19~~04/22**
Environmental Health & Safety Committee Approval:	**~~06/19~~09/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/19~~10/22**
Administration Approval:	**~~09/19~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/19**

A. **PURPOSE:**

1. To provide staff with guidelines for conducting examinations of patients and their belongings and/or rooms, and to include guidelines with screenings of patients/visitors and their belongings when there is clear evidence to suspect there is entry of prohibited items into the hospital to avoid harm or potential to harm to Tri-City Healthcare District ("TCHD") staff, patients, and visitors.

B. **DEFINITIONS:**

1. Weapon - A weapon is defined as any firearm, knives, night sticks, brass knuckles, and other items defined as weapons by California and Federal law or device that could inflict bodily harm or injury.
2. Contraband - Any item that is banned from TCHD property and/or could inflict harm to the patient or others. Items include, but are not limited to weapons, illegal drugs or drug paraphernalia, and other items that pose safety or risk as determined by TCHD security staff and a strong suspicion by staff
3. Examination – a systematic inspection of a person, personal effects, or room.

C. **POLICY:**

1. TCHD recognizes that patients have a right to privacy, dignity, and to be free from unreasonable examinations. Patients, staff, and visitors also have the right to a safe and therapeutic environment which under certain circumstances necessitates taking steps to ensure persons on TCHD property are not in possession of items that may present a hazard to personal safety, health, or the therapeutic environment. It is TCHD's policy to balance the right to privacy with the safety and security of patients, staff, and visitors.
2. For the health, safety and protection of patients and staff, TCHD staff may conduct examinations of the patient or visitors and their belongings and/or rooms when there are facts and circumstances known to TCHD staff that exist that provide the basis for a reasonable person to believe that contraband articles are in a patient's possession.
3. All examinations will be carried out in a professional and courteous manner recognizing the intrusion to personal privacy that occurs. The examination may not be any more intrusive than necessary to ensure the person is not in possession of contraband.

D. **PROCEDURE:**

1. Upon admission, an inventory of the patient's property shall be completed per Patient Care Services Policy: Patient Valuables, Liability and Control 317.
2. Before conducting an examination of a patient or visitor, their belongings and/or room after admission, facts and circumstances known to TCHD staff must exist that provide the basis for a reasonable person to believe that contraband articles may be hidden at the place to be examined.
3. TCHD staff shall take the following steps before conducting an examination:
   a. If the TCHD staff member requesting the examination "actually sees" contraband:
      i. The staff member shall notify the Manager or Administrative Supervisor and Security that the staff member is requesting permission to conduct an examination, what was seen, and why they believe an examination is necessary.
      ii. The Manager or Administrative Supervisor and Security will then determine if an examination is appropriate.
      iii. If there are questions concerning whether an examination is appropriate, the Manager or Administrative Supervisor or Security should contact the Legal Department or its designee.
   b. If the TCHD staff member requesting the examination does not see contraband:
      i. The staff member shall notify the Manager or Administrative Supervisor and Security that the staff member is requesting permission to conduct an examination, what is suspected, and why they believe an examination is necessary.
      ii. The Manager or Administrative Supervisor and Security will then contact the Legal Department or its designee to determine whether an examination is appropriate.
   c. If there is an imminent threat to personal safety:
      i. TCHD staff can conduct an examination if it will not put them in danger and then notify the Manager or Administrative Supervisor, Security and the Legal Department or its designee afterward.
      ~~ii. In emergency situations, TCHD staff should follow TCHD's Emergency Operations Procedure Manual.~~
4. At least two staff members shall be present when conducting an examination, including one member of Security and one member of the clinical staff.
5. At the time of the examination, the patient and/or visitor will be provided with an explanation of the rationale for the examination. Whenever possible, an examination of a patient or visitor's belongings and/or room shall be conducted with the patient or visitor present. Examinations of a patient or visitor shall be conducted in a location which affords reasonable privacy. All non-contraband articles must be put back in an orderly manner.
6. If contraband is found:
   a. The items shall be given to Security in accordance with Administrative Policy: Disposal of Drugs and Drug Paraphernalia 217, Administrative Policy: Weapons on Medical Center Campus 284 and Security Policy: Property Custody 232. If necessary, Security shall contact the Oceanside Police Department in accordance with Administrative Policy: Disposal of Drugs and Drug Paraphernalia 217, and Administrative Policy: Weapons on Medical Center Campus 284.

   Security shall complete an Incident Report.
   b. A note describing the nature of the contraband will be entered into a clinical note in the patient's medical record.
   c. If the contraband is illegal drugs which may affect the patient's medical treatment the physician will be notified.
7. After an examination is conducted there will be a patient debriefing meeting in which patient questions will be answered and concerns and comments will be addressed.

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

1. Administrative Policy: Disposal of Drugs and Drug Paraphernalia 8610-217
2. Administrative Policy: Weapons on Medical Center Campus 8610-284
3. Patient Care Services Policy: Patient Valuables, Liability and Control
4. Security Operations Policy: Property Custody 232

F. **REFERENCE(S):**

1. Code of Federal Regulations, Title 42, Section 482.13(c)(2)
2. California Code of Regulations, Title 8, Section 3342
3. Joint Commission~~, EC.01.01.01 and 02.01.01~~
4. Angela T. Burnette, Searches of Hospital Patients, Their Rooms and Belongings, Health Care Law Monthly, Vol. 2012, Issue 10, at 2
5. "Preventing Violence in the Health Care Setting" Sentinel Even Alert, Issue 45, June 30, 2010, **revised June 18, 2021**.
6. Penney, Susan. "Consent 201: Varying Scenarios." CHA Consent Law Seminar. Sacramento, CA. 6 June 2019.

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 11/94 **SUBJECT:** Portable Space Heaters, Use of

REVISION DATE: 05/03, 01/09, 11/09, 05/15, 05/19 **POLICY NUMBER:** 8610-247

Administrative District Operations Content Expert Approval:	~~03/19~~06/22
Administrative Policies & Procedures Committee Approval:	~~04/19~~08/22
Environmental Health & Safety Committee Approval:	09/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
~~**Finance, Operations & Planning Committee Approval:**~~	~~n/a~~
Administration Approval:	~~05/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	~~05/19~~

A. **PURPOSE:**

1. The purpose of this policy is to **identify the process for using portable space heaters**~~provide for the safety of all patients, staff and visitors to~~ **at** Tri-City Medical Center

B. **POLICY:**

1. The use of any portable space heater in patient care areas is strictly prohibited.
2. The use of portable space heaters in all other non-patient care areas of the Tri-City Medical Center is strictly limited. The portable space heaters must be of an oil filled type, must be operated by a digital thermometer and is either Underwriters Laboratories (UL) approved or listed. Staff utilizing a portable space heater must obtain approval by the Director of Facilities or designee prior to its usage.
3. **Portable space heating devices** ~~shall be~~ **permitted in approved areas shall be used by** ~~to be used~~ **by**~~in~~ **non-sleeping workforce members**~~staff~~**.**

~~2.~~4. **The** ~~and employee areas where the~~ **heating elements of the portable space heater shall not**~~such devices do not~~ **exceed 212 degrees Fahrenheit (100 degrees Celsius).**

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 04/19 **SUBJECT: Recyclable Waste**

REVISION DATE~~(S)~~: **POLICY NUMBER: 8610-209**

Administrative District Operations Content Expert Approval:	~~10/18~~01/22
Administrative Policies & Procedures Committee Approval:	~~02/19~~04/22
Environmental Health & Safety Committee Approval:	~~04/19~~09/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. **PURPOSE:**

1. In order to ensure that Tri-City Healthcare District (TCHD) maintains proper hygiene and infection control practices for all staff and visitors in all facilities with recyclable waste products and containers.

B. **DEFINITIONS:**

1. Recyclable Waste: Includes paper and cardboard; non-contaminated plastics or metals; aluminum cans or glass bottles;
2. Waste Sharps: All objects and materials are closely linked with health care activities and pose a risk of injury and infection due to their propensity of puncturing the skin.
3. Biodegradable Waste: Waste comprises of left-over food; or garden type waste that can be composted.

C. **POLICY:**

1. It is the policy of TCHD to ensure waste materials are reduced, reused, repurposed, recycled or disposed of properly, in order to protect the public health and environment. The TCHD Health Care Waste Management (HCWM) program is an integral part of the hospital hygiene and infection control. TCHD has incorporated proper procedures to minimize the overall risks associated with staff or visitors to the hospital of coming into direct contact with infected waste or sharp items located in waste containers.
2. All Recyclable or Biodegradable Waste items are considered the property of TCHD and not to be confiscated by staff, visitors or guests to any TCHD facility to be utilized for their own personal use.
3. All staff, visitors or guests to any TCHD facility are not to retrieve or scavenge for any Recyclable or Biodegradable Waste item(s) from any receptacle or container on the hospital premises.
   a. Any TCHD staff member observed scavenging through any recyclable or waste containers or removing recyclable or biodegradable TCHD property for their own personal use will be subject to disciplinary actions.
4. All recyclable or waste receptacles will be managed by and are to only be emptied or changed out by TCHD EVS staff, Food and Nutrition staff or contracted services into approved waste receiving containers.

5. TCHD EVS staff, Food and Nutrition staff or contracted services that handle or empty any recyclable or waste receptacles are to follow hospital hand hygiene procedures to prevent any risks to themselves, staff or visitors to the facility.

D. RELATED DOCUMENT(S):

1. Infection Control Policy: Hand Hygiene ~~IC.8~~
2. Tri-City Healthcare District Code of Conduct

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 08/19 **SUBJECT: Secure Environment**

REVISION DATE~~(S)~~: **POLICY NUMBER: 8610-204**

Administrative District Operations Content Expert Approval:	**~~03/19~~03/22**
Administrative Policies & Procedures Committee Approval:	**~~05/19~~04/22**
Environmental Health & Safety Committee Approval:	**~~06/19~~09/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/19~~10/22**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **PURPOSE:**

1. To clearly define ~~the procedures~~ and process by which patients, visitors and workforce members are provided with a secure environment and how that outcome is achieved.

B. **DEFINITION(S):**

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. ~~Contingent Worker: Freelancer, independent contractor, consultant, or other outsourced and non-permanent worker hired on a per-project basis whose job or project is structured to last a limited length of time.~~

C. **POLICY:**

1. TCHD requires Workforce Members, visitors to patient areas, guests, and patients to have appropriate identification to establish a safe and secure environment for all patients and Workforce Members.
2. All identification badges are to be worn/adhered on the outside of their clothing, **above the** waist ~~high or above~~ and clearly visible.
3. **Workforce Members**~~Employees, Travelers, Physicians/AHPs, Volunteers, and Contingent Workers~~:
   a. Will have a TCHD issued name and picture identification badge, which is to be worn so the photo, name and vocational classification is clearly visible to any patient, visitor or Workforce Member.

~~b.~~**4.** **Workforce Members**~~Employees, travelers, physicians/AHPs, volunteers, and contractors~~ without the proper TCHD identification will be given a visitor badge and their Director/Manager will be notified.

~~4.~~**5.** Registry:
   a. Will have a TCHD issued badge to be worn in addition to a registry badge with photo and name.

~~5.~~**6.** Guests/Visitors:
   a. Will have an authorized visitor badge indicating date and area they are visiting or rendering services from.

b. The guests/visitors are to check in with the Main Lobby, Security or Information Desk to receive their badges, which are to be adhered on the outside of their clothing, chest high and clearly visible.

~~6.~~**7.** Patients:
a. Will have the patient identification band to be worn around the wrist and clearly visible.

~~7.~~**8.** Students:
a. Will **have** a TCHD issued name and picture identification badge or a TCHD issued student badge to be worn in addition to their school badge with photo and name.

~~8.~~**9.** Independent Contractors and Vendors:
a. Will have a badge issued via vendor management software (i.e. Reptrax) or through Purchasing.

D. **SECURITY/TRAFFIC CONTROL, ACCESS TO FACILITY:**

1. TCHD Security Officers will be posted at the Main Lobby Security Desk ~~from 0530-2000 hours~~ and will ensure all guests, visitors or Workforce Members have the required identification badge(s) visible prior to entering the facility. After 2000 hours, only the following persons will be allowed access to the facility:
   a. Badged members of the medical staff
   b. TCMC staff and affiliates (Registry, Travelers, Students)
   c. Vendors/Contractors having confirmed business
   d. Visitors for patients currently receiving care at TCHD.
2. Guests/visitors requiring room numbers or additional information will be directed to the Information Desk.
3. Clearly defined visitations procedures, expectations and hours will be posted at entrances to facility.
4. All perimeter entrances to the facility except for the Main Lobby and Emergency Room Lobby are to be locked at all times to prevent unauthorized access to the facility. Staff members will be permitted to utilize controlled access areas allowed by their TCHD issued badge.
5. After visiting hours, the only public access to Tri-City Medical Center is through the Emergency Department Lobby controlled entrance.
6. Traffic flow or access to departments/patient care areas are managed and controlled at all times.
7. TCHD Security Staff in collaboration with all facility Workforce Members are responsible for safeguarding patients, employees, visitors and the property TCHD. Security Staff and Workforce Members are required to contact any guest, visitor or vendor observed without proper identification and direct them to Security, Information Desk or notify security staff.
8. Security Staff has the right to refuse admittance to the facility to any visitor or guest not complying with TCHD Policy.
9. All persons entering ~~the~~ TCHD shall be subject to a reasonable search as a condition of entry to the property. Persons refusing search will be denied services until a safe environment may be established.

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

1. Administrative Policy: 436 Identification of Staff

Tri-City Medical Center
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE: 08/19

SUBJECT: Weapons Scanning in the Emergency Department

REVISION DATE~~(S)~~:

POLICY NUMBER: 200

Administrative District Operations Content Expert Approval:	**~~05/19~~03/22**
Administrative Policies & Procedures Committee Approval:	**~~05/19~~04/22**
Environmental Health & Safety Committee Approval:	**~~06/19~~09/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~06/19~~10/22**
Administration Approval:	**07/19**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **PURPOSE:**

1. To provide Security staff with guidelines for conducting searches of individuals when entering the Emergency Department to prevent the entry of prohibited items into the hospital and to keep Tri-City Healthcare District ("TCHD") staff, patients and visitors safe from items that may harm or have the potential to harm.

B. **DEFINITIONS:**

1. Weapon - A weapon is defined as any firearm, knives, night sticks, brass knuckles and other items defined as weapons by California and federal law or device that could cause bodily harm or injury.
2. Contraband - Any item that is banned from TCHD property and/or is of harm to the patient or others. -Items include, but are not limited to weapons, illegal drugs or drug paraphernalia and other items that pose safety or risk as determined by TCHD staff.
3. Search – a systematic inspection of a person~~,~~ **or** personal effects **via metal detector** ~~or room~~.

C. **POLICY:**

1. TCHD recognizes that patients, staff, and visitors have a right to privacy, dignity and to be free from unreasonable searches. -Patients, staff, and visitors also have the right to a safe and therapeutic environment which under certain circumstances necessitates taking steps to ensure persons on TCHD property are not in possession of items that may present a hazard to personal safety or the therapeutic environment.
2. For the safety and protection of both patients and staff, Security may conduct searches of persons and their belongings when entering the Emergency Department in order to prevent weapons from entering TCHD. -(See Administrative Policy: Weapons on Medical Center Campus 284).
3. All searches will be carried out in a professional and courteous manner recognizing the intrusion to personal privacy that occurs. -The search may not be any more intrusive than necessary to ensure the person is not in possession of weapons.

D. **PROCEDURE FOR SEARCHES AT EMERGENCY DEPARTMENT ENTRANCE:**

1. All persons, including off duty TCHD staff, entering through the Emergency Department entrance will be subject to a search of their person via a metal detector by Security. -It is

designed to be a non-intrusive search to prevent weapons from entering the facility and to maintain the safety of patients, visitors and staff.

a. On duty TCHD staff and public safety personnel are not subject to a search when entering through the Emergency Department entrance.

2. Patients entering the Emergency Department entrance with obvious life threatening emergencies will be allowed to pass through the metal detector unchallenged. -If the metal detector alarms, notification will be given to the Emergency Department nurse. -Unconscious, critically ill, or seriously injured patients need not pass through the metal detector provided that medical staff will be removing the patient's clothing.
3. The ambulance entrance is restricted to entry by public safety personnel along with private vehicles. -Non-ambulatory patients in private vehicles will be allowed access to the ambulance entrance. -However, occupants other than the patient, must enter via the metal detection area.
4. Persons are allowed to approach the metal detection area and depart without passing. However, once entry and activation of the metal detector occurs, Security will complete the screening process prior to allowing the person to depart.
5. All baggage, briefcases, purses, back-packs, sacks, baby carriers, etc., will be inspected for weapons by Security at the metal detection area. Attention should be given to belt buckles, pagers, metal canes, and other questionable items that may conceal weapons.
6. Persons declining searches of items will not be allowed to bring the items into the facility and may be allowed to return to their vehicle and store their possessions in a locked vehicle.
7. TCHD prohibits all persons, except those expressly authorized in Administrative Policy: Weapons on Medical Center Campus 284, from bringing firearms onto TCHD property. Any person with a valid carry permit will be asked to return the firearm to their vehicle.
8. In the event of discovery of weapons, drugs, drug paraphernalia, or other contraband, Security shall secure the items and take the necessary steps in accordance with Administrative Policy: Disposal of Drugs and Drug Paraphernalia 217 and Administrative Policy: Weapons on Medical Center Campus 284, including contacting the Oceanside Police Department.
9. Persons refusing to comply with the search may be denied entrance. Persons seeking emergency medical services will not be refused services.
10. All persons who leave the Emergency Department will be screened upon their return.

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

1. Administrative District Operations Policy: Disposal of Drugs and Drug Paraphernalia 8610-217
2. Administrative District Operations Policy: Weapons on Medical Center Campus 8610-284
3. Patient Care Services Policy: Visiting Guidelines
4. Security Operations Policy: Property Custody 232

F. **REFERENCE(S):**

1. Code of Federal Regulations, Title 42, Section 482.13(c)(2)
2. California Code of Regulations, Title 8, Section 3342
3. Angela T. Burnette, Searches of Hospital Patients, Their Rooms and Belongings, Health Care Law Monthly, Vol. 2012, Issue 10, at 2

Tri-City Health Care District
Oceanside, California

ADMINISTRATIVE ~~POLICY MANUAL~~
COMPLIANCE

ISSUE DATE: 03/03

SUBJECT: Patient Requests To Receive Communications Of Protected Health Information (Phi) By Alternative Means Or At Alternate Locations

REVISION DATE: 03/06; 02/09, 10/15

POLICY NUMBER: 8610-519

Administrative Policies & Procedures Content Expert:	**11/20**
Administrative Policies & Procedures Committee Approval:	**~~09/15~~12/21**
Organizational Compliance Committee Approval:	**10/22**
Administration Approval:	**12/22**
Audit, Ethics and Compliance Committee Approval	**~~10/15~~ n/a**
Board of Directors Approval:	**10/15**

A. **PURPOSE:**

1. To set guidelines for accommodating reasonable requests by Tri-City Healthcare District (TCHD) patients to receive communications of protected health information (PHI) by alternative means or at alternate locations.

B. **DEFINITIONS:**

1. Protected Health Information (PHI): Individually identifiable health information transmitted or maintained in electronic form 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.

C. **POLICY:**

1. TCHD will permit patients to request and TCHD will accommodate reasonable requests by patients to receive confidential communications by alternative means or at alternative locations.
2. Patient requests for confidential communications by alternative means or at alternative locations must be made in writing as described in this Policy.

D. **PROCEDURES:**

1. TCHD will permit patients to request that communications of PHI by alternative means or alternative locations which may include:
   a. Alternative phone numbers. (For example, a patient may wish to designate a specific phone number for communications).
   b. Alternative addresses. (For example, a patient who does not want ~~his or her~~**their** family to know about a medical condition may request that communications be directed to ~~his or her~~**their** workplace address instead of a home address).
   c. By closed envelope instead of postcard.
2. TCHD determines the reasonableness of the request based on the administrative difficulty of complying. TCHD may not require an explanation from the patient as to the basis for the request as a condition of providing communications on a confidential basis.

3. Requests for alternative communications made after registration must be submitted in writing to the Registration Manager. Termination of the request will require submitting a separate signed form.
4. At the time of registration or at the point of entry, patients or their representatives will be asked if they wish to receive communications by alternative means or at alternative locations.
   a. Those that do request alternative means of communication must complete and sign the Request for Restriction on the Manner/Method of Confidential Communications form.
   b. When wishing to terminate the request, the Termination of Special Restriction form must be completed and signed.
   c. Registration staff will complete the appropriate fields in Cerner ~~and Affinity~~ upon receipt of request.
   d. Both forms, upon completion, are to be forwarded to Medical Records/Health Information for inclusion in patient's record.
5. Requests for special communications after the visit date can be directed to the **Compliance and** Privacy Officer, who will mail the form to the requesting individual.
   a. Upon receipt, the information will be forwarded to the Registration Manager for input in to both Cerner and Affinity.
   b. Upon completion, forms will be forwarded to Medical Records/Health Information for inclusion in the patient's record.
6. TCHD may condition the provision of reasonable accommodation on, if and when appropriate, information as to how payment, if any, will be handled and specification of an alternative addresses or other method of contact.

E. **REFERENCES:**
1. 45 CFR Section 164.522(b)~~(1)~~

F. **FORMS:**
1. Request for Restriction on the Manner/Method of Confidential Communication

Name: _____ Date: _____
(Last) (First) (MI)

Address: _____

Telephone Number: _____

Date of birth: _____ Social Security #: _____
(Optional)

You may request to receive confidential communications of your protected health information (PHI) by alternative means or at alternative addresses. For example, you may not want your appointment notices or your bill to go to your home.

We may not ask you the reason for your request. We will accommodate all reasonable requests.

If you make a special request, you must give us an alternative address or other method of contacting you. Please specify how or where you wish to be contacted by marking the box and recording the detailed information. ☐

ڤ **Address:** _____

ڤ **Phone Number:** _____

Signature of patient or representative: _____

If representative, give relationship: _____

For more information about your privacy rights, see the "Notice of Privacy Practices" on our website at tri-citymed.org or in the Medical Records/Health Information Department or by sending a written request to our Privacy Officer.

If you believe your privacy rights have been violated, you may file a complaint with ~~the~~ **Tri-City** Medical Center or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

To file a complaint with the Tri-City Healthcare District, contact our **Chief Compliance and** Privacy Officer at:

Tri-City Medical Center
4002 Vista Way
Oceanside, CA 92056
Attn: Privacy Officer
Values Line ~~(800) 273-8452~~**(844) 521-7862**

REQUEST FOR RESTRICTION ON THE MANNER/METHOD OF CONFIDENTIAL COMMUNICATIONS

Tri-City Medical Center
4002 Vista Way
Oceanside, California 92056

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Neonatal
Standardized Procedures

Approvals

Neonatology Division (Signature):	August 13, 2021
Pediatrics Department (Signature):	May 3, 2022
Interdisciplinary Practice Committee (Date):	~~July 14, 2017~~July 18, 2022
Medical Executive Committee (Date):	~~July 24, 2017~~September 26, 2022
Administration Approval:	December 05, 2022
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
III. Management of Controlled Substances by the NP
IV. Supervision of the NP by Physician
V. NP Qualifications – Education and Licensing
VI. Quality Improvement

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

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

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Neonatal NP will:
   a. Assume responsibility for the *Neonatal* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Neonatal Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Neonatal Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for NICU are as follows:

i. NICU Acyclovir
ii. NICU Admission _1
iii. NICU Amphotericin Liposomal
iv. NICU Caffeine Citrate Initiation
v. NICU Diflucan
vi. NICU Decadron DART
vii. NICU Feeding
viii. NICU Flagyl
ix. NICU Follow Up Labs
x. NICU Gentamicin
xi. NICU IV Fluids/PICC Line Insertion
xii. NICU Meropenem
xiii. NICU Neonatal Abstinence Syndrome
xiv. NICU PICC Line Insertion
xv. NICU Phenobarbital
xvi. NICU Pre Eye Exam Medication Orders
xvii. NICU Respiratory
xviii. NICU Sepsis Work Up
xix. NICU Treatment for HIV Exposure
xx. NICU Vaccines
xxi. NICU Vancomycin
xxii. NICU CSF Labs
xxiii. SP NICU Newborn Medications – Nursing

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Division of Neonatology.

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

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

B. Each NP will at all times have a supervisory relationship with a specifically identified TCMC physician member.

C. No physician shall provide concurrent supervision for more than four NPs.

D. The Supervisor is not required to be present at the time of the patient assessment/examination, but must be available for collaboration/consultation by telephone.

E. Ongoing case specific Supervision occurs as needed, with frequency determined by the NP and/or the Supervisor. The consultation, including recommendations, is documented as considered necessary by the Supervisor in the clinical record.

1. Additional Supervision occurs as described below under "Quality Improvement."

F. Supervisor notification and consultation is obtained under the following circumstances:

1. Emergent conditions requiring prompt medical intervention after stabilizing care has been started.
2. Acute exacerbation of a patient's situation;
3. History, physical or lab findings that is inconsistent with the clinical formulation or diagnostic or treatment uncertainty.
4. Patient refusal to undergo a medical examination and/or appropriate medical monitoring.
5. Upon request of the patient, another clinician or Supervisor.
6. Upon request of the NP.
7. The supervising physician will examine the patient on the same day as care is provided by the NP for non-scheduled patient admissions.

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:

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

B. Licenses and Certification:

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

VI. QUALITY IMPROVEMENT

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

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

VII. **Practice Prerogatives**

A. As determined by the NP – Neonatal Card.

Acknowledgement Statements:

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

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

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

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – OB/GYN
Standardized Procedures

Approvals

OB/GYN Department (Signature):	June13, 2022
Interdisciplinary Practice Committee (Date):	~~July 14, 2017~~July 18, 2022
Medical Executive Committee (Date):	~~July 24, 2017~~September 26, 2022
Administration Approval:	December 05, 2022
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
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V. NP Qualifications – Education and Licensing
VI. Quality Improvement

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

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

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The OB/GYN NP will:
   a. Assume responsibility for the *OB/GYN* care of patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the OB/GYN Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the OB/GYN Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for OB are as follows:

i. OB Admit to L&D C-Section
ii. OB Admit to Postpartum C Section
iii. OB GYN Pre Operative Hold
iv. OB GYN Pre Operative Education
v. OB Pre-Op Teach Labs
vi. OB Tubal Ligation Pre/Intra Orders
vii. Discharge Women's
viii. OB 2016 L&D C-Section
ix. OB 2016 Postpartum C Section
x. OB 2016 Postpartum Vaginal Delivery
xi. OB 2016 Tubal Ligation Pre/Intra Orders

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of OB/GYN.

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

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. NRP, BLS or ACLS in accordance with the specialty requirement.
    6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

A. NPs participate in the identification of problems that may pose harm for patients to facilitate change and improvement in patient care.
    1. The NP will complete clinical quality review reports when necessary and inform appropriate personnel.
    2. The NP will note errors or inconsistencies in patient records and intervene to correct and resolve these.
    3. NP cases referred for peer review shall be evaluated by the Supervisor in conjunction with the medical staff peer review processes.
    4. The Supervisor conducts an annual review of the NP's performance, and gives input into the Annual Performance Evaluation.

5. The NP will be subject to existing methods of monitoring and quality improvement will be utilized where appropriate. These methods include, but are not limited to supervision, medication monitoring and the medical staff peer review process.

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

VII. **Practice Prerogatives**

A. As determined by the NP – OB/GYN Card.

Acknowledgement Statements:

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

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

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

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Pediatrics
Standardized Procedures

Approvals

Pediatrics Department (Signature):	May 3, 2022
Interdisciplinary Practice Committee (Date):	~~July 14, 2017~~July 18, 2022
Medical Executive Committee (Date):	~~July 24, 2017~~September 26, 2022
Administration Approval:	December 05, 2022
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

NURSE PRACTITIONER STANDARDIZED PROCEDURES

TABLE OF CONTENTS

I. Development, Review and Approval of Nurse Practitioner (NP) Standardized Procedures
II. Setting and Scope of NP Practice (Functions)
III. Management of Controlled Substances by the NP
IV. Supervision of the NP by Physician
V. NP Qualifications – Education and Licensing
VI. Quality Improvement

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

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

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Pediatric NP will:
   a. Assume responsibility for the *Pediatric* patients, under written standardized procedures and under the supervision of the TCMC medical staff member (physician) as outlined in the TCMC Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCMC medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Pediatric Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Pediatric Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve patient outcomes.

m. Provide patient health education related to medications and health issues.

n. The PowerPlans for Pediatric are as follows:

i. Discharge Newborn

ii. PED Admission to Peds

iii. PED Hyperbilirubinemia

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

B. Definition: controlled substances are defined as those scheduled drugs that have a high potential for dependency and abuse.

1. Schedule II through V drugs require successful completion of an Advanced Pharmacology continuing education course that includes Schedule II controlled substances based on standards developed by the California Board of Registered Nursing.

a. This course must be successfully completed prior to the application to the United States Drug Enforcement Administration (DEA) for a Schedule II registration number.

2. When Schedule II through V drugs are furnished or ordered by a NP, the controlled substances shall be furnished or ordered in accordance with a patient-specific Power Plans approved by the treating or supervising physician and the Department of Pediatrics.

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

A. Supervision for purposes of this standardized policy is defined as supervision by and MD or DO for the performance of standardized procedure functions and for the furnishing or ordering of drugs by a NP pursuant to California (CA) Business & Professions Code.

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
    1. Master's degree in Nursing from an accredited college or university; AND
    2. Completion of an approved Adult, Pediatric, or Family Nurse Practitioner program.
B. Licenses and Certification:
    1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
    2. Currently certified by the State of California as a Nurse Practitioner;
    3. Possession of a California State-issued medication Furnishing Number;
    4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
    5. BLS or NRP in accordance with the specialty requirement.

VI. QUALITY IMPROVEMENT

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

VII. Practice Prerogatives

A. As determined by the NP – Pediatrics Card.

Acknowledgement Statements:

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

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

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

Tri-City Medical Center

Allied Health Professional

Nurse Practitioner – Psychiatry Division
Standardized Procedures

Approvals

Psychiatry Division (Signature):	March 16, 2022
Medicine Department (Signature):	March 16, 2022
Interdisciplinary Practice Committee (Date):	~~April 11, 2017~~July 18, 2022
Medical Executive Committee (Date):	~~July 24, 2017~~September 26, 2022
Administration Approval:	December 05, 2022
Professional Affairs Committee (Date):	~~August 10, 2017~~n/a
Board of Directors (Date):	August 28, 2017

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TABLE OF CONTENTS

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V. NP Qualifications – Education and Licensing
VI. Quality Improvement

I. DEVELOPMENT, REVIEW AND APPROVAL OF NP STANDARDIZED PROCEDURES

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

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

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

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

II. SETTING AND SCOPE OF NP PRACTICE (FUNCTIONS)

A. **SETTING**

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

B. **SCOPE OF NP PRACTICE (FUNCTIONS)**

1. The Psychiatry Division NP will:
   a. Assume responsibility for the *Psychiatry* care of patients, under written standardized procedures and under the supervision of the TCHD medical staff member (physician) as outlined in the TCHD Allied Health Professionals Rules and Regulations.
      i. Patients may be seen for the initial medication assessment by the NP with the agreement and under the supervision of the physician. The NP must consult the supervising physician if assessing a medication outside of the NP defined scope of practice as defined in the standardized procedure. The supervising physician may choose to perform the initial medication assessment and then assign the NP responsibility for implementation and follow through of the plan of care for the patient, subject to the supervision requirements of the TCHD medical staff.
   b. Admit and discharge patients only with physician order and consultation. Patients are admitted to, and discharged from, inpatient and outpatient services, with the order of the supervising physician. Telephone/verbal orders for admission and discharge can be obtained from the physician and entered by the NP. Telephone orders are systems directed for physician signature which is required within 48 hours.
   c. Order medications as included in the Psychiatry division Cerner Power Plans.
      i. The NP will provide an explanation of the nature of the illness and of the proposed treatment; a description of any reasonable foreseeable risks, side effects, interactions with other medications, or discomforts; a description of anticipated benefits; a disclosure of appropriate alternative

procedures or courses of treatment, if any; and special instructions regarding food, drink, or lifestyles to the patient.

ii. The NP orders the medication and documents the information into the chart and in the clinical notes.

iii. If a medication needed is not listed on a Power Plan the NP must consult the supervising physician, document the consultation in the medical record, and place the order via telephone order communication type for supervising physician co-signature.

d. Administer medications (including an injectable) as necessary for patient needs. Medication administration by an NP does not require a standardized procedure.

e. Obtain psychiatric and medical histories and perform overall health assessment for any presenting problem.

f. Order and interpret specific laboratory studies for the patient as included in the Psychiatry division Power Plans.

g. Provide or ensure case management and coordination of treatment.

h. Make referrals to outpatient primary care practitioners, and/or Mental Health Physicians for consultation or to specialized health resources for treatment, as well as any subsequent modifications to the patient's care as needed and appropriate. Inpatient consultations must be physician to physician as stipulated in the medical staff bylaws.

i. Document in the patient's medical record, goals, interventions clinical outcomes and the effectiveness of medication in sufficient detail so that any Practitioner can review and evaluate the effectiveness of the care being provided.

j. Identify aspects of NP care important for quality monitoring, such as symptom management and control, health behaviors and practices, safety, patient satisfaction and quality of life.

k. Utilize existing quality indicators or develop new indicators to monitor the effectiveness of the care provided to the patient.

l. Formulate recommendations to improve mental health care and patient outcomes.

m. Provide patient health education related to medications, psychiatric conditions and health issues.

n. The PowerPlans for the Psychiatry Division are as follows:

i. 5150 Order/Sub Phase
ii. Alcohol and Benzodiazepine Detoxification SubPhase (Decision to Admit)
iii. BHU Admission
iv. BHU Alcohol and Benzodiazepine Detoxification
v. BHU Anxiety
vi. BHU Bipolar-Mania
vii. BHU Clozapine Titration
viii. BHU Depression
ix. BHU Emergency Medications
x. BHU Invega Sustenna
xi. BHU Nicotine Smoking Cessation Plan
xii. BHU Opiate Detox
xiii. BHU Psychosis
xiv. BHU Standard Admission Medications
xv. BHU Suboxone Taper Off
xvi. Discharge BHU (NEW)
xvii. Discharge BHU Patient

III. MANAGEMENT OF CONTROLLED SUBSTANCES

A. The NP may furnish non-controlled substances and devises included in the Standardized Procedure under the supervision of a designated supervising physician.

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

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

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

V. QUALIFICATIONS - EDUCATION AND LICENSING

A. Education and training:
   1. Master's degree in Nursing from an accredited college or university; AND
   2. Completion of an approved Adult, Child, or Family Nurse Practitioner program.
B. Licenses and Certification:
   1. Currently licensed by the State of California Board of Registered Nursing as a Registered Nurse;
   2. Currently certified by the State of California as a Nurse Practitioner;
   3. Possession of a California State-issued medication Furnishing Number;
   4. Possession of a DEA Number: Issued by the Drug Enforcement Administration the DEA number is required to prescribe controlled drugs. Drugs and/or devices furnished by the NP may include Schedule II through Schedule V controlled substances.
   5. BLS or ACLS in accordance with the specialty requirement.
   6. CNOR Certification if assisting in surgery.

VI. QUALITY IMPROVEMENT

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

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

VII. **Practice Prerogatives**

A. As determined by the NP – Psychiatry Division Card.

Acknowledgement Statements:

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

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

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

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL
GENERAL INFORMATION

ISSUE DATE:	**06/08**	**SUBJECT: Emergency Operations Plan**	
REVIEW DATE:	**06/11**	**POLICY NUMBER: 4001**	
REVISION DATE:	**01/17, 03/19**		
Department Approval:		**~~03/22~~09/22**	
Environmental Health & Safety Committee Approval:		**~~03/22~~09/22**	
Medical Executive Committee Approval:		**n/a**	
Administration Approval:		**~~03/22~~12/22**	
Professional Affairs Committee Approval:		**n/a**	
Board of Directors Approval:		**03/22**	

A. **PURPOSE:**

1. The purpose of the Emergency Operations Plan (EOP) is to define strategies and activities designed to prevent, prepare for, respond to, and recover from adverse events that may occur within the hospital and its campus (internal incident) or outside of the hospital and its immediate campus (external incident) that cause or have the potential to cause a negative impact on normal hospital operations or services. The plan is based on a dynamic, functional, and practical emergency management approach that is founded on:
   a. Preventing or minimizing the loss of life and injuries
   b. Ensuring personnel safety
   c. Minimizing disruptions to the organization's critical operations
   d. Comprehensive emergency management practices
   e. Flexible, scalable plan activation
   f. Integrated command, control, and communications
   g. Fully implementing the Hospital Incident Command System (HICS)
   h. Integrating the hospital's mitigation, preparedness, response, and recovery efforts with those of its community

B. **SCOPE:**

1. The plan is designed to provide guidance and direction for the establishment, management, maintenance, and oversight of the EOP and, as such, applies to all hospital staff. The EOP establishes policies for response and recovery activities associated with any emergency activation. This plan supersedes all previous hospital emergency operations plans. Changes to any portion of this plan shall be submitted in writing to the hospital Emergency Operations Coordinator or designee.
2. This plan applies to Tri-City ~~Hospital~~**Healthcare** District (TCHD) and its affiliated clinics/offices.

C. **PLANNING ASSUMPTIONS:**

1. TCHD will continue to be exposed to the impact of hazards described in the Hazard Vulnerability Analysis (HVA) as well as others previously unidentified or that may develop in the future.
2. It is possible for an emergency or major disaster to occur at any time. In some cases, advance warning and implementation of increased preparedness measures may be possible. However, many events could occur with little or no warning.
3. State and local governments will have limited resources to support initial hospital response operations.

4. Federal emergency response assets may not be available within the first 96 hours following an event.
5. Emergency conditions may require modification of normal patient care activities. Conditions may require discontinuation of services, patient transfer or early discharge, establishment of alternative care sites, or facility evacuation.
6. Preparedness activities and strategies based on the most plausible worst-case scenario for each hazard strengthen response and recovery capabilities.
7. Preparedness initiatives pursued in collaboration with the local community further enhance hospital response capabilities and promote community resilience.
8. TCHD will utilize the four phases of emergency management-mitigation, preparedness, response, and recovery-to frame its approach to emergency events.
9. TCHD has adopted an all-hazards approach to emergency management planning—one that supports a general response capability sufficiently nimble to address a wide range of emergencies of various duration, scale, and cause.
10. The recovery period may be longer in duration than the response period and may result in prolonged disruption of normal operations.

D. KEY ROLES AND RESPONSIBILITIES:

Executive Leaders	Reviews reports, as appropriate, communicates concerns about identified issues and regulatory compliance. Provides support for ongoing activities of the EOP
Senior Leaders	Ensure EOP policies are establish Authorize mitigation and preparedness strategies Assume responsibility for the overall response and recovery operations. Identify individuals (by title or position) responsible for serving as Incident Command Management Team (IMT) members.
Emergency Operations Coordinator/Designee	Provides overall management and oversight for the EOP Coordinates the development and implementation of emergency management plans, policies and procedures Ensures that all emergency management–related regulatory requirements are satisfied and routinely monitored for continued compliance. Champions the ongoing implementation and sustainment of the Hospital Incident Command System (HICS) throughout the organization. Serves as the hospital's emergency management liaison with external entities (e.g., local/state emergency management entities, regional healthcare planning groups, volunteer and support organizations). Chairs the Environmental Health and Safety Committee (EHSC)
Emergency Health and Safety Committee	Conducts an annual review and revision of the Hazardous Vulnerability Analysis (HVA), and EOP. Works closely with all department leaders to identify department-specific planning and training requirements. Develops a training and exercise plan that focuses on high-priority hazards from the hospital's HVA; findings from previous drills, exercises, and actual events; newly developed plans and procedures; current grant guidance; and changes in regulatory requirements. Conducts after-action analysis and reporting for emergency drills/exercises and actual events and develops corrective actions plans, as required. Proposes and incorporates changes to policies, plans, and procedures based on identified findings. Tracks and reports on progress of corrective actions. Leads emergency management program improvement initiatives. Investigates, researches, and incorporates industry best practices into the emergency management program.
Department Leadership	Develop and maintain current personnel notification rosters. Reviews and provides input to the EHSC to ensure department-specific emergency plans are updated annually and as required

	Ensures staff complete and participate in emergency management specific education and training. Ensures staff understand their roles during EOP activation. Provide personnel, equipment, and supplies to support emergency operations upon request. Report changes in operational status to the Incident Commander (IC)
All Hospital Staff	Complete annual emergency management training Identify their roles and responsibilities during EOP activation. Participate in emergency preparedness activities, as assigned. Provide current emergency notification information to department manager. Accomplish emergency response and recovery tasks, as assigned.

E. **CONCEPTS OF OPERATIONS:**

1. TCHD will respond to an emergency by activating its EOP using a scalable. The event will be managed by a pre-identified, trained Incident Management Team (IMT) using the HICS. Designated incident operating locations will be activated by the Incident Commander as required. The initial response by hospital departments will be guided by their department leaders or incident command structure. Related policies and procedures may be activated to provide event-specific guidance for hospital responders. A demobilization and recovery plan will be developed to provide an orderly return to normal operations. After-action analysis and reporting will be conducted to identify lessons learned and opportunities for improvement. The EHSC will develop a corrective action plan and track progress. Emergency management program improvements will be implemented and tested.

F. **PLAN ORGANIZATION:**

1. The TCHD EOP is organized in three principal sections:
   a. Emergency Management Program: Description of the hospital's comprehensive emergency management program, core elements of the all-hazards planning framework, and Incident Command System (ICS).
   b. Emergency Operations Base Plan—Provides an overall systems description of how TCHD resources are organized during response, and then describes how they interact during emergency response and initial recovery.
   c. Policies and Procedures – Hospital policies and procedures that provide specific information and direction.
2. National Incident Management System (NIMS)
   a. Adoption of NIMS
   b. NIMS is implemented throughout the healthcare organization including all appropriate departments and business units.
   c. Education is provided to hospital leadership on the benefits of interoperability and coordination for effective incident management across jurisdictions.
   d. Accordingly, elements of the Five-Year NIMS Training Plan that are applicable to healthcare facilities are addressed (such as completion of required NIMS training, tracking and complying with personnel qualification requirements for emergency management/response personnel). This structure provides a cohesive disaster management structure, and integrates directly into the cities plan, as well as fire, law enforcement, the federal government, emergency medical services and the military.

G. **EMERGENCY OPERATIONS PLAN – MISSION:**

1. The mission of the EOP is to provide leadership and management of a coordinated and organized effort to mitigate, prepare for, respond to, and recover from any emergency with varying degrees of complexity, scope, or duration.
2. Objectives
   a. Utilize the four phases of emergency management—mitigation, preparedness, response, and recovery—to frame its approach to wide range of emergency events.

b. Utilize an all-hazards approach to emergency management that are applicable to any type of situation or event, whether pre-identified or not.
c. An HVA is completed to assess the impact of likely emergencies. The HVA is used to guide the development of the EOP. The HVA is reviewed at least annually to determine if the likely emergencies have changed.
d. Define and prepare for the service needs created by the hazard impact on the healthcare organization and the community.
e. Utilize the National Incident Management System (NIMS) and the national standard Hospital Incident Command System (HICS) as the command and management model for emergency response.
f. Orient and educate leadership and staff to their emergency management roles.
g. Facilitate community emergency management, integrating the hospital's activities with emergency management programs across the region, thereby fostering the coordination of medical planning, preparedness, response, information sharing, and recovery throughout the region.
h. Leaders are active participants in TCMC's EOP. The signatories of this plan, members of the Environmental Health and Safety Committee, and other key department managers have been involved in the Hazard Vulnerability Analysis (HVA) development/revision, plan development, training, and implementation and routinely provide management oversight and input for program improvement.

3. Coordinator
   a. See the EHSC Coordinator/ Designee outlined in Key Roles and Responsibilities
4. Committee
   a. See the Environmental Health and Safety Committee roles and responsibilities outlined in Key Roles and Responsibilities

H. **TRAINING AND EXERCISES:**

1. Education and in-service training are provided during the onboarding process for new employees, annually, using periodic drills and tabletop exercises. Education is provided using computer-based training.
2. Emergency Preparedness and Response Capabilities
   a. The ability of a hospital to respond to an emergency depends upon staff knowing their roles and responsibilities during an emergency. Education is provided to all staff annually using computer based learning (CBL) module, hospital newsletters, policy reviews and/or unit base meetings. Additional education and training is provided during drills and actual emergencies.

   Staff and Leadership Competencies
   - i. Staff are required to completed an annual CBL that provides education on the EOP.
   - ii. Staff are responsible for identifying their roles and responsibilities during and emergency.
   - iii. Examples of education provided to all staff include but is not limited to the following:
     1) Equipment use e.g., personal protective equipment
     2) Communication methods
     3) Implementing the chain of command

   b. Leadership additional responsibilities may include the following:
   - i. Describe the mission of the hospital during response to emergencies of all kinds, including the emergency response chain of command and the HICS system.
   - ii. Manage and implement the EOP during drills or actual emergencies within an assigned functional role and chain of command.
   - iii. Describe the key elements of the hospital's emergency preparedness and response roles and policies to other agencies and community partners.

iv. Initiate and maintain communication with other emergency response agencies as appropriate to assigned management responsibilities.
v. Demonstrate flexible thinking and use of resources in responding to problems that arise carrying out their functional role during emergency situations or drills.
vi. Evaluate the effectiveness of the response within their area of management responsibility in drills or actual emergencies and identify improvements needed.

3. Drills and Exercises
   a. Drills are conducted throughout to year to assess the appropriateness, adequacy, and effectiveness of mitigation strategies.
      i. Drills are coordinated, supervised activities to test a single, specific operation or function and are conducted periodically to assess staff training, alert/notification systems e.g., fire drills, radiation decontamination.
      ii. Participation in countywide tabletop exercise are conducted to assess and if required develop and/or revise policies and procedures.
4. Program Evaluation and Improvement
   a. Effectiveness Measures
      i. The EHSC Coordinator/designee has overall responsibility for:
         1) Coordinating all EOP performance improvement activities.
         2) Establishing performance improvement standards to objectively measure the effectiveness of the EOP.
         3) Coordinating the evaluation of equipment and process performance opportunities.
         4) Assisting with the development of corrective action plans, if deficiencies are identified as outlined in the EHSC charter.
   b. The performance improvement measurement process is one part of the evaluation of the effectiveness of the EOP. Each year, a performance improvement standard is identified based on deficiencies or opportunities for improvement.
   c. The current performance improvement measure:
      i. Revise current process for reviewing all elements of the EOP.
      ii. Conduct one actual emergency drill.
5. Critique and After-Action Reporting
   a. An important component of this plan is the review and critique of each EOP activation (actual or simulated) by hospital staff and appropriate outside agencies with analysis of response documentation. The information shall be documented and disseminated as part of the ongoing performance improvement process and incorporated into the plan as indicated.
   b. The EHSC Coordinator/designee shall compile the results of the written reviews and critique proceedings reporting the outcomes to the EHSC and other committees as outlined the EHSC charter.
6. Plan Review and Revision
   a. The EOP shall be reviewed annually. Related policies and procedures shall be reviewed and revised according to hospital policy.
   b. Reassessment of the HVA based on experience and input from local/county/tribal/state external response partners.
      i. Development or revision of any incident-specific plans necessitated by the revised HVA.
   c. Revision of response procedures based on actual experiences and new information, standards, or best practices in the emergency management (EM) community;
   d. Coordination with the San Diego County Office of Emergency Services (OES) to assure consistency with their plans and coordination of the hospital's role in community plans
   e. Establishment of the EM training and exercise objectives and plan for the upcoming year.
   f. Department-specific plans shall be reviewed annually. At a minimum, an updated a current telephone notification list for all department personnel.

7. Mitigation
   a. Mitigation measures are designed to reduce or eliminate hazards or lessen the actual or potential effects or consequences of a hazard. Infrastructure and critical systems are routinely evaluated to ensure required performance during potential events. Mitigation activities are undertaken based on vulnerabilities identified in the HVA.
   b. Community/Regional Planning Initiatives
      i. TCHD actively participates in emergency management initiatives at the local, state, and regional levels. Hospital representatives meet regularly with their emergency management colleagues from public safety e.g., law enforcement, Emergency Medical Services, and fire, public health, emergency management, other hospitals and healthcare facilities, and appropriate private and nongovernmental entities.
      ii. TCHD is a member of the San Diego Healthcare Disaster Coalition (SDHDC) whose mission is to define organizational roles and responsibilities; develop regional response plans and procedures; seek available funding; and plan, conduct, and evaluate joint training and exercises. On a periodic basis, TCMC meets, under the auspices of the SDHDC, California Hospital Association (CHA), and Department of Homeland Security, with other healthcare agencies to share information, and discuss their resources. This meeting focuses on the essential elements of their command structures and control centers for emergency response. The names and roles of individuals in their command structures and command center telephone numbers, the resources and assets that could potentially be shared in an emergency response and the processes by which names of patients and deceased individuals brought to their organizations can be shared to facilitate identifying and locating victims of the emergency.
   c. External Support Agreement
      i. TCHD has negotiated various external support agreements (e.g., Memorandum of understanding (MOU), memorandum of agreement (MOA,) with local, state, and regional entities to obtain and/or share critical resources during emergencies. During community-wide emergency events, resource inventories are monitored, updated, and shared. All external support agreements are reviewed annually and updated as capabilities and/or organizational needs change.
      ii. TCHD has reviewed its contracts with vendors and suppliers of essential supplies, services, and equipment that may be needed to support emergency response and recovery operations. Where possible, contracts have been modified to identify TCHD as a priority client during emergencies.
         1) At a minimum, vendor/supplier points of contact, after-hours contact information, and alternate order/delivery modes have been identified.
   d. Hazard Vulnerability Analysis
      i. Annually a Hazard Vulnerability Analysis (HVA) is performed to identify potential emergencies that could affect demand for the hospital's services or its ability to provide those services, likelihood of those events occurring, and consequences of those events.
      ii. The HVA is used as the basis for developing emergency plans and procedures, conducting training and exercises, budgeting for and acquiring resources and assets, establishing external support agreements, and prioritizing mitigation and preparedness activities.
      iii. The EHSC Coordinator/designee consults with the San Diego Healthcare Disaster Coalition (SDHDC) at least annually regarding the HVA—and whenever the hospital's needs or vulnerabilities change – to review probability, impact, level of preparedness, and vulnerability scores; communicate the hospital's needs and vulnerabilities to the appropriate community emergency response agencies; and

identify the community capabilities needed to meet its needs during an event. These organizations include:

iv. Public safety (fire, law enforcement, Emergency Medical Services [EMS])
v. Neighboring hospitals
vi. Local/county/state public health departments
Public works/utilities
vii. Local/state emergency management

viii. EHSC coordinator/designee maintains documentation of all external review and coordination efforts. The HVA is reviewed and updated in conjunction with annual EOP review and revision, after each EOP activation, and whenever the hospital's hazards, capabilities, or vulnerabilities change.

8. Preparedness
   a. Advanced Preparations
      i. Although many incidents occur with little or no warning, there are others where advance notice is provided to the hospital hours, days, or longer ahead of an occurrence. For such situations, there are actions that may need to be implemented by the hospital in advance of the event to prepare the organization to respond when and if the threat materializes or an adverse impact occurs. As an event approaches, general readiness measures may include but are not limited to:
         1) Activating the EOP
         2) Establishing a planning section to prepare specific contingency plans for the impending situation.
         3) Activating the ICC to monitor evolving conditions.
         4) Activating external support agreements (e.g., security augmentation, staff transportation, staff lodging, and dependent/pet care) or placing in alert status.
         5) Maintaining monitoring of local and/or relevant news media and weather forecasting for updates and status changes.
         6) Reviewing emergency plans and procedures with staff and other stakeholders
   b. Department-Level Preparedness
      i. Each nursing unit/department EOP included within this plan leadership team will maintain the following at the unit/department level:

      Current call back list

         1) Ensure that complete address information, including apartment numbers, and contact information, including cell phone, pager. numbers, and e-mail and text messaging addresses are updated
         2) Maintain a posted evacuation plan visible to staff.
         3) Ensure staff review the EOP and can identify their roles and responsibilities as outlined in this EOP.
         4) Informed of the location to assemble.
         5) Ensure their staff complete new hire and annual education on the EOP.

      ii. Departments leaders with approved unit/department emergency plans not outlined in this plan shall follow the requirements outlined for nursing unit/departments listed in b.1. and the following:
         1) Maintain electronic emergency policy/procedures
         2) Reviewed annually and updated as needed the unit/department plan
         3) Submit a copy of the plan to the EHSC for review prior to completing the hospital approval process

9. Communications
   a. Communicate information with staff regarding the impending event, hospital and community activities being undertaken, staff/ family personal preparedness measures.

b. Test radio, paging mass notification satellite phone, government emergency telecommunications service (GETS) and alternate communications plans and equipment.
   i. Ensure all batteries are fully charged.
c. Establish contact with the Corporate EM team, the SD County Medical Operations Center (MOC) and San Diego County Department of Health and Office of Emergency Management.
d. Maintain effective communications with all involved parties: staff, patients, patient families, vendors, assisting and cooperating agencies, and the community.

10. Resources and Assets
    a. Review inventory of critical supplies to support loss of community support lasting more than 96 hours.
    b. Inventory and replenish (as necessary) resource stockpiles, including food, potable water, linen, pharmaceuticals, medical supplies, spare batteries, generator fuel, and damage control materials.
    c. Place advance or accelerated orders to reinforce stockpiles as needed/anticipated.
    d. Activate or mobilize emergency stores and/or vendor-managed inventories.
    e. Review status of emergency purchase orders and standing order deliveries.
    f. Service and fuel hospital vehicles and generators.
    g. Stock food and bedding or make preliminary arrangements for staff lodging and hygiene.
    h. Secure or consolidate supplies of scarce resources (e.g., antibiotics, fuel).
    i. Consider fiscal needs, including availability of cash reserves to support post-event purchases and staff cash advances.
    j. Relocate critical assets to safer/more secure areas.
11. Security and Safety
    a. Secure materials (e.g., pharmaceuticals, narcotics, radioisotopes) requiring special handling or security measures.
    b. Evaluate parking areas for restriction or traffic flow adjustment.
    c. Establish staging areas for incoming resources.
    d. Review procedures for security reinforcement (including external vendor and law enforcement contacts).
    e. Consider plans for restriction of facility access/egress and traffic flow
    f. Activate surge traffic plan as needed.
12. Staff Management
    a. Prepare staff scheduling enhancements during the event, including shift alterations, extended shifts, and additional contracted coverage.
    b. Place off-duty/on-call staff in alert status.
    c. Implement denial of leave requests, cancellation of prescheduled leaves and days off, and medical clearance for use of sick leave.
    d. Update lists of employees. Ensure that complete address information, including apartment numbers, and contact information, including cell phone, pager numbers, and e-mail and text messaging addresses are updated.
    e. Create sleeping arrangements or reserve hotel accommodations for key staff as needed.
    f. Identify potential need for staff dependent care (including pets) and activate plans as needed.
13. Utility Management
    a. Review and practice event-specific utility management, shutdown, restoration, and recovery procedures.
    b. Activate protective air filtration systems or ventilation zoning controls.
    c. Activate systems requiring advance priming before operations (e.g., generators, utility backup, and electronics).
    d. Consider engineered pre-event shutdown or controlled degradation of utilities and/or critical systems (e.g., medical gases, vacuum).
    e. Establish contact with service and support vendors and public utilities.

14. Patient Management
    a. Prepare modifications of clinical scheduling, including cancellation of elective procedures, census reduction, and discontinuation of outpatient activities. Pre-assign available staff to meet projected facility staffing needs.
    b. Notify patients regarding the potential cancellation/suspension/delay in planned services (e.g., admission, treatment, procedure).
    c. Prepare home care clients for extended periods without staff visitation. Identify those clients who will be leaving the area or who will be assisted by an alternate caretaker. Identify clients who may require assistance with shelter-in-place and/or evacuation plans. Prioritize service needs for scheduling purposes when visits can be resumed.
    d. Prepare to activate surge-capacity spaces (alternate care sites) for intake of evacuated special needs populations, overflow, evacuees from other impacted medical facilities, or patients generated by the event

I. **RESPONSE:**

1. Plan Activation
    a. The EOP will be activated in response to internal or external threats to the facility.
        i. Internal threats could include fire, bomb threat, loss of power or other infrastructure, or other incidents that threaten the well-being of patients, staff, and/or the facility itself.
        ii. External threats include events that may not affect the facility directly but have the potential to overwhelm facility resources or put the facility on alert.
    b. Person(s) responsible for plan activation: When a threat is suspected or has been identified the employee obtaining the information must notify their supervisor immediately. If the employee cannot contact their supervisor, they must immediately contact the Security
    c. Security will contact the Administrator Supervisor. See the Chain of Command Policy.
    d. Individuals responsible for EOP Activation:
        i. Chief Executive Officer
        ii. Chief Nurse Executive / Chief Patient Care Services
        iii. Administrative Supervisor
2. Activation Levels
    a. Level 3 Activation (Monitoring)
        i. An actual situation or event that is having a minor unusual impact on facility operations. When an event/disaster may occur- notification is made to System Administrative Leadership and support staff who would potentially need to take action as part of their responsibilities.
    b. Level 2 Activation (Moderate Impact)
        i. An actual situation or event that is having a moderate unusual impact on facility operations. Limited activation of ICC when an event/disaster is very probable or following an event which doesn't require full activation. All primary or lead staff will be notified and will staff the ICC.
    c. Level 1 Activation (Major Impact)
        i. An actual situation or event that is having a major unusual impact on facility operations. All primary and support staff are notified. All ICC support personnel will staff the ICC.
3. Pre-Designated Incident Locations and Facilities
    a. Incident Facilities Matrix - The facility has pre-established specific locations on the campus where predetermined incident management activities will occur. Should a particular facility or location be unsuitable for any reason, the responsible Leader ensures that a suitable alternate site is selected and its location provided to the IMT and all concerned parties.
4. Command and Coordination

a. Command or Incident Management will be organized following ICS and according to the Hospital Incident Command System (HICS). Roles are activated based on the needs, scope and scale of the event.
   i. Hospital Incident Command System (HICS)
   ii. The command center is located in French Rooms.

b. Assumption of Command
   i. Once the EOP is activated, the AS, a member of the operations team, senior administration, or OS shall assume command and be designated as the IC for that incident. The IC is the designee of the Chief Executive Officer, and is responsible for all hospital resources and operations necessary to manage the incident. The IC is responsible for making policy decisions during emergency operations.
   ii. Assignment of Incident Command Functions - Consistent with HICS principles, the only position that must be activated is that of the IC. Should the IC determine that he or she can manage all necessary functions for the incident without additional assistance; no other positions need be activated. Additional positions are activated after the IC has assessed the situation, developed a plan to manage it, and can assign individual leaders to manage elements of the plan. In every department, the senior person present shall take charge and make all necessary decisions until relieved by a superior or otherwise directed by the ICC. Department heads are responsible for succession and continuity planning for leadership within their departments. Once notification of the incident has occurred, the EOP has been activated, and command assumed, further plan implementation will occur based on the situation.

c. Delegation of Authority –
   i. Delegation is the downward transfer of authority from a supervisor to a subordinate in a management organization. When such authority is delegated, the subordinate is empowered to carry out the work on the supervisor's behalf, while the supervisor remains accountable for the outcome. As with any management system, HICS leaders may delegate their authority to carry out certain functions by establishing a lower level in the IMT. During EOP activation, delegation of authority will occur based upon the needs of the incident (i.e., the quantity and complexity of the objectives to be met), the facility resources, and the available personnel. This may be an ongoing and dynamic process. The IC is ultimately responsible for all incident functions, although the IC delegates authority for activities and functions to Section Chiefs and Unit Leaders to carry out. Both clinical and operational functions will be managed administratively in the same manner.

d. Transfer of Command –
   i. As conditions evolve or higher-level leadership arrives at the hospital, command may be transferred between leaders. The decision to do so is generally at the discretion of the higher-ranking leader. The transfer of command is accomplished following a face-to-face briefing, during which the IC informs the person relieving him or her of conditions at the hospital, impacts, problems, progress, the strategy for managing the incident, and any other pertinent information. As an incident de-escalates, consideration may be given to having lower-level leadership assume command roles, both for relief purposes and for ongoing leadership development.

e. Integration with Unified Command –
   i. Depending on the nature and extent of the incident, it is likely that a wide variety of agencies will be engaged to some degree in the response effort; therefore, the hospital must be effectively integrated into the community response, including the overall incident command structure. This integration begins before an incident

occurs, through the hospital's regular participation in community preparedness meetings, training, and exercises.

f. Order of Succession
   i. Orders of succession show who assumes authority and responsibility if leadership is incapacitated or unavailable. The Emergency Management Committee has pre-identified internal hospital positions that could be potential candidates for various HICS positions. In doing so, the committee has created an Order of Succession chart

g. Escalation of Response
   i. An incident may be appropriately handled with the initial response activities, but it may also require escalation due to a need for additional resources, personnel, or because of incident scope or duration. Escalation of plan activation is at the discretion of the IC, based on the impact that an event actually or potentially has on the organization. The rationale for escalating plan activation is that at each level of activation, additional sets of nonessential functions may be set aside in each department, making staff and other resources available for higher-priority assignments.

5. Planned Degradation of Services
   a. In the event that demand exceeds capabilities and external support and solutions (including patient transfer or evacuation) are not available, a plan for degradation of services shall be developed and initiated by the IC. Such degradation of services may include (but are not limited to):
      i. Conserving, consolidating, and/or rationing scarce resources
      ii. Reducing or curtailing services, capacity, and capabilities
      iii. Closing the hospital to new patients
      iv. Altering standards of care
      v. Staged or partial evacuation
      vi. Full facility evacuation and relocation

J. **PUBLIC INFORMATION:**

1. Media Relations
   a. When an incident involving EOP activation generates media interest, the IC shall assign a Public Information Officer (PIO). The mission of the PIO, is to serve as the conduit for information to internal and external stakeholders, including staff, visitors and families, and the news media. The following general policies apply to any situations involving the media during EOP activation:
      i. Members of the press will not be allowed elsewhere inside the hospital without prior approval from the IC.
      ii. In the event that a member of the press is granted access to any part of the facility, they shall be accompanied and escorted at all times by the PIO or an assigned assistant.
      iii. Still or video photography is only permitted with signed written authorization from Corporate Communications.
2. Written consents will be required prior to any photographs or video taken of people (including patients, staff, and visitors) on the hospital campus.
3. Public Information System
   a. During an incident involving multiple agencies or organizations, it is vital that public information be consistently communicated across all participating community response entities.
   b. A Public Information System (PIS) provides accurate, timely, and coordinated information to incident leadership and the public.
   c. When a PIS is established—as directed by the San Diego County Office of Emergency Services (OES), Department of Health, or other authority—TCMC will ensure any

information released is only done in coordination with the PIS guidelines as established at the time of the incident.

4. Support to the Joint Information Center
   a. At the discretion of OES or Department of Health, a PIS may be supported through the establishment of a Joint Information Center (JIC). In a JIC, the Public Information Officers of all healthcare partners and jurisdictional authorities, including TCMC, collocate and develop a joint public information message for dissemination. Under those circumstances, all media releases shall be coordinated through the JIC.
5. Communication and Information Management
   a. Common Communications
      i. When establishing HICS, the IC shall ensure that a common communications plan is utilized. (HICS 205A) The common communications plan must ensure that all operating elements of HICS are able to maintain a common operating picture and consistent situational awareness, and are able to share information effectively across the organization, as well as with any external partners or agencies who may be participating in the response. All communications with external entities shall be in plain English, without the use of codes or ambiguous language.
   b. Backup Communications
      i. Backup communication systems include:

Basic Telephone System	Overhead Announcement
Nurse Call System	E-Mail
Overhead Announcement	Text Messaging
Cell Phones	Communications Systems for Hearing Impaired
Telephone Translation Lines & Services	Communication with Emergency Operations Centers
Fax Machines	Intranet Messaging Posting
Access Control Systems	Emergency Medical Services Communication
Hand Held Radios	Public Health Monitoring & Notification, CAHAN)
Runners	Hand-Held Radios

6. Staff Notifications and Communications
   a. The person receiving the first notification that an emergency incident has taken place will quickly obtain as much information as possible on the situation. The person receiving notification shall immediately contact the Administrative Supervisor. . The Administrative Supervisor will ascertain the facts, assess the situation, notifies the administrator on call, makes the decision to assume command and activate the EOP.
7. Intradepartmental Notifications
   a. On-Duty Personnel Notified of an Emergency
      i. On-duty personnel (including licensed independent practitioners) will be notified either by overhead page, e-mail, in-house cell phones, pagers, or via direct supervisor.
      ii. When notified of EOP activation, all personnel shall:
         1) Cooperate and comply with directions of person assuming command of the department.
         2) End all nonemergency telephone conversations.
         3) Avoid using telephones or elevators.
         4) Continue working in usual areas unless otherwise instructed.
         5) Wear Hospital Identification (ID) badge conspicuously for clear identification.
         6) Remain on duty until released by immediate supervisor.
         7) Refer to the supervisor in assigned area for immediate actions.

8) If reassigned by immediate supervisor, follow instructions of supervisor in new area.

b. The Logistics Section Chief shall ensure that ongoing communication of information and instructions is accomplished by the most appropriate available communication mechanism (e.g., public address announcement, text message, e-mail)
   i. For longer-term incidents, the Public Information Officer is responsible for updating and communicating with employees, patients, patients' families, and other stakeholders to ensure a flow of accurate, consistent information through the course of the incident.

c. Off-Duty Personnel Notified of an Emergency
   i. Off-duty personnel (including licensed independent practitioners) will be notified in a tiered manner; that is, those who are expected to report for duty during the activation or for the next shift will be notified first.
      1) If available, mass notification systems will be used.
      2) Should manual telephone calls be required, those will occur at the direction of the IC and be conducted by each department.
      3) Messaging will be at the discretion of the IC or his or her designee.
   ii. Off-duty personnel notified of an emergency at the hospital or in the community shall:
      1) Keep phone lines open for updates and await a call from ICC or department leaders.
      2) Make arrangements for child/dependent care in the event employees are called to report to work.
      3) Turn on local radio news station to listen for announcements requesting hospital employees to report to work.
      4) Not respond to the scene of an emergency or disaster as a medical care provider unless properly trained, equipped, and part of the community's organized emergency response.

d. Off-Duty Mobilization
   i. If the response of off-duty personnel becomes necessary, the IC will notify the Communications Unit Leader and direct the activation of the Emergency Disaster Call Back Procedure. This procedure enables each department's personnel to be mobilized as needed, quickly and efficiently.
   ii. The plan consists of notification of affected department leaders and, if they cannot be reached, an alternate. It then becomes the responsibility of the department leaders or designees to mobilize their departments' off-duty personnel as necessary. The plan minimizes impact on any one person for contacting personnel.

e. Patient and Family Communications
   i. Only those patients and families affected will be notified as determined by the IC. Should notifications be necessary, supportive and consistent messages will be directed by Corporate Communications. It is the job of the Logistics Section to handle communications with family members of staff, whereas Operations is responsible for notifications to patient next of kin. Outpatients will only be notified if it is necessary to cancel or reschedule appointments during the activation, as directed by the IC.
   ii. When a patient is relocated, for any reason, the family will be notified (via telephone) of the patient's new location and the phone number if available. Actual telephone notifications will be handled by the designated hospital staff (per the IC) or in the case of a mass casualty event or large evacuation, the Logistics section may coordinate family notifications with the American Red Cross (ARC) or other appropriate outside agencies.
   iii. Patient Information Sharing

iv. Patient information will be provided to third parties (e.g., other healthcare organizations, state or county health departments, law enforcement entities) when such information is required to stop the spread of disease, protect the lives and safety of the general population, and/or preserve evidence. In addition, during large-scale regional incidents, patient tracking and decedent information will be shared with other local healthcare facilities identified in regional Memorandum of Understanding (MOU). Requests for patient information will be processed through and documented by the Planning Section within the ICC.

v. There are two scenarios for communicating patient information to third parties under this section, in accordance with hospital policy and the Health Insurance Portability and Accountability Act (HIPAA) guidelines:
   1) During the response phase of an incident.
   2) During the recovery phase of an incident.

f. Information Sharing during Response Phase
   i. Protected information such as, but not limited to, the personal identity information, clinical diagnosis and services or resources needed, and patient disposition, may be immediately and readily shared by and between incident response participants with a clear and evident "need to know." Such recipients should be reminded that patient-specific information is considered "protected" and is not appropriate for release to the media or for public information. Note: the media or general public releases of information are never considered "incident response participants" or appropriate recipients of protected information under this section.

g. Information Sharing during Recovery Phase
   i. During the recovery phase and/or following the termination of incident activities, any requests for patient information shall be managed in accordance with routine hospital policy, and all HIPAA compliance regulations shall be in effect. Requests for unusual or special consideration shall be referred to the Planning Section Chief for action.

h. Clinical Information Management
   i. Clinical Information will be managed using the hospital's electronic medical record (EMR), as appropriate. In certain circumstances (e.g., rapid volume of incoming victims, large number of unidentified individuals) the IC may direct staff to use downtime paper records. The use of downtime paper records will be consistent with the facility's computer downtime procedure.

i. HIPPA Privacy Rule and Disclosures during Emergency Operations
   i. The HIPAA Privacy Rule allows patient information to be shared to assist in disaster relief efforts. Healthcare providers can share patient information as necessary to:
      1) Treatment -Provide treatment
      2) Notification - -Identify, locate, and notify family members, guardians, or anyone else responsible for the individual's care or the individual's location general condition, or death.
      3) Imminent Danger - Share information with anyone as necessary to prevent or lesson a serious and imminent threat.

j. Community Liaison
   i. Mutual Aid
      1) TCMC participates in local/regional preparedness and response initiatives and is prepared to share resources and assets both within its local jurisdiction and within its region. Inventories of critical resources (e.g., beds, linens, transportation, fuel, personal protective equipment [PPE], medical equipment, supplies) and access to incident-specific Medical/Technical Specialists are tracked by the ICC. Requests for mutual aid will be processed through the ICC as approved by the IC.

ii. State/County/Local
1) Appropriate state/county/local entities will be notified upon activation of the EOP, but are not limited to:
a) San Diego Office of Emergency Services
b) Law Enforcement
c) Fire Services
d) Emergency Medical Services
e) Department of Health
f) San Diego County Department Operations Center (DOC)/Medical Operations Center (MOC)
2) Initial event notifications may be made by the IC or designee.
3) Ongoing communications with appropriate state/county/local entities will be managed through the ICC. Primary and alternate communication modes have been established and are periodically tested during drills and exercises. When necessary, TCMC will provide a hospital liaison to the local/state DOC and/or MOC to serve as a conduit between the hospital and supporting agency/entity.

iii. Federal
1) Federal assets may be deployed to San Diego County to support incident response and recovery operations. Requests for assistance will be developed by the IMT, approved by senior leadership, and communicated to the San Diego County DOC for processing, consolidation with other local/regional requests for assistance, and forwarding to the Governor or other appropriate elected official for transmission to the federal entity. These federal entities may include but are not limited to:
a) Department of Health and Human Services
i) National Disaster Medical System (NDMS)
ii) California National Guard
iii) Strategic National Stockpile (SNS)
iv) Laboratory Response Network (LRN)
b) Law Enforcement
i) Federal Bureau of Investigation (FBI)
ii) Drug Enforcement Agency (DEA)
iii) Bureau of Alcohol, Tobacco, and Firearms (ATF)
iv) United States Marshalls

K. **PATIENT CARE & CLINICAL SUPPORT ACTIVITIES:**

1. Patient Scheduling, Triage, Assessment, Treatment, Admission, Transfer & Discharge
a. Upon activation of the EOP, normal admission requirements will be determined by the IC, Outpatient care will be restricted as identified by the IC.
b. All elective admissions, procedures, elective surgery, non-emergency outpatient procedures, transferring patients who are stable for discharge will be canceled per the IC
c. Transferring patients to other facilities to accommodate emergency victims will be determined by the IC.
d. In the event that the hospital's EOP is activated, persons may be transferred prior to being stabilized if, based upon the circumstances of the emergency the hospital is unable to provide proper care, treatment or services. (Section 1135(b) of the Social Security Act §489.24(a)(2)).
2. Evacuation Plan
a. See TCHD Evacuation Plan.
b. Pediatric, Geriatric and Other Vulnerable Populations
c. ED providers are board certified to care for all emergency patients. All ED nurses are required to complete annual age specific competency testing. Clinical activities for vulnerable patient populations including pediatric, geriatric, disabled, or have serious

chronic conditions (example: dialysis patients, respiratory patients, transplant unit patient, etc.) and psychiatric and addiction patients will be provided in the customary way but additional emphasis will be placed on security, safety, mobility in terms of evacuation should it become necessary during an emergency.

3. Patient Mental Health Support
   a. The Mental Health Unit Leader is responsible for coordinating care for the mental health needs of patients.
4. Infectious Disease Patients
   a. For contagious patients in need of isolation the Infection Prevention department has guidelines for isolation and standard precautions to adhere.
5. Mortuary Services
   a. The hospital has limited resources to handle mass fatalities. The Casualty Care Unit Leader will identify the morgue area and appoint a Morgue Team Leader. The mass fatality plan can be implemented as needed and will address:
      i. Family notification
      ii. Family information center
      iii. Safe and respectful storage
      iv. Security
      v. Evidence preservation/chain of custody
      vi. Preservation of personal effects
      vii. Documentation
      viii. Integration with medical examiner/coroner
   b. The San Diego County Office of the Medical Examiner is responsible for developing, activating and implementing the County of San Diego Mass Fatality Plan. The Mass Fatality Plan will be activated if there is an increase in the number of deaths in the operational area due to a disaster or public health emergency which is expected to continue over a period of time and to:
      i. Overwhelm local system resources, including hospitals, mortuaries and Medical Examiner; or,
      ii. Overwhelm the Medical Examiner when all event victims are identified as Medical Examiner cases.
6. Personal Hygiene and Sanitary Needs
   a. Personal hygiene and sanitary needs of patients during emergencies will be provided. Availability of water supply used for personal hygiene and sanitary water pumps / lift stations at the hospital are connected to emergency power sources. In addition, when water intended for hand washing is not available, the hospital utilizes waterless alcohol based hand rub, which is maintained in ample supply at the hospital.
   b. The alternative means to personal hygiene can be baby wipes, personal wipes, or alcohol-based rubs.
   c. The alternative means to sanitation, if toilets are inoperable include the use of portable bed side commodes, and red bags in toilets.
   d.
   e. Environmental Services use of water will be curtailed to the extent of one change of water per day for mopping except in surgery, delivery rooms, and isolation areas.
7. Departmental Roles and Responsibilities
   a. Departmental Status Reporting
      i. Within 15 minutes of EOP activation, each on-duty department leader or designee, shall submit the Emergency Incident Message Form to the ICC. This form will be faxed (see fax number on form) or delivered by runner. The following information should be submitted:
         1) Department/Unit
         2) Emergency Department Capacity
         3) Number of:
            a) Available beds

b) Staff on duty
c) Staff for the labor pool
d) Patients that can be discharge
e) Vents
f) Patients that can be transferred to lower level of care
g) Tracking (patient count)
h) Comments/questions

ii. Status reports should be communicated to the ICC periodically through the incident. Problems encountered shall be communicated immediately.

8. Departmental Plans/Preparedness
   a. Specific department shall have a department plan to implement during an emergency incident prepared by the department leadership. Department specific plans shall be reviewed annually and update at least every three years. The plans at a minimum shall include the following:
      i. Process for reporting status to the IC
      ii. Notification process for departmental staff, including staff augmentation process
      iii. Process for terminating and reactivating nonessential functions
9. Safety and Security
   a. Safety
      i. The Safety Officer/designee is assigned to ensure the safety of staff, patients, and visitors, conduct a safety assessment, and to monitor and correct hazardous conditions related to the incident. The Safety Officer/designee has the authority to halt any incident-related activity that poses an immediate threat to life and health.
      ii. Some activities include, assessing and understanding the situation and the hospital's response, conducting a focused safety threat/risk assessment, determining and directing implementation of necessary risk reduction and protective measures (including use of personal protective equipment), and maintaining situational awareness of self and others regarding safety risks and evolving hazards or their mitigation.
   b. Security
      i. Security Officers or designees shall:
         1) Be deployed to the Emergency Department's (ED) point of entry to monitor access and restrict it to employees
         2) Be assigned to provide crowd control at incident-related/affected areas per policy
         3) Establish contact with on-scene police department representatives immediately upon their arrival.
10. Coordination of Security Activities with Community Security Agencies
    a. Coordination Activities
       i. The TCMC's Security Departments maintains an ongoing relationship with the community security agencies in San Diego County. For an incident with a primary security focus, the Security Supervisor / designee shall establish a Security Command Post (SCP).
       ii. Each community security agency participating in on-site security activities shall assign a radio-equipped senior officer to the SCP as a liaison to ensure optimal coordination and maximize effectiveness. As needed, the SCP may issue hospital security radios to ensure interoperability and coordination with community security agency liaisons.
       iii. The Security Supervisor /designee shall participate in a unified command structure with the responding community security agency commanders, where possible.
    b. Control of Facility Access, Egress, and Individual Movement
       i. Review the Security Traffic Control in the Event of a Disaster policy

ii. During a disaster the following actions will be implemented:
1) Access Restriction - Workforce members will display their hospital photo-identification badge prominently on their outermost garments during EOP activation. Security officers will stop and deny access to incident facilities to any staff member not properly identified.
2) Signage - appropriate signage will be posted to secure entrances. Only workforce members with proper identification will be allowed access to the facility. Security officers and designated staff members will be assigned to all entrances to control visitors. Non-direct patient care personnel, hospital volunteers, and chaplains will be assigned to assist visitors as needed.

iii. Facility Visitor Control
1) As directed by the IC, Security Officers prepare to institute identification checks of all personnel entering hospital buildings.
2) Only individuals wearing hospital identification (ID) badges or accompanied by such a person wearing a hospital ID will be allowed in the hospital.
3) Relatives of incident victims will be directed to an identified location.
4) Direct deliveries (e.g., food, flowers) will not be permitted; items will be left in a designated location for staff delivery within the building.

iv. Media Access
1) Security Officers should be alert to the potential for news media presence, be prepared to escort credentialed members of the press to the Media Staging/Briefing Area where press briefings will be given, and keep news media away from family members. At no time will members of the press be permitted access to the facility without authorized escort.

v. Vehicular Restriction
1) As directed, Security Officers shall establish barriers at all vehicular entrances to hospital grounds and parking facilities.
2) Officers shall attempt to expedite removal of vehicles from key areas to facilitate access for emergency equipment. Only the following vehicles shall be permitted onto grounds:
a) Law Enforcement
b) Fire Department
c) Emergency Medical Service
d) San Diego County Office of Emergency Services (OES)
e) Authorized Emergency Vehicles
f) Staff (with proper identification badge/card)

vi. Vehicle Removal
1) Unattended vehicles will not be permitted in restricted areas. Such vehicles will be towed as needed.
2) Press vehicles will be directed to the Media Staging Area.

11. Hazardous Materials & Waste Management during EOP Activation
a. In the absence of functioning processes for management of sewage, bio-hazardous waste, and/or other hazardous materials during an emergency, the Environmental Services Supervisor or designee shall assume responsibility for waste management. Strategies may include (but are not limited to):
i. Waste stream reduction strategies
ii. Use of alternate waste collection and disposal methods
iii. Use of improvised on-site storage facilities for securing toxic or hazardous materials until proper disposal methods can be re-established
b. In the event of a disaster the hospital will follow hospital policies along with using their approved vendors for medical waste and hazardous waste.

i. If identified vendors are unable to provide services for an extended amount of time, we would store/stock pile all waste in their pre-determined secured areas. Should a large radiological event occur, the radioactive material, (clothing, personal belongings, shrapnel, etc.) would be stored in a pre-designated area, .
ii. Items will be placed in a red bag, labeled with the patient's identification (if known) and kept there until advised what to do with the material by the County of San Diego Hazardous Materials (HAZMAT) Team.
iii. The hazardous material will be placed in a covered container and if need be larger containers will be obtained.
iv. A security officer or designee will be placed at the perimeter of this area, in proper PPE if indicated. If needed, the area may be secured per hospital policy.

c. TCMC is equipped to manage decontamination with known chemical, biological, and radiological contaminates
d. Disposing of Hazardous Waste
   i. See the Hazardous Waste policy
e. Facility Contamination
   i. If the facility is contaminated, a contractor experienced in the isolation and decontamination process is notified by the IC or designee. Security will ensure containment and isolation of the affected area until it is declared safe by appropriate experts.

12. Staff and Family Support
   a. Housing
      i. When conditions warrant the implementation of staffing augmentation plans and/or require boarding arrangements for staff members, the IC will delegate a leadership team member to coordinate such arrangements.
   b. Staff Transportation
      i. External conditions may create transportation difficulties for staff, inhibiting their ability to report for duty. When needed, the Transportation Unit shall coordinate transportation resources and arrangements through the Support Services Branch. If necessary, the hospital's utility vehicles, passenger vans, cars assigned to facility executives/leaders will be used.
   c. Dependent Care
      i. Dependent care areas may be established as needed. At the discretion of the IC, when conditions warrant, the hospital will provide on-site child and elder dependent care for staff dependents, enabling the staff members to report for duty. These areas will be supervised by a designated Dependent Care Unit Leader, and staffed by hospital volunteers, designated hospital staff and staff from the Labor Pool.
   d. Staff Augmentation
      i. It is the policy of TCMC to consider any employee on the premises during an EOP activation to be on duty. An employee may be called upon to support other duties within their scope of practice, other work in departments or carry out functions other than those normally assigned, and/or work hours in excess of (or different from) his or her normal schedule.
   e. Staffing Expansion Considerations
      i. Options for expansion of both clinical and nonclinical staff include the following:
         1) Temporarily increase nurse-to-patient ratios on floors
         2) Ask current staff to remain on overtime after shift
         3) Modify or extend 8 and 12-hour shifts. Call back off-duty staff from earlier shift
         4) Contract additional agency nurses
         5) Cancel staff days off (first one per week, then both)
         6) Cancel holidays and vacation leaves

7) Coordinate through the Corporate Command Center, who will work with the San Diego County Department of Health and San Diego County Medical Operations Center for staffing support from outside the hospital

f. Staff Health Surveillance

i. The employee Health Department will take measures to effectively anticipate, recognize, evaluate, control, and mitigate health threats encountered during response and recovery operations. Specific activities include:

1) Ensuring staff/workplace health surveillance requirements are identified
2) Directing and documenting health risk assessments
3) Determining required post-incident health surveillance activities based on known or potential health threats
4) Updating health risk assessments and medical countermeasures as new information becomes available
5) Enforcing the use of all required prophylactic medications, treatments, and personal protective equipment
6) Developing and implementing health risk communication plans
7) Submitting medical information related to infectious disease or environmental exposures to Infection Control, Risk Management, Safety and/or Human Resources.
8) Submitting health-related lessons learned after debrief to the Emergency Management Coordinator.

ii. Following demobilization, staff involved in event response and recovery operations shall be evaluated by a trained healthcare provider as indicated. The assessment will address actual/potential environmental exposures, injury or illness resulting from the event, and mental health or psychosocial issues. Appropriate medical referrals will be coordinated by the Employee Health Department. Required medical treatment and follow-up will be provided as directed by the Workers Compensation Program and related Human Resources policies. Referral providers will document staff member suitability for returning to work and any physical or other work restrictions and considerations. Essential data and records of staff work locations, medical evaluations, occupational/environmental health activities, patient/casualty encounters, and reportable medical events are collected and made available to appropriate entities for review as necessary.

13. Disaster Privileging

a. Licensed Independent Practitioners (LIP)

i. LIPs – See LIP policy.

ii. Under the direction of the Chief of Staff, IC or designee, disaster privileges may be granted to licensed independent practitioners who volunteer to assist the facility. The privileges should be effective immediately and continue through the completion of the patient care needs or until the orderly transfer of patient care to an appropriately credentialed member of the medical staff can be accomplished.

iii. Following approval for emergency credentialing privileges the practitioner shall be provided and maintain on his or her person written verification of said privileges and identifies the practitioner's role in the emergency response and identifies by name the person to whom they report.

iv. The practitioner shall take direction from the Department Chairman, or designee, in their clinical specialty regarding patient care services. The practitioner's notations in the medical record shall reflect that the physician is working under "Disaster Privileges." Practitioners will complete the Temporary Disaster Privileges Application.

b. Medical Volunteer Credentialing and Identification

i. The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identity and credentialing verification processes are followed. Review the Temporary Disaster Privileges Application.

14. Resource and Asset Management
    a. Inventory Management
        i. TCMC maintains a current inventory available to support the organization and patients during an emergency. Assets listed include volunteers, PPE, food and water, medical/surgical supplies, pharmaceuticals, linen, fuel for generators and vehicles, emergency lighting and communications equipment, evacuation chairs and slides, patient movement equipment, durable medical equipment, administrative supplies, and other items. The Resource Inventory is reviewed at least annually to ensure that adequate resource levels are maintained and supplier/vendor contact information is current.
15. Communication with Surveyors of Essential Supplies, Services, and Equipment
    a. Contact information for around-the-clock access to primary, secondary, and tertiary/alternate vendors for all critical supplies, services, and equipment are maintained:
        i. By the leadership of the Supply Chain Department that routinely orders and maintains the stock of the particular good or service.
        ii. By the supply chain department, which assumes the role of the Procurement Unit during EOP activations
    b. At the outset of an incident during which critical resources may be needed, the Procurement Unit Leader shall be notified by the Planning Section Chief of a projected resource shortfall, and vendor contact shall be initiated. As conditions warrant, the Procurement Unit Leader shall contact one or more vendors, including others not listed, until an acceptable source of supply is identified and arrangements are made to meet the need.
16. Resource Monitoring
    a. During EOP activation, the Resource Unit (Planning Section) shall maintain current operational inventory status on all resources used for, or affected by, the incident. Such information shall be gathered and documented during the first eight hours of the incident, and every operational period thereafter, when pre-identified par level thresholds are met, the Resource Unit Leader shall follow up with Finance/Administration and Logistics Sections to ensure that necessary resource replenishment has been accomplished.
    b. In the event resource replenishment cannot be accomplished, the Planning Section Chief shall develop alternative strategies for resource conservation and/or service reduction. This shall be done in coordination with the appropriate department managers of IS, Supply Chain Management, Pharmacy, and Facilities Management. In the event that resource shortfalls are projected, the following actions may be implemented at the direction of the IC:
        i. Procurement from alternate or nontraditional vendors
        ii. Procurement from communities outside the affected region
        iii. Resource substitution
        iv. Resource sharing arrangements with mutual aid partners
        v. Request for external stockpile support from the County Department of Health logistics cache
        vi. Request for external stockpile support from the State Department of Health Medical Emergency Response Cache (MERC), or the Strategic National Stockpile (SNS) (these requests go through the San Diego County Office of Emergency Services (OES).
17. Resource Sharing
    a. In the event of a large-scale emergency or regional crisis, there may be a need for sharing resources and assets with our mutual aid partners, other healthcare organizations in the community or contiguous geographic area, or organizations across

a larger region of the country. Resources and assets that may be shared include but are not limited to beds, transportation resources, linen, fuel, PPE, medical equipment, and supplies.

b. Communication and coordination regarding the need for resources and assets shall be communicated initially through the Liaison Officer, to or from the mutual aid partner or local entity requesting or providing support.

c. If resources are needed beyond the scope of our mutual aid partners or local entities, the Logistics Section Chief shall direct the Liaison Officer to establish contact with the County Office of Emergency Management Emergency Support Function (ESF) #8—Public Health Preparedness & Response desk. County Office of Emergency Management (OEM) will serve as the coordinating point for managing resources and asset deployment both within and outside the county during a large-scale incident.

18. Mutual Aid
    a. TCMC participates in local/regional preparedness and response initiatives and is prepared to share resources and assets both within its local jurisdiction, operational area, and within its region.
19. Volunteer Management
    a. The Logistics Section Chief shall ensure that, as conditions warrant, appropriate identification and access authorization processes are followed. Hospital identification indicating "Volunteer" and the individual's name shall be provided and displayed conspicuously at all times while the volunteer is engaged in the response.
20. Donation Management
    a. Three donation scenarios may arise when affected by a major emergency in the community. These donation scenarios include offers of miscellaneous goods and services from members of the public, blood donations from individuals, and donations of medical supplies and/or equipment, including pharmaceuticals, from an identified supplier/vendor.
    b. The following processes will be used to ensure the most efficient and effective utilization of donated goods received by the hospital during an incident. It is likely the receipt of goods and services will not coincide with the needs of the hospital or the healthcare needs of the community. Therefore, goods and services must be coordinated to realistically assess what is available versus what is needed.
21. Miscellaneous Goods and Services—General Policy
    a. Except in extraordinary circumstances, unsolicited offers of donated goods or services should be referred to the County Emergency Operations Center through the Corporate Emergency Operations Center operated by the Corporate Disaster Preparedness Department. Depending on the scope of the incident, the county, or a designated Voluntary Organization Active in Disaster (VOAD), may establish a Donations Coordination Center (DCC) under the direction of a Donations Specialist. The DCC will be the responsible entity for receipt, cataloguing, warehousing, and integration/distribution of donated goods into and through the county's overall disaster supply system.
    b. Press releases and other forms of public information will be used to encourage and guide public donations. Donors will be discouraged from sending unsolicited goods directly to the hospital. Donors should be encouraged to make cash donations to locally sponsored funds or to established local charitable organizations.
    c. As needed, the Logistics Section Chief shall be responsible for assessing unmet needs and coordinating with the DCC regarding availability of donated goods and services to meet these needs from the available donations and volunteers responding. The Logistics Chief shall also arrange for the transport of goods and materials to or from the hospital as conditions warrant.
22. Responsibility

a. The Support Branch Director shall be responsible for leading the donations management process (goods other than blood). If necessary, a Donations Specialist shall be assigned to the Logistics Section. The Logistics Section shall:
   i. Establish a process for receiving and securing donated goods
   ii. Establish a database and maintain tracking of all donated goods and services, including a record of the source and date received
   iii. Warehouse and safeguard donated goods until they can be distributed
   iv. Be alert for perishable items (e.g., food), hazardous or unidentified items (which may pose a threat), or items requiring special handling (e.g., medications requiring refrigeration)
   v. Maintain a listing of goods and services offered or available from any source
   vi. Coordinate with recognized local support agencies to determine available resources and needs, and to arrange for distribution of donated goods to the community as available

23. Blood Donations
   a. Often, during a traumatic event, people present themselves at community hospitals to donate blood. The need for this is often promoted by the media, typically without a request from the hospital. In fact, any blood donated during a disaster must be screened by multiple tests to maximize the safety of transfused blood and components. These tests may be performed at the hospital laboratory or at the American Red Cross Southern California Blood Services Region, and will take about 48 hours to complete. However, to reinforce initial blood stores that may be rapidly depleted during a crisis, the hospital will establish an emergency blood donation program if the need arises. The following steps will be taken:
      i. The Blood Donor Services Unit (Operations Section, Medical Care Branch, Clinical Support Services Group) shall be activated. The Unit Leader shall be responsible for carrying out all blood donation-related activities.
      ii. A blood donor waiting area shall be established
      iii. Signage shall be posted directing prospective blood donors to the waiting area
      iv. As needed, other pre-identified areas may be converted to an overflow blood drawing facility
      v. A Security Officer shall be assigned to monitor the waiting area and assist donors on arrival. All security procedures in effect (e.g., access control; 100 percent identification check) shall be enforced for arriving blood donors.
      vi. The Blood Donor Services Unit Leader shall coordinate with the Support Branch Director to arrange for needed staff, supplies, and transportation, including additional blood storage space if necessary.

24. Donations from an Identified Supplier/Vendor
   a. In the event that an unsolicited apparent donation of supplies or equipment arrives at the hospital, the shipment shall not be accepted without the express authorization of the Finance Section Chief. The identity of the purveyor shall be established, and the Supply Unit Leader, in consultation with supply chain, shall determine whether the goods have been ordered or are needed. If no valid order can be verified, only the Finance Section Chief or designee is authorized to accept the delivery.

25. Utility Management
   a. TCMC has identified alternative means of providing critical utility services including but not limited to:
      i. Electricity
      ii. Water needed for consumption and essential care activities
      iii. Water needed for equipment and sanitary purposes
      iv. Fuel required for building operations, generators and essential transport services
      v. Medical gas/vacuum systems
      vi. Elevator
      vii. Heating, ventilation and air conditioning (HVAC)

viii. Steam for sterilization

26. Loss of Community Support
    a. There may be incidents or times when the local community is unable to support the hospital in six critical areas: communications; resources and assets; safety and security; staff responsibilities; utilities management; and patient clinical and support activities. Significant degradation or loss of local community support for any of the six critical areas may result in the suspension of specific services, alterations to the standards of care, temporarily or partial facility closure, or facility-wide evacuation.
    b. Redundant communication systems are utilized to mitigate the impact on the facility and sustain operations for 96 hours. Multiple forms of communication have been identified within the facility.
    c. Resources and assets are inventoried and maintained by the responsible department. These departments include but are not exclusive to Supply Chain Management, Dietary, Respiratory Therapy, Laboratory Services, and Engineering. Each of these departments maintains independent inventories of their supplies and estimate approximate usage timelines. These departments assist as advisors to the ICC to make difficult decisions to reduce or eliminate usage of certain supplies. When supplies and assets to support certain service lines are gone, the service lines are prioritized based on acuity and life-sustaining variables and are evacuated accordingly at the direction of the ICC.
    d. In the All-Hazards approach, safety and security will be assessed through individuals deemed responsible for safety and security during an event. These individuals may include the following: Emergency Management Coordinator, Safety Officer, Plant Operations Director, or Infection Control. Each event may take on different characteristics as time progresses, which may require operational changes to be considered. Individuals deemed responsible for Safety and Security will continue to assess situations throughout the events.
    e. Staff responsibilities are provided to each department with communication through the HICS organizational structure and DEAPs. During an event, departments and activities may be considered nonessential. Departments and individuals that are regarded as nonessential will be designated to the Labor Pool for reassignment to essential/business sustaining service lines at the request of the ICC. Department emergency call lists will be used to contact additional staff off campus. Volunteers will be credentialed and assigned tasks at the direction of the Labor Pool. Personal situations will be considered and resolved for staff members to sustain staffing for additional periods of time.
    f. Utilities are managed by the Engineering Department. The department has policies and procedures to respond to utility failures. An inventory of critical supplies on site, such as water and diesel, is maintained. Plant Operations provides direction to the ICC on the remaining resources during the event to estimate when utility resources may end.
    g. Patient clinical and support activities would be available based on the supply, staff, and utility contingency plans. Clinical and support activities are altered to treat an influx of patients in the ED. An ED emergency plan includes predetermined locations for patients triaged. Difficult decisions in regard to continuing or eliminating certain patient activities would be determined by the IC. The Senior Medical and Administrative Staff, Operations Chief, as well as Medical Technical Specialists would serve as advisors when necessary. When patient clinical and support services cannot be provided, patients are evacuated to the nearest available facility.

27. Surge Support
    a. Bed Capacity/Expansion (Internal)
        i. When the IC determines that normal bed vacancies cannot accommodate the admission requirements of casualties, the following steps shall be taken.
            1) The Incident Commander shall:
                a) Identify capacity level needed and duration
                b) Determine which surge spaces will be activated, in what order

c) Initiate transfer activities as needed to clear the ED of all pending admissions and holds, and maximize available ED and pre-admission holding space as rapidly as possible
d) Refrain from initiating in-patient discharge activities until valid confirmation of need is received from competent authority
e) Ensure notifications are made and waivers requested

2) The Planning and Operations Section Chiefs /Director Throughput/Designee shall:
i) Initiate actions to maximize ED and holding capacity
ii) Begin canvassing to identify available rooms or space, patients ready for discharge, and prioritization of patients for discharge
iii) Initiate measures to staff surge spaces as directed
iv) The Logistics Section Chief shall initiate measures to open, acclimatize, clean, equip, and supply surge spaces as directed.
v) The Finance/Administration Section Chief shall initiate cost tracking for all associated expenses, and shall prepare projections of daily impact based on anticipated surge level.

ii. As many patients as possible normally scheduled for discharge the following day will be discharged immediately; available house staff physicians shall be prepared to discharge these patients upon notification.
iii. Patients admitted for elective surgery will be discharged and re-admitted at a later date.
iv. Additional beds can be made available by doubling and tripling bed capacity in existing patient rooms, or using classrooms and waiting rooms as patient rooms.
v. Patients selected for evacuation, either discharged to home or to another facility, will be sent to the hospital lobby. Nursing will supply staff to oversee these areas with the help of house staff and other physicians. Patients who are discharged to home will be directed to leave immediately and directed to the hospital lobby.

28. Alternate Care Site Operations (ACS) External
a. 1135 Waiver
b. These waivers under section 1135 of the Social Security Act 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 Health and Human Services (HHS) extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

29. Alternate Care Site Operations (ACS) External
a. There are several circumstances under which establishment of an alternate care site may become necessary. These include:
i. The need to evacuate all or part of the hospital due to an internal or external event threatening the facility or its occupants
ii. An external incident producing a patient load that exceeds the facility's in-patient capacity for care
iii. An event where special circumstances, such as a communicable disease threat, require separation of some patients from the general hospital population
iv. An event where the facility is tasked with establishing a screening facility or point of distribution for medication or vaccination during a community-wide crisis.
1) Under such circumstances, the IC may elect to activate one or more preplanned alternate care facilities.

30. Incident Demobilization

a. Demobilization is the orderly, efficient disengagement and release of resources from the incident response and the hospital's return to normal operations. Planning for demobilization should actually begin from the outset of the response.
b. The criteria to begin demobilization will vary incident by incident, but fundamental considerations are based on a reduction of impact of the event on the hospital. Impact assessment should include the following:
   i. The number of incoming patients is declining to a level manageable using normal staffing patterns and resources.
   ii. There is no secondary rise in patient volume expected.
   iii. Other responders are beginning their demobilization.
   iv. Other critical community infrastructure returns to normal operations.
c. For large-scale and/or community-involved incidents, the IC shall consult not only with Command and General Staff but also with external decision makers, such as other hospitals, public health/ public safety agencies, and the local EOC, before making a final decision to begin demobilization. Depending on the situation, not all areas of the hospital may be able to begin demobilization at the same time. Thus, planning will need to address not only when the demobilization process is to begin but also how it will be implemented.

31. Finance/Administration
a. The IC maintains overall responsibility for tracking and managing incident-related costs and expenditures. Incident financial activities involve developing financial monitoring strategies and outlining costs, expenses, funding sources, and contracting arrangements to accomplish the incident goals as determined by the IC. Finance/administration functions include tracking of personnel time and related costs, ordering items and initiating contracts, arranging for personnel-related payments and Workers' Compensation, tracking of response and recovery costs, and payment of invoices.
b. To optimize the tracking process, incident-related costs shall be accounted for from the outset of the response. The primary costs to be closely tracked should include any expense that may be considered either directly or indirectly incident-related. Costs that would be incurred on a routine basis (such as routine facility operations, or staff that would have been working their regular shifts anyway) are not generally reimbursable, so their tracking is not essential.
c. Costs to be monitored closely include:
   i. Personnel (especially overtime and fee-for-service staff)
   ii. Event-related patient care and clinical support activities
   iii. Incident-related resources
   iv. Equipment repair and replacement
   v. Costs for event-related facility operations
   vi. Vendor expenses
   vii. Mutual aid financial remuneration
   viii. Personnel illness, injury, or property damage claims
   ix. Loss of revenue-generating activities
   x. Cleanup, repair, replacement, and/or rebuild expenses

L. **RECOVERY**:
1. Recovery and Resumption of Normal Activities
a. Recovery activities are designed to return the organization to its pre-event state by restoring systems critical to the provision of care, treatment, and services. Recovery actions include compiling event documentation, conducting a critique, preparing an after-action report, performing critical incident stress debriefing, replenishing stock, repairing or replacing equipment, addressing physical plant issues, reviewing and revising the emergency operations plan and/or procedures, and training or retraining personnel, as necessary.
2. Facility Repair and Inspection

a. As the hospital enters the recovery phase, there are several facility issues to consider. The first, general housekeeping and cleanup is likely to be indicated following almost any response. The combination of response-related activity, coupled with the possible suspension of nonessential routine housekeeping services to free up staffing for other assignments, suggests that early attention is needed in this area. The Infrastructure Branch shall take the lead in inspecting the facility and in planning, prioritizing, and organizing the cleanup personnel and assignments to accomplish the work expeditiously.

b. The second issue damage assessment and mitigation—is indicated if the facility was involved in the problem (e.g., fire, flood, and earthquake) or has been unable to maintain an environment of care. In such cases, the Buildings/Grounds Unit, working within the Infrastructure Branch and the Safety Officer, shall be activated. One or more damage assessment teams shall be sent out to mitigate immediate threats, assess general safety and habitability, and survey and document damage. The Infrastructure Branch Director shall develop a plan of action for facility restoration and begin to carry out the plan as approved by the IC.

c. Longer-term recovery is the third issue. Depending on the extent of the damage, repairs and restoration may take days to months to carry out. To expedite the necessary activities, the hospital may use outside vendors or contractors to perform some or all of the work. The Building/Grounds Unit, supported by the Infrastructure Branch, shall initiate the planning process, transitioning the information into the IAP process when possible. TCMC will reconstruct the facility using federal, state, and local authorities (California Occupational Safety and Health Administration (Cal/OSHA), National Electric Code (NEC), Uniform Building Code (UBC), Universal Product Code (UPC), and National Fire Protection Agency (NFPA) life safety code guide lines.

3. Accreditation and Licensure

a. The Joint Commission (TJC) provides specific re-accreditation requirements for organizations that have been closed or out of service as the result of a disaster and/or the organization's decision to cease operations. TJC will also work with responsible state and federal agencies to assist in re-establishing operations as well as its qualification for accreditation. This will be accomplished through State Department of Health Services architecture review and licensing department review.

4. Resumption of Clinical Services

a. Once an environment of care is restored, the restoration of on-campus clinical service can begin. The Medical Care Branch Director shall investigate and report on the status of clinical services—specifically, what can be resumed (and in what timeframe), and what must continue to remain out of commission pending further activity or developments. If significant, the resumption and restoration process shall be prioritized and incorporated into the IAP for each operational period until completed.

5. Repatriation of Patients and Staff

a. Repatriation is the process of returning patients and staff from relocation outside their normal service areas to their original hospital placement. Key elements of any repatriation planning include establishing communications between the facility and the returning individuals and leadership consideration of the evacuees' difficulties when returning to the facility.

6. Resumption of Pre-Incident Staff Scheduling

a. As circumstances allow, personnel should be released from emergency duties to resume normal duties, attend to personal or family needs, be sent home, or to attend critical incident stress debriefing sessions, memorial services, or religious services. A staffing schedule should be quickly established, with early efforts targeted at releasing mutual aid personnel from other facilities, as well as volunteer licensed and non-independent licensed practitioners. Alternately, if the mutual aid and volunteer staffing will be used to provide relief for hospital staff, then one-for-one relief scheduling should be arranged, and a relief schedule posted. Other staff members may be released based on personal

necessity. Personnel from other departments that were temporarily reassigned should be returned to their own departments for assignment. Personnel schedules may need to be adjusted to allow for rest periods and resumption of normal scheduling.

7. Resource Inventory and Accountability
   a. Department managers/ supervisors shall initiate an inventory of all supplies and equipment, and should request repair, replacement, or replenishment as needed from the Logistics Section and/or from appropriate departments. This should be done by on-duty personnel immediately after the incident has ended and should not be postponed until the next shift or ordering day. Department managers/supervisors shall ensure that their areas are returned to a state of full operational readiness as quickly as possible.
8. Critical Incident Stress Management (CISM)
   a. Following a crisis, it is essential that all participating staff come together within 24 hours for a debriefing that will focus on the prevention and alleviation of incident-related emotional trauma. The debriefing will be held with members of the Employee Assistance Program (EAP) Team, which is a crisis intervention support service.
   b. The goal of the EAP Team is to provide assistance to help staff manage their reactions to the crisis so that they may return to their normal daily routine. The team offers confidential, nonjudgmental, emotional support and may suggest coping strategies that can assist in preventing delayed reactions to critical incident stress.
9. Staff Health Surveillance
   a. The Employee Health Department) will take measures to effectively anticipate, recognize, evaluate, control, and mitigate health threats encountered during response and recovery operations. Specific activities include:
      i. Ensuring staff/workplace health surveillance requirements are identified
      ii. Directing and documenting health risk assessments
      iii. Determining required post-incident health surveillance activities based on known or potential health threats
      iv. Updating health risk assessments and medical countermeasures as new information becomes available
      v. Enforcing the use of all required prophylactic medications, treatments, and personal protective equipment
      vi. Developing and implementing health risk communication plans
      vii. Submitting medical information related to infectious disease or environmental exposures to Infection Prevention, Risk Management, Safety and/or Human Resources.
      viii. Submitting health-related lessons learned and after-action reports through the Emergency Management Coordinator.
10. Following demobilization, staff involved in event response and recovery operations shall be evaluated by a trained healthcare provider (e.g., physician, LIP, EAP) as indicated. The assessment will address actual/potential environmental exposures, injury or illness resulting from the event, and mental health or psychosocial issues. Appropriate medical referrals will be coordinated by Employee Health.

M. **REFERENCE(S):**

1. County of San Diego Emergency Operations Plan, 2018
   https://www.sandiegocounty.gov/content/sdc/oes/emergency_management/oes_il_oparea.html
2. The Joint Commission Emergency Management Standards
3. The Centers for Medicare & Medicaid Services (CMS) Emergency Preparedness Requirements
4. Section 319 of the Public Health Service Act
   a. Hospital Incident Command System Incident Response Guides 2014 | EMSA (ca.gov)

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

ISSUE DATE: 8/91	**SUBJECT: Code Green Policy**
	POLICY NUMBER: 8007
REVIEW DATE~~(S)~~: 08/15	
REVISION DATE~~(S)~~: 03/94, 03/97, 05/00, 05/03, 05/06, 05/09, 06/12, 10/15	
Department Approval:	~~03/20~~04/22
Environmental Health and Safety Committee Approval:	~~04/20~~09/22
Administration Approval:	~~08/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/21

A. **PURPOSE:**
1. To establish guidelines to follow in the event of an oxygen system failure

B. **POLICY:**
1. The responsibility of providing emergency sources of oxygen in the event of a failure of the normal oxygen supply system is coordinated between Engineering and Pulmonary Services with the support of Security, Nursing, and notification by PBX. Department Directors will be notified and further activation of the disaster call back tree will be implemented depending upon the scope of the event and the available personnel. Documentation of the emergency with all pertinent details and outcomes, including any adverse patient reactions, will be completed by the above.

C. **RESPONSIBILITY:**
1. Pulmonary Services is responsible for:
   a. Notifying the PBX operator (66) of Code Green and location
   b. Providing patients with oxygen from portable tanks and manually ventilating them if necessary in coordination with nursing
   c. Initially activating the emergency H-cylinder back-up system for the affected area
   d. Coordinating action plan with Engineering
   e. Monitoring continued use and need for more H-cylinders
   f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
2. Engineering Department is responsible for:
   a. Troubleshooting and repairing the oxygen system
   b. Determining if designated valves need closing and for the proper actuation of the appropriate valves
   c. Coordinating action plan with Pulmonary Services
   d. Aiding in the replenishment of H-cylinders
   e. Notifying the oxygen supply company and arranging for additional oxygen
   f. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
3. Nursing Services is responsible for:
   a. Notifying PBX (66) of O2 pressure alarm and location if Facilities is unaware.

b. Oversight of clinical issues; communicating patient oxygen needs to Respiratory Care Practitioners (RCP)
c. Assisting RCPs in providing E cylinders and/or manually bagging patients as necessary Communicating the situation to the Department Director and activating the Disaster Call Back as necessary

4. Security is responsible for:
   a. Providing immediate response to affected area
   b. Providing a spare walkie-talkie to the RCP Supervisor or Lead in that affected area
   c. Assisting Engineering (back-up for night shift)
   d. Communicating the situation to the Department Director and activating the Disaster Call Back as necessary
5. PBX Operator is responsible for:
   a. Announcing CODE GREEN and LOCATION on the overhead paging system
   b. Notifying the Pulmonary Supervisor/Lead Therapist, Engineering, and Administrative Supervisor immediately upon notification of CODE GREEN.

D. **PROCEDURE:**

1. CODE GREEN and location is communicated by PBX Operator who notifies Engineering, Pulmonary and Administrative Supervisor
2. Security and Pulmonary respond to affected area; Security provides walkie talkie to RCP Supervisor/Lead
3. Once the Engineers have shut down the affected zone valves, the RCPs shall place the emergency H-cylinder connector into an available wall outlet and slowly open the cylinder valve to re-pressurize the zone.
4. RCP Supervisor communicates and coordinates action plan with Engineering via channel 1 on walkie talkie
5. RCPs communicate with nursing in affected area to assure that patient oxygen needs are met
6. H-cylinders are monitored for pressure levels; Engineering assists with additional H-cylinders and vendor ordering if needed
7. CODE GREEN is deactivated with notification from Engineering that the system has been charged to full operating pressure utilizing normal or alternate bulk oxygen sources.

E. **LOCATIONS OF EMERGENCY CYLINDERS:**

1. Pavilion: Rooms 277&278 - 2 oxygen H-cylinders in each room.
2. South Tower; 1st room on left in ILU – 4 H-cylinders.
3. Center Tower: Pulmonary 2 South – 1 H-cylinder
4. NICU: 1 Air H-cylinder and 1 oxygen H-cylinder in ABG lab.
5. 1 North /Rehab: Dirty utility room – 2 oxygen H-cylinders.
6. Emergency Room: Dirty utility room – 3 oxygen H-cylinders.

Tri-City Medical Center
Oceanside, California

ENGINEERING
EMERGENCY PREPAREDNESS

ISSUE DATE: 07/94

SUBJECT: Fire Drills

POLICY NUMBER: 8014

REVISION DATE~~(S)~~: 03/97, 05/00, 05/03, 12/05, 05/09, 06/12

Department Approval:	**~~03/20~~06/22**
Environmental Health and Safety Committee Approval:	**~~03/20~~09/22**
Administration Approval:	**08/21**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/21**

A. **PURPOSE:**

1. The purpose of this policy is to set forth an orderly, systematic method of providing fire response training for the staff of the hospital.

B. **GENERAL INFORMATION:**

1. The hospital is constructed in such a way as to create numerous areas known as smoke compartments. These compartment areas are intended to control ~~smoke~~ **the** spread **of smoke and fire** in the event of a fire.
2. To insure that all hospital staff are involved in fire drills. All fire drills will be held **once per shift per quarter. The Engineering staff will follow the fire drill matrix schedule which indicates which department is due for a fire drill.** ~~and documented by smoke compartment.~~

C. **POLICY:**

1. Fire drills are to be held:
   a. Fire drills will be rotated among the three shifts so that each shift will have at least **one** ~~two~~ drills in each calendar quarter.
   b. Fire Drills are to be held in a different ~~smoke compartment~~ **departments** each month. ~~Smoke compartments will not be repeated until all compartments have had a drill.~~
2. Fire drills are to be observed and documented in the following areas:
   a. ~~Smoke compartment~~ **Department** where the drill is held.
   b. All ~~smoke compartments~~**Departments** immediately adjacent to the ~~compartment~~ **department** where the drill is held. This includes above and below **(at least 3 departments)**.~~.~~
   c. Documentation will be done by completing the "Fire Drill Observers Comments" form.
      i. Prior to the drill, these forms are to be distributed by ~~Engineering~~**engineering** personnel holding the drill.
      ii. Distribution will be to the person in charge of the unit/**department** ~~occupying the smoke compartments~~ involved in the drill.
      iii. Observers comments are to be collected immediately after the drill.
      iv. All reports are to be sent to Engineering Management.
      v. Engineering Management will immediately correct and deficiency identified during the drill.
      ~~iv.~~**vi. If the deficiency cannot be corrected within 24 hours and ILSM must be initiated.**
3. Observations will be made of the following criteria:
   a. Does the staff know what to do in the event they should discover a fire?
      i. Rescue, Alarm, Contain, Extinguish

b. Does the staff know what to do if they hear the fire alarm?
   i. Report to your assigned work place, close all doors and wait for instructions.
c. Does the staff know how to use a fire extinguisher?
   i. Pull the pin, aim at the fire, squeeze the trigger, ~~sweep~~**and sweep** across **the base of the** fire.
d. Does the staff know where the nearest fire extinguisher and fire alarm are located?
e. Does the staff know where transportation equipment is located?
f. Does the staff know how to use transportation equipment?
g. Did the staff hear the fire alarm?
h. Did the staff hear the "code red" announcement?
i. Did the fire doors close and latch in the area you observed?
j. Does the staff know their evacuation location?
k. California Department of Corrections Rehabilitation Unit (CDCR) will collaborate with facilities when conducting fire drills.

D. **FORM(S):**
1. Fire Drill & Event Form
2. Fire Drill Procedure
3. Observer's Report
4. **Fire Drill Matrix**
~~3.~~**5. ILSM Policy**

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
SAFETY MANAGEMENT

ISSUE DATE: 11/87

SUBJECT: Disposing of Recalled Products

POLICY NUMBER: 1030

REVISION DATE: 01/97, 07/00, 05/15

Department Approval:	~~10/20~~01/22
Environmental Health and Safety Committee Approval:	~~11/21~~09/22
Administration Approval:	~~11/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/21

A. **PURPOSE**

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

B. **POLICY**

1. The following procedure will be implemented when disposing recalled products:
   a. Isolate products awaiting disposition in a secure area of the department.
   b. Label the recalled product(s) "Do Not Use".
   c. Notify Risk Management and Biomedical Department for directions on disposal.

~~TRI-CITY MEDICAL CENTER~~ ~~Safety Policies & Procedures~~	~~Section: SAFETY MANAGEMENT~~ ~~Subject: Employee Safety Information~~ ~~Policy Numb~~
~~Department: Hospital Wide~~	~~EFFECTIVE~~ ~~REVIEWED~~ ~~REVISED: 3/97; 7/00; 4/03~~

RETIRE: Safety topics covered in annual Symplr (formerly Netlearning) modules

Department Approval: 09/22
Environmental Health and Safety Committee Approval: 09/22
Medical Executive Committee Approval:
Administration Approval: 12/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval:

~~1.0 POLICY~~

~~1.1 All general employee safety information will be posted in the following locations:~~

~~1.1.1 Employee Health Office~~
~~1.1.2 Human Resources Department~~
~~1.1.3 Department Bulletin Boards~~

~~1.2 Safety Communications **Hot Topics:**~~

~~1.2.1 Safety Communications and warning signs are effective in impressing on the minds of employees the need for working safely.~~

~~1.2.2 Safety Communications must be posted on conspicuously placed bulletin boards and must be changed at regular intervals.~~

~~1.2.3 Warning signs must be posted at appropriate locations where specific dangers exist and must not be placed indiscriminately around work areas.~~

~~1.2.4 Safety Communications/Hot Topics are distributed to the Area Safety Representative to be discussed at department staff meetings.~~

~~1.3 Participation in safety functions:~~

~~1.3.1 All employees will participate in safety functions, including completing the Computer Based Learning Modules for Environment of Care.~~

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
LIFE SAFETY MANAGEMENT

ISSUE DATE:	**11/87**	**SUBJECT: Fire Plan (Code Red)**
REVIEW DATE:	**11/90, 11/93, 11/97, 04/06, 06/12, 08/15**	**POLICY NUMBER: 3005**
REVISION DATE:	**11/94, 03/00, 04/03, 10/11, 04/13, 10/15 03/19**	

Department Approval:	**~~10/21~~09/22**
Environmental Health & Safety Committee Approval:	**~~11/11~~09/22**
Administration Approval:	**~~11/21~~12/22**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE:**

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

B. **DEFINITIONS:**

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

C. **POLICY:**

1. WFM will be provided education to use the following acronyms RACE and PASS to assist with remembering the following:

2. Supervisors are responsible for showing new employees the location of extinguishers and alarm pull stations during department orientation
3. The Code Red policy will be reviewed by all WFM during orientation.
4. Fire safety will be reviewed annually using a computer-based learning module (CBL). The following topics will be reviewed:
   a. Actions to implement in the event of a fire
   b. How to initiate a fire pull alarm station
   c. Instructions to identify the fire pull alarm stations, location of fire extinguishers, and evacuation map on their assigned departments
5. AHP, Volunteers, Medical Staff, students, and non TCHD personnel do not have a defined role in the fire response plan and should remain in their current location at the time a fire alarm sounds and render assistance under the direction of the department leadership team as needed.

D. **PROCEDURE:**

1. When a fire or smoke is observed, staff will notify the public broadcast exchange (PBX) via telephone and if possible activate a fire pull alarm.
   a. The PBX operator will announce using the overhead page system "Code Red" and the location of the code red three times.
   b. If you are away from your assigned area when the alarm sounds, stay where you are and wait for further instructions from the overhead page system.
   c. The hospital's Fire Response team will consist of designated personnel in Facilities Services, Environmental Services and Security Services. Upon hearing the alarm, these WFMare to stop their work and go immediately to the area indicated by the overhead page system.
   d. An Engineer Leader will take immediate charge of the Fire Response Team. In his or her absence, the Engineer on duty will take command. This team is subject to the direction of the Administrator and/or City Fire Captain upon his or her arrival.
   e. Patients are not to be evacuated from floors without the order of the Incident Commander or designee. If it is apparent to the Department Director/or designee an evacuation is absolutely necessary for patient safety, and if it is not possible to obtain the authoritative order, he or she may elect to evacuate patients.
   f. Engineering will clear the fire alarm after the fire is secured.
   g. Clinical personnel on other units should remain at their stations. All other personnel should remain in their work areas unless their assistance is requested.
   h. The hospital Public Broadcast Exchange (PBX) Operator will announce on the overhead page system "Code Red All Clear" when fire is secure.
2. Code Red (Implementing a Code Red in Your Work Area):
   a. Remove patients and other persons from immediate danger.
   b. Go to the nearest fire alarm pull station and pull the handle to activate the alarm.
   c. Dial "66" to report "Code Red." Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".
   d. Extinguish fire if it is safe. Use a fire extinguisher to attempt to bring fire under control using the acronyms RACE and PASS – See addendum A
      i. If fire is out of control, close doors to room/area and shut off oxygen if possible. Move patients to the other side of the fire door away from the fire. Allow no one except the fire department to enter.
   e. Check for smoke and flames in other rooms then close all doors.
   f. Stand by to assist as needed.
3. Fire in Patient's Room:
   a. Patient's bed in flames:
      i. Remove the patient from bed to a safe place such as another bed, chair or hallway.
      ii. Depress the nurse call button in the bathroom for immediate assistance. Do not

take a smoldering bed out of the room.

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

iv. Activate the fire alarm pull station nearest to the fire.

v. Call PBX Operator, dial "66". Provide your location, size, extent and location of fire, and material burning, if known. Affiliated campus dial "911".

4. Area Not Evacuated Secondary to the Condition of the Fire:
   a. Provide maximum protection:
      i. Instruct people to stay in their rooms with the door closed.
      ii. Reassure patients of their safety.
      iii. Place a wet blanket or linens at the base of the doors of all occupied room to prevent smoke from entering room.
   b. If safe to do so one WFM must remain in the corridor to assist fire department upon their arrival.
5. Evacuation
   a. Always use stairs, never the elevator, during a fire.
      i. If evacuation is ordered for an area, the following are methods to be used:
         1) Blanket Carry
         2) Two Person Carry
      ii. Once a room has been evacuated, it should be marked "empty" by placing a pillow in front of the door. Only firefighters may enter the room after an evacuation .is completed.
      iii. Remove Medical Records if possible.
      iv. Review the evacuation plans to identify the most appropriate evacuation route.
6. Fire Hazards:
   a. Never prop open fire doors.
   b. Hallways must be kept clear at all times.
   c. Never place flammable liquids or oxygen near an ignition source.
   d. Do not use unapproved appliances - appliances brought from outside source must be cleared by Facilities Management.
   ~~e.~~ ———.
   ~~f.~~**e.** Do not store items to obstruct sprinkler heads, maintain an 18" minimum clearance from the items and the sprinkler heads)
   ~~g.~~**f.** If you see or smell smoke, report it immediately for investigation. Early detection means prompt extinguishing of fire.
7. Duties of Personnel
   a. Review the Fire Safety Program, evacuation routes, and your responsibilities identified policies and procedures
   b. Participate in all fire drills and practice sessions as required.
   c. Study the fire alarm code and how to report a fire - Dial "66". Affiliated campus locations dial "911".
   d. Identify the locations of and how to operate the fire alarm pull stations and fire extinguishers.
   ~~e.~~ ———.
   ~~f.~~**e.** Observe the "No Smoking" rules.
   ~~g.~~**f.** Never store flammable liquids in your desk or cabinet.
   ~~h.~~**g.** Report any defective wiring - such as frayed cords, loose or broken plugs, blown fuses, etc.
   ~~i.~~**h.** Properly dispose of waste or rags used with cleaning solvents per manufacturer's instructions.
   ~~j.~~**i.** Do not use portable heating units.
      i. These units, particularly portable types are not permitted anywhere on the hospital premises unless approved by Engineering,
      ii. No portable heaters are allowed in patient care areas.
   ~~k.~~**j.** California Department of Corrections Rehabilitation Unit (CDCR) – 3 North South.

i. If necessary, fire response will be coordinated via CDCR staff for custody patients' evacuation.

~~l.~~**k.** Switchboard personnel:

i. If the fire is in the area of the PBX office follow the steps outlined in the general instructions section.

ii. If the fire is not threatening the PBX office initiate the steps below:

1) Upon receipt of a call notifying PBX of a Code Red/Fire, or when the fire alarm is activated, I immediately:

a) Notify the Fire Department, giving the address and location of the fire in the hospital.

b) Notify all personnel through the use of the public address system. Use the following code:

i) "Attention, Please – CODE RED and specific location." Repeat the page three (3) times.

2) Prepare the switchboard for emergency operations only, restricting calls.

3) Notify:

a) Safety Leader
b) Administrator On-call
c) Administrative Supervisor on duty
d) Security Supervisor or Lead
e) Director of Engineering
f) Emergency Department Clinical Leader
g) Other key personnel, as needed

4) Implement administrative orders as directed.

5) If PBX system is inoperative, use the RED phones system or cell phones.

E. **FIRE HAZARDS:**

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

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

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

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

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

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

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

f. Electrical Hazards - Report promptly any frayed, broken or overheated electrical cords or

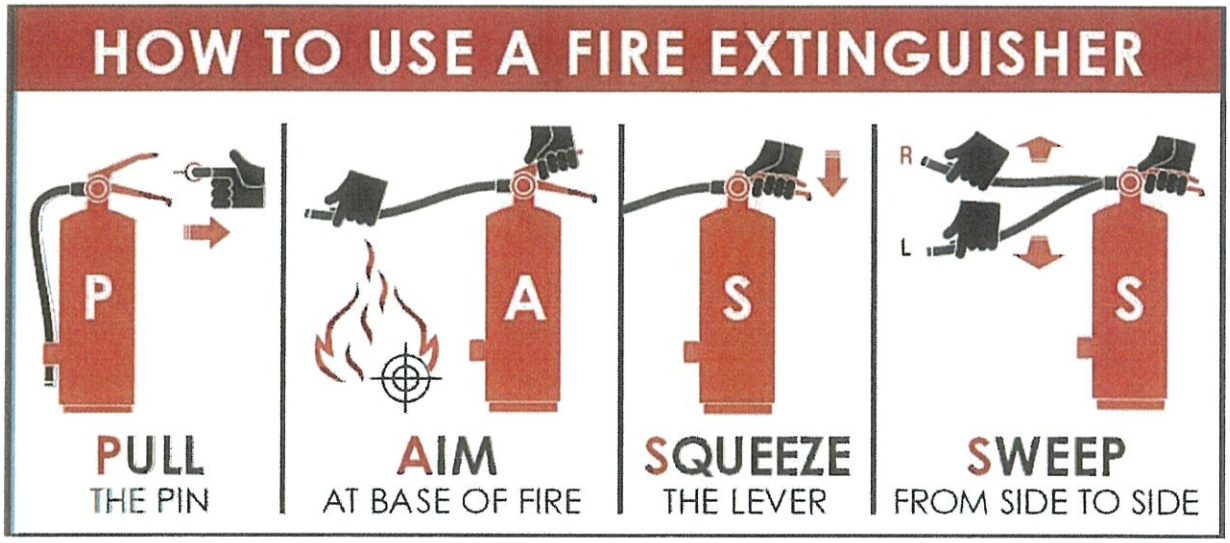
electrical equipment. Do not operate light switches, or connect or disconnect equipment where any part of your body is in contact with metal fixtures or is in water. Specially built equipment is in use in the operating and delivery rooms to eliminate electric sparks, and to control static electricity.

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

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

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

Addendum A



What is the Fire Plan?

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



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

How is a fire extinguisher used?

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

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
LIFE SAFETY MANAGEMENT

ISSUE DATE: 11/87 **SUBJECT: Life Safety Management Plan**

REVISION DATE: **03/00, 04/06, 04/09, 04/13, 05/12, 06/15, 12/17, 03/19**

Department Approval:	~~11/21~~09/22
Environmental Health & Safety Committee Approval:	~~11/21~~10/22
Administration Approval:	11/21
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/21

A. **EXECUTIVE SUMMARY:**

1. 1. Each environment of care and the physical condition of occupants poses unique fire safety risks to the patients served, the workforce and medical staff who use and manage it, and to others who enter the environment.
2. 2. The Life Safety Management Program is designed to identify and manage the risks of the environments of care operated and owned by Tri-City Healthcare District (TCHD). The specific fire safety risks of each environment are identified by conducting and maintaining a proactive risk assessment. A fire safety program based on applicable laws, regulations, codes, standards, and accreditation standards is designed to manage the specific risks identified in each healthcare building or portions of buildings housing healthcare services operated by TCHD.
3. 3. The Life Safety Management plan describes the risk and daily management activities that TCHD has put in place to achieve the lowest potential for adverse impact on the safety and health of patients, staff, and other people, coming to the organization's facilities.

   4. The Life Safety Management plan is evaluated annually to determine if it accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.5. The program is applied to the Tri City Medical Centers, and all service lines under its license.

B. **PRINCIPLES:**

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

C. **OBJECTIVES:**

1. The objectives of the Life Safety Management plan are to provide a physical environment free from physical harm and hazards created by the risk of fire, or products of combustion for the patient care population, staff, volunteers, physicians and visitors. The risk of fire carries with it the

most significant single threat to the environment of care as our patients are routinely incapable of self-preservation, and must rely on correct staff response and building for protection features to assure their safety.

D. **PROGRAM MANAGEMENT STRUCTURE:**

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

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

1. Life Safety Management Plan
   a. The Life Safety Management Program is described in this management plan. The Life Safety Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other people coming to the facilities of TCHD experience an adverse outcome in the event of a fire.
2. Processes for Protecting Building Occupants and Property
   a. The Director of Facilities or designee and Safety Manager are responsible for coordinating the development of design, operations, maintenance, and training processes to minimize the potential for fires and of adverse consequences related to the presence of fire, smoke, or other products of combustion.
   b. Design
      i. The Director of Facilities or designee and other project managers collaborate with qualified design professionals, code enforcement, and facility licensing agencies to ensure that buildings and spaces are designed to comply with local, state, and national building and fire codes. American Institute of Architects (AIA) guidelines are also considered in the design process for compliance with the International Building Codes with California amendments. The Director of Facilities or designee assures that all required permits and inspections are obtained or completed prior to occupancy. The Director of Engineer or designee permanently maintains all plans, inspection reports, and other documents related to the design and construction of any building or space housing patient care or treatment services.
   c. Management
      i. The Director of Facilities or designee oversees the design, implementation, and documentation of processes designed to assure optimal performance and

continual compliance with code requirements of fire alarm, detection, and suppression systems. Similar programs are in place for maintenance of building elements operating conditions that play a role in the fire safety level of the environment.

ii. The Director of Facilities or designee is responsible for assuring that all renovation and new construction within existing buildings is done in a manner that preserves compliance with codes and standards.

d. Fire Response Process

i. The Safety Manager is responsible for the design and management of a fire response plan that meets the unique needs of the occupants of each department or service of TCHD. The current fire response plan is based on the removal from immediate danger, activate alarms, confine fire, extinguish or evacuate area "RACE" principle. Area specific response and evacuation plans that include training and equipment required to manage unique risks identified in areas are in place. The plans are evaluated annually as part of the overall program review.

ii. The emergency number "66" is to be dialed to report a fire.

iii. The buildings located on the Medical Center campus will dial "66" to report a fire.

iv. Off-Site building will dial "911" for assistance in case of a fire.

3. The hospital prohibits smoking on all facility grounds

a. TCHD has implemented a Smoke- Free Environment policy. The policy prohibits smoking of all kinds (i.e., cigarettes, cigars, pipe, chewing tobacco, e-cigarettes, and all vapor producing devices) in any hospital building or campus grounds by all, including staff, visitors and patients.

b. TCHD has identified alternatives to tobacco products that are offered to all. TCHD has developed tobacco replacement resources to assist staff and patients with smoking cessation as desired.

c. The procedures for managing the use of tobacco replacement materials are followed and enforced by all managers and staff.

4. The hospital maintains free and unobstructed access to all exits

a. Leaders in all areas of the hospital are responsible for assuring that equipment, furniture, and supplies are not stored in corridors. The condition of corridors is evaluated during each environmental rounds/tours activity. All violations are reported to the Director and/or Manager of the area where the deficiency was identified, the Safety Manager, and the EHSC.

5. The hospital has a written fire response plan

a. The Safety Manager is responsible for coordinating the implementation of the fire response plan. The WFM are oriented:

i. i. to the R.A.C.E. response method and P.A.S.S. acronym for use of a portable fire extingusisher.to the department or service specific plans that account for the unique challenges posed by the condition of occupants and the design of space in which they work.

b. The department and area specific fire response plans include information about:

i. The roles of all WFM, medical staff, volunteers, contract staff and students near the point of fire origin.

ii. The roles of all employees, medical staff, volunteers, contract staff and students away from the point of fire origin.

1) Note: TCHD believes strongly in the principle of life safety. The organization recognizes as a practical matter that members of the medical staff and many volunteers and students are not present much of the time and are not likely to be a reliable resource during a fire response. Therefore, the medical staff, volunteers, and students do not have a specific defined role in the fire response plan. They are instructed to remain in the area they are located at the time an alarm sounds and to render assistance under the direction of the manager or employees of the

area as needs arise.

iii. Operation of the fire alarm system.

iv. Exit routes and use of equipment used to relocate or evacuate patients, visitors, and staff.

6. Fire Drills
   a. Regular fire drills are conducted to reinforce training and education. At least 50% of the drills are unannounced. The frequency of drills is based on regulations and accreditation requirements. All healthcare, ambulatory healthcare and overnight sleeping areas are drilled at least once per shift per quarter.
   b. If conditions evaluated as part of the Interim Life Safety Measures (ILSM) indicate a need for additional drills to enhance staff awareness of degraded life safety protection in various areas, there is documentation that the additional drills are performed. All freestanding business occupancies are drilled at least once per shift per year.
   c. All fire drills are evaluated to determine if individual areas respond appropriately. An aggregate evaluation of fire drills is done at least twice a year. The aggregate analysis looks for patterns or trends of deficiencies. When deficiencies are identified, there is documentation that the deficiencies are corrected.
7. Inspection, Testing, and Maintenance of Fire Safety Systems
   a. The Director of Facilities or designee works with qualified contractors and staff to design a program of calibration, inspection, maintenance, and testing to assure the reliability of all fire safety systems and equipment. The program includes systems and equipment such as fire sprinklers, smoke detection, fire pumps, fire dampers, doors, and shutters, and smoke control elements of the environment. Each system or piece of equipment is maintained to comply with requirements of the NFPA or other applicable codes and standards. The hospital conducts annual tests of battery powered exit lights for 90 minutes.
   b. The hospital conducts monthly evaluations of nuclear-powered exit signs and verified for expiration dates and replaced accordingly.
   c. Deficiencies are corrected within 48 hours. If a deficiency cannot be corrected within 48 hours, the Facilities Supervisor or designee evaluates the impact of the deficiency using the ILSM criteria to determine if an ILSM plan needs to be put in place until the deficiency can be corrected. All ILSM plans are monitored for effect and documentation demonstrating compliance with the plan is maintained by the Safety/Security Leader.
8. Life Safety Management
   a. The Director of Facilities or designee is responsible for maintaining the Statement of Conditions. The Director of Facilities or designee prepares a quarterly report of the rate of completion of any Plan for Improvement for the EHSC. If any items will not be completed within the established timeframe the Director of Facilities or designee is responsible for preparing a letter to the Joint Commission requesting an extension of the timeframe or a change of the method of correction.
9. Management of Fire Safety Risks
   a. A program of Interim Life Safety Management based on Interim Life Safety Measures (ILSM) is used to manage degradation of the level of life safety required by NFPA 101 – 2012 Life Safety Code. The ILSM program consists of a screening tool used to assess the severity of the potential impact of a degraded level of life safety. When risk factors indicate a need to implement one or more of the ILSM, a project specific Interim Life Safety Management Plan (ILSMP) is designed.
   b. The Director of Facilities or designee and Safety Manager are responsible for implementation of the ILSMP may include training, installation of Facilities controls, posting of temporary advisory signs, and other actions deemed necessary. Affected staff are oriented and drilled, as appropriate, to familiarize them with the Interim Life Safety Management Plan.
   c. The Director of Facilities or designee and Safety Manager are responsible for monitoring the effectiveness of the implementation of the ILSMP. When deficiencies are identified, the Safety Manager and/or the Director of Facilities or designee take appropriate action

to resolve the deficiencies.

d. All monitoring and actions to resolve deficiencies related to an ILSMP are documented and presented to the EHSC as part of the quarterly Life Safety Management report to the Committee. All ILSM evaluations, plans, and monitoring documentation are maintained for at least three years.

10. The hospital monitors conditions in the environment
    a. The Risk Management coordinates the design and implementation of the incident reporting and analysis process. The Safety Manager works with the Risk Management to design appropriate forms and procedures to document and evaluate patient and visitor incidents, WFM incidents, and property damage related to environmental conditions.
    b. Incident reports (RLs) are completed by a witness or the WFM to whom a patient or visitor incident is reported. The completed reports are forwarded to Risk Management who in turn works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.
    c. In addition, Risk Management and the Safety Manager collaborate to conduct an aggregate analysis of incident reports generated form environmental conditions to determine if there are patterns of deficiencies in the environment of staff behaviors that require action. The findings of such analysis are reported to the EHSC and the Patient Safety Committee, as appropriate, as part of quarterly Environmental Safety reports. The Safety Manager provides summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.
    d. The Safety Manager coordinates the collection of information about environmental safety and patient safety deficiencies and opportunities for improvement from all areas of TCHD. Appropriate representatives from hospital administration, clinical services, and support services, and department managers are consulted to analyze safety and environmental issues and to develop recommendations for addressing the identified risks.
    e. The EHSC and the PSC are responsible for identifying important opportunities for improving environmental safety, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.
    f. The Safety Manager prepares a quarterly report to the leadership of TCHD that summarizes key issues and recommendations reported to the committee.
    g. The quarterly report also communicates information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure leaders of management responsibilities have been carried out. Semi-annual EOC activity reports are provided to the Board of Directors.

11. Annually (approximately every twelve months) the hospital evaluates each environment of care management plan including a review of the scope, objectives, performance, and effectiveness of the program described by the plan.
    a. The Safety Manager coordinates the annual evaluation of the management plan associated with the Life Safety Management Program functions.
    b. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks. The review also evaluates the operational results of each Environment of Care Program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable. The annual evaluation uses a variety of information sources that include aggregate analysis of environmental rounds and incident reports; findings of external reviews or assessments by regulators; accrediting bodies, insurers, and consultants: minutes of Safety Committee meetings, and analytical summaries of other activities. The findings of the annual review are presented to the EHSC by the end of the first quarter of the fiscal year. Each report presents a balanced summary of an Environment of Care Program for the preceding fiscal year, as well as, an action plan to address identified weaknesses.

c. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review. Any deficiencies identified on an annual basis will be immediately addressed by a plan for improvement. Effective development and implementation of the plans for improvement will be monitored by the Safety/Security Leaders.

d. The EHSC reviews and approves the annual reports. Actions and recommendations of the committee are documented in the minutes. The annual evaluation is distributed to the Chief Executive Officer, organizational leaders, Board of Directors, the PSC, and others as appropriate. The manager of each Environment of Care Program is responsible for implementing the recommendations in the report as part of the performance improvement process.

12. Analysis and actions regarding identified environmental issues
    a. The EHSC receives reports of activities related to the environmental and patient safety programs based on a quarterly reporting schedule. The Committee evaluates each report to determine if there are needs for improvement. Each time a need for improvement is identified, the Committee summarizes the issues as opportunities for improvement and communicates them to the leadership of the hospital, the performance improvement program, and the patient safety program.
13. Improving the Environment
    a. When the leadership of the hospital, quality improvement, or patient safety concurs with EHSC recommendations for improvements to the Environment of Care Management Programs, a team of appropriate staff is appointed to manage the improvement project. The EHSC works with the team to identify the goals for improvement, the timeline for the project, the steps in the project, and to establish objective measures of improvement.
    b. The EHSC also establishes a schedule for the team to report progress and results. All final improvement reports are summarized as part of the annual review of the program and presented to hospital leadership, performance improvement, and patient Safety Manager ship.
14. Orientation and Ongoing Education and Training
    a. Orientation and training addressing subjects of the environment of care is provided to each WFM, volunteer, and to each new medical staff member at the time of their employment or appointment.
    b. Current WFMs complete an annual review of life safety via a Computer Base Learning (CBL) module and documented in the Netlearning system.
    c. The Human Resources (HS) Department assisted by the Education Department coordinates the general New Employee Orientation (NEO) program per TCHD policies and procedures.
    d. The Safety Manager collaborates with the managers, Regulatory and Infection Control, the PSO and others as appropriate to develop content materials for general and job-related orientation and continuing education programs.
        i. The content and supporting materials used for general and department-specific orientation and continuing education programs are reviewed and updated to meet all applicable laws and regulations as necessary.
    e. The Safety Manager gathers data during environmental rounds and other activities to determine the degree to which staff is able to describe or demonstrate how job-related risks are to be managed or eliminated as part of daily work. The Safety Manager evaluates the degree to which WFMs understand or can demonstrate the actions to be taken when an environmental incident occurs and how to report environment of care risks or incidents.
    f. Information about staff knowledge and technical skills related to managing or eliminating environment of care risks is reported to the EHSC. When deficiencies are identified action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

F. **EFFECTIVENESS:**

1. Program effectiveness will be regularly monitored using significant incidents as well as trending of performance measures to indicate the effectiveness of the processes and/or systems in place. Performance monitoring and assessments of program effectiveness will be reported to TCHD Environmental, Health & Safety Committee. Significant events and outcomes of regular trending are reported by the Safety Manager to the EHSC committee annually or immediately as an expectation for serious events.

G. **ANNUAL GOALS/OBJECTIVES FOR 2023**

1. 1. Comply with regulatory standards of fire drill requirements.
2. 2. Conduct at least 15 random tracers quarterly inspecting fire rated doors for compliance with NFPA 80.
3. 3. Conduct at least 10 random tracers quarterly in conjunction with EOC rounds insuring proper compliance with specific clearance for fire extinguishers, pull-down stations and electrical panels.
4. Provide annual Fire extinguishers training to the maintenance department staff.

H. **REFERENCE(S):**

1. The Joint Commission (TJC). (2021). Accreditation Requirements.
2. The 2012 Edition NFPA 101 Life Safety Code
3. The 2012 Edition NFPA 99 Health Care Facilities Code

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE MANUAL
SAFETY MANAGEMENT PLAN

ISSUE DATE: 11/87 **SUBJECT: Safety Management Plan**

REVISION DATE: 05/96, 06/97, 07/00, 06/08, 03/11, 06/12, 06/15, 12/17, 03/19, 12/21

Department Approval:	~~02/22~~09/22
Environmental Health & Safety Committee Approval:	~~03/22~~10/22
Administration Approval:	~~03/22~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/22

A. ~~EXECUTIVE SUMMARY:~~PURPOSE:

1. **The Safety Management Plan is designed to address potential safety risks that the environment of Tri City Health District (TCHD) presents to patients, staff, and visitors. The plan should also assure compliance with all applicable local, state, and federal codes and regulations.** ~~This is a high-level Management Plan that helps us to better manage risks in the environment. Each environment poses unique risks to the patients, employees, staff, and visitors. The Environment of Care (EC) Safety Program is designed to identify and manage the risks that could negatively affect patients, staff, visitors, and the physical buildings and equipment owned and operated by Tri-City Healthcare District (TCHD).~~

~~2. This Plan applies to the Medical Center and all offsite clinics and care sites owned and operated by TCHD. The Plan also applies to all staff members, regular or temporary, patients, inpatient or outpatient, contractors, vendors, and visitors.~~

~~3. Proactive risk assessments are conducted for each building that provides healthcare services and is reviewed annually. All risk assessments conducted are based on current accreditation standards (The Joint Commission) and all applicable laws, and regulations.~~

~~4. This Management Plan is evaluated annually to determine the effectiveness of the plan and the activities related to mitigation efforts and managing adverse events related to illness, injury, risk identification, near misses, and injuries that occur in the environment.~~

B. ~~PRINCIPLES:~~POLICY:

1. **The scope of this management plan applies to all Tri City Health District (TCHD) facilities. It is the responsibility of the Safety Manager to assess and document compliance with elements of the safety management plan during environmental tour activities, and when Safety-related issues are brought to the attention of the Safety/EHSC committee.** ~~The identification of specific risks in the environment is essential for ensuring a safe environment for all who enter and must occur in an ongoing manner.~~

~~2. Identified risks and risk assessments will be used to educate staff so that they can assist with maintaining a safe environment for all.~~

~~3. Safety is everyone's responsibility.~~

~~Ongoing monitoring and evaluation of performance, assessment of accidents and incidents, and regular environmental rounds are essential management tools for maintaining a safe environment. The knowledge developed using these management tools is used to make changes in the physical environment, work practices, and increase staff knowledge.~~

~~C. GOALS/OBJECTIVES FOR FY 21~~

~~1. Complete:~~

~~a. Safety risk assessments for all departments throughout the medical center and off-site locations.~~
~~b. Continue educating and raising awareness on COVID-19 safety protocols regularly.~~

C. **RESPONSIBILITIES:**

~~D.~~1. **Leadership, Directors, Managers and staff have varying levels of responsibility relating to the Safety Management Plan as follows:**

a. ~~The Chief Executive Officer (CEO) is responsible to assign leaders to the Environmental Safety Leadership Team (ESLT~~**EHSC). CEO/Board of Directors: The CEO and Board of Directors support the Safety Management Plan by:**

i. **Review and feedback if applicable of the Safety/EHSC reports.**
ii. **Endorsing budget support as applicable, which is needed to implement safety improvements.**

~~1.~~**b. Facility Compliance and Regulatory: Reviews Environmental, Health and Safety reports from ESHC committee, and provides broad direction in the establishment of performance monitoring standards. Provides direction if there is a safety-related issue that has impact on the care and treatment of patient(s).**

~~2.~~**c. Environmental, Health, and Safety Committee (EHSC): EHSC members review and approve the Environmental, Health, and Safety reports, which contain a Safety Management Component. Members also monitor and evaluate the Safety Management Plan, and afford a multidisciplinary process for reviewing issues related to safety issues and or failures. Committee members represent clinical, nursing, administrative and support services. The committee addresses Environment, Health, and Safety issues in a timely manner, and makes recommendations as appropriate for approval. Environmental, Health and Safety issues are communicated to the organization's leaders through quarterly and annual evaluation reports.** ~~The ESLT~~**EHSC** ~~is responsible for ensuring the safety program is implemented, managed, and evaluated to ensure improvements are made.~~

~~3.~~**d.** ~~The EOC Specialist, or designee, is responsible for the day-to-day management of the safety program.~~**Directors/Managers: Directors/Managers are responsible for implementing policy and procedures at the unit level and ensuring that unit-specific education and annual education is provided to staff. Directors/Managers are responsible for ensuring their staff members know how to report a safety issue or concern.**

~~4. The Board of Directors (BOD) and the CEO collaborate with senior leadership to assure budget and staffing resources are available to support the safety program and maintain a safe environment for all.~~

~~5.~~e. The Human Resources Department with assistance from the Education Department and other leadership staff is responsible for the development and presentation of appropriate safety and infection control materials for New Hire Orientation training, department training, and task-specific training.

~~6.~~**f. Staff: Staff members are responsible for actively participating in all required safety training, practicing work behaviors that promote a proactive safe environment, reporting any observed or suspected unsafe conditions to department management as soon as possible.**~~Department leaders are responsible for assuring that all staff members actively participate in the environmental safety program and that they work safely with established procedures and conduct work-related activities in a manner consistent with their training.~~

~~7. Department leaders are responsible for reporting and assisting with incident investigation activities as well as participating in monitoring, evaluating, and improving the safety of their specific areas of responsibility.~~

~~Individual staff members are responsible for working safely, reporting risks in the environment, knowing the inherent risks of their jobs and job environments, and knowing how to report unidentified risks, near misses, illnesses and injuries. All incidents shall be reported immediately or as soon as possible to the staff member's supervisor~~.

~~E. PROGRAM MANAGEMENT STRUCTURE:~~

1. ~~(EC.01.01.01 EP1) The Environmental Safety Leadership Team (ESLT~~**EHSC**~~) is an interdisciplinary team, appointed by the CEO, that is responsible for the effectiveness of the Safety Program. This team collaborates with other leaders in the organization to update, improve or make changes to the program to increase its effectiveness. Members of the team include the following positions:~~
   a. ~~Manager of Safety (EOC Specialist)~~
   b. ~~Manager of Risk Management/Quality Improvement~~
   c. ~~Manager of Regulatory Compliance~~
   d. ~~Infection Control~~
   e. ~~Director of Facilities~~
2. ~~The ESLT~~**EHSC** ~~. collaborates with the Patient Safety Committee to integrate EOC safety concerns into the Patient Safety program.~~
3. ~~The ESLT~~**EHSC** ~~coordinates the development of reports to the Environmental Health and Safety (EH&S~~**EHSC**~~) Committee. The reports summarize the organizational experience, performance management, and improvement activities, and other environmental safety issues.~~
4. ~~The ESLT~~**EHSC** ~~maintains current knowledge of environmental safety laws, regulations, and standards of safety, assesses the need to make changes to procedures, controls, training, and other activities to assure that the environmental safety management program reflects the current risks present in the environment.~~
5. ~~The EH&S~~**EHSC** ~~Committee monitors and evaluates the processes used to manage the environment.~~
6. ~~The EH&S~~**EHSC** ~~Committee meets a minimum of four (4) times per year.~~
7. ~~During each meeting, the following topics are presented:~~
   a. ~~One or more EOC performance management and improvement reports~~
   b. ~~EOC rounds reports~~
   c. ~~Incidents analyses~~
   d. ~~Regulatory changes~~
   e. ~~Other relevant issues~~
8. ~~The EH&S~~**EHSC** ~~Committee acts on recommendations for improvement, changes in procedures and controls, orientation and education, and program changes that may be necessary due to regulatory changes.~~
9. ~~The EH&S~~**EHSC** ~~Committee assigns individuals or groups the responsibility for developing solutions to identified issues. These assignments are documented and the individual or group is held accountable for completing their assignments.~~
10. ~~The EH&S~~**EHSC** ~~Committee maintains a tracking log to ensure that risks are identified, changes are made, and the effectiveness of the changes are analyzed.~~
11. ~~Membership of the EH&S~~**EHSC** ~~Committee includes the following representatives:~~
    a. ~~Senior Administration~~
    b. ~~Nursing Administration~~
    c. ~~Facilities~~
    d. ~~Security~~
    e. ~~Risk Management~~
    f. ~~Quality Improvement~~
    g. ~~Human Resources,~~
    h. ~~Bio-Medical Services~~

~~i. Education~~
~~j. Medical Staff~~
~~k. Infection Control~~
~~l. Others as deemed appropriate~~

~~12. The Board of Directors (BOD) receives regular reports of the activities of the environmental safety program from the EH&S**EHSC** Committee. The Board reviews the reports and, as appropriate, communicates concerns to the EOC Specialist **EOC/Safety Manager**or representative.~~

~~13. The CEO or designee program. receives regular reports of the activities of the Environmental Safety Program. The CEO or designee collaborates with the ESLT**EHSC** and other appropriate staff to address environmental safety issues and concerns.~~

~~F.~~D. ~~ELEMENTS OF THE PLAN~~PROCEDURES:~~:~~

1. The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems. (EC.01.01.01 EP3)
   a. Each department responsible for inspection, testing and maintenance, keeps logs and records as well as manuals, manufacturer's procedures, technical bulletins, and other information in their respective departments. For example:
      i. Biomedical Engineering is responsible for maintaining all medical equipment maintenance records and they keep all records in an electronic database
      ii. Facilities Management keeps all utility equipment inventory and maintenance records in the Computerized Maintenance Management System (CMMS)
2. The hospital has a written plan for managing the following: The environmental safety of patients and everyone else who enters the hospital's facilities. (EC.01.01.01 EP4)
   a. The Illness and Injury Prevention Program (IIPP) outlines the overall safety program for the hospital's facilities.
      i. The IIPP outlines the following:
         1) Responsibility
         2) Compliance
         3) Communication
         4) Hazard Assessment
         5) Accident/Exposure Investigation
         6) Hazard Correction
         7) Training and Instruction
         8) Recordkeeping
      ii. Staff members are trained to report all incidents, potential hazards, injuries, patient events and near misses immediately to their supervisors, the EOC ~~Specialist~~**/Safety Manager**, or anonymously to the Health Care Values compliance hotline at 844-521-7862
   b. The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital's facilities. (EC.02.01.01 EP1)
      i. The ~~ESLT~~ **EHSC** performs proactive risk assessments to identify risks in the environment. The information gathered is used to develop procedures and controls to minimize these risks that could negatively affect staff, patients, contractors, and visitors
         1) The ~~ESLT~~**EHSC** coordinates the risk assessment process with the EOC**/Safety Manager** ~~Specialist~~, department directors, and others as appropriate.
      ii. Information used to create the risk assessments include, but are not limited to the following:

1) EOC Rounds
2) Root Cause Analyses (RCA)
3) Incident Reports
4) External reports such as The Joint Commission Sentinel Event Alerts, CDPH All Facilities Letters (AFLs), Cal/OSHA standards, and FDA product recall notices

c. The hospital takes action to minimize or eliminate identified safety and security risks in the physical environment (EC.02.01.01 EP3)
   i. Risk assessment data, injury report data, and all reported incident data is used to improve the environment and minimize risk. This data is also used to procure equipment, supplies, or other technology that can minimize identified risks.

d. EOC rounds are conducted throughout the year on a prepared schedule. Each patient care area is scheduled for EOC rounds.
   i. The EOC ~~Specialist~~**Safety Manager**, or designee, coordinates the identified deficiencies with the ~~ESLT~~**EHSC** and the appropriate department director(s).
   ii. EOC rounds are performed when construction or other activities create unusual risks that may require the design and implementation of a plan to manage Interim Life Safety Measures, Infection Control Risk Measures, Proactive Construction Risk Management Measures, or other temporary issues.
   iii. The ~~ESLT~~**EHSC** analyzes the results of the EOC rounds to determine if deficiencies are corrected in a timely manner and to determine trends that require action to improve practices or environmental conditions.

e. The hospital maintains all grounds and equipment (EC.02.01.01 EP5)
   i. The Director of Facilities is responsible for managing the appearance and safety of the hospital grounds.

f. The Director of Facilities is responsible for scheduling the work required to maintain the ~~appearance and safety~~**environment and safety** of hospital grounds.
   i. The Engineering staff and Security Officers make regular rounds of the grounds to identify unsafe conditions.
   ii. The Security Manager and Engineering staff report all deficiencies to the Director of Facilities for appropriate action.

g. The hospital responds to product notices and recalls (EC.02.01.01 EP11)
   i. The ~~EOC Specialist~~ **EOC/Safety Manager** and the Director of Materials Management coordinate a product safety recall system. TCHD utilizes the National Recall Alert Center (NRAC) E-Class system that is designed to quickly assess safety recall notices, respond to those that affect TCHD, and assure all active safety recalls are completed in a timely manner.
   ii. A quarterly report of safety recall notices that require action to eliminate defective equipment or supplies from TCHD is presented to the ~~EH&S~~**EHSC** Committee by the EOC ~~Specialist~~**Safety Manager**.

h. The hospital collects information to monitor conditions in the environment (EC.04.01.01 EP1, EP3, EP4, EP5, EP6, EP8, EP9, EP10, EP11)
   i. The hospital establishes a process for continually monitoring, internally reporting, and investigating the following:
      1) Injuries to patients or others within the hospital's facilities
      2) Occupational illnesses and staff injuries
      3) Incidents of damage to its property or the property of others
      4) Security incidents involving patients, staff, or others within the facilities

5) Hazardous materials and waste spills and exposures
6) Fire safety management problems, deficiencies, and failures
7) Medical or laboratory equipment management problems, failures, and use errors
8) Utility systems management problems, failures, or use errors

ii. The Manager of Risk Management coordinates the incident reporting and analysis process.

iii. The ~~EOC Specialist~~ **EOC/Safety** ~~works~~**Manager works** with Risk Management to design appropriate processes to document and evaluate patient and visitor incidents, staff incidents, and property damage related to environmental conditions.

i. Completed incident reports are forwarded to Risk Management. Risk Management works with appropriate staff to analyze and evaluate the reports. The results of the evaluation are used to eliminate immediate problems in the environment.

i. In addition, the Manager of Risk Management and the ~~EOC Specialist~~ **EOC/Safety** ~~collaborate~~**Manager collaborate** to conduct an aggregate analysis of incident reports generated from environmental conditions to determine if there are patterns of deficiencies in the environment or staff behaviors that require action.

1) The findings of such analysis are reported to the ~~EH&S~~**EHSC** Committee and the Patient Safety Committee, as appropriate.
2) The ~~EOC Specialist~~ **EOC/Safety** ~~provides~~**Manager provides** summary information related to incidents to the CEO and other leaders, including the Board of Directors, as appropriate.

ii. The ~~EOC Specialist~~ **EOC/Safety** ~~coordinates~~**Manager coordinates** the collection of information about environmental safety, patient safety deficiencies including identification of opportunities for improvement from all areas of TCHD.

1) The ~~EH&S~~**EHSC** Committee and the Patient Safety Committee are responsible for identifying opportunities for improving the environment, for setting priorities for the identified needs for improvement, and for monitoring the effectiveness of changes made to any of the environment of care management programs.

iii. The Chairperson of the ~~EH&S~~**EHSC** Committee prepares quarterly reports to the leadership of TCHD.

1) The quarterly reports summarize key issues reported to the ~~EH&S~~**EHSC** Committee and the Patient Safety Committee with their recommendations.
2) The quarterly report is also used to communicate information related to standards and regulatory compliance, program issues, objectives, program performance, annual evaluations, and other information, as needed, to assure Hospital leaders that management responsibilities have been carried out.
3) Annual reports are provided to the Board of Directors related to EC, or more often if warranted.

j. Development and Management of Policies and Procedures (LD.04.01.07 EP1)

i. The ~~EOC Specialist~~ **EOC/Safety Manager** follows the administrative policy for the development of organization-wide and department-specific policies, procedures, and controls designed to eliminate or minimize identified risks.

ii. The ~~EOC Specialist~~ **EOC/Safety Manager** assists department leaders with the development of department or job-specific environmental safety procedures

and controls.

iii. The organization-wide policies, procedures, and controls are available to all staff members on the organizational intranet.

iv. Depart specific procedures and controls are maintained by department directors.

1) The department directors are responsible for ensuring that all staff is familiar with organizational, departmental, and appropriate job-related policies, procedures, and controls.

2) Department directors are also responsible for ensuring implementation of these policies, procedures, and controls

3) Individual staff members are held accountable for implementing the policies, procedures, and controls related to their specific work duties and tasks

v. The policies, procedures, and controls are reviewed when significant changes occur when new technology or space is acquired, and at least every three years.

vi. The ~~EOC Specialist~~ **EOC/Safety Manager** assists with the reviews of policies and procedures with department directors and other appropriate staff.

k. Every twelve months the hospital evaluates each environment of care management plan including a review of the plan's objectives, scope, performance, and effectiveness. (EC.04.01.01 EP15)

i. The ~~EOC Specialist~~ **EOC/Safety Manager** coordinates the annual evaluation of the Environment of Care management plans.

ii. The annual evaluation examines the management plans to determine if they accurately represent the management of environmental and patient safety risks.

1) The review also evaluates the operational results of each Environment of Care program to determine if the scope, objectives, performance, and effectiveness of each program are acceptable.

2) The annual evaluation uses a variety of information sources. The sources include aggregate analysis of EOC rounds and incident reports, findings of external reviews, benchmarking programs or assessments by regulators, accrediting bodies, insurers, and consultants, minutes of the ~~EH&S~~**EHSC** Committee meetings, and analytical summaries of other activities.

3) The findings of the annual review are presented to the ~~EH&S~~**EHSC** Committee by the end of the first quarter of the fiscal year.

4) Each report presents a balanced summary of an EOC program for the preceding fiscal year.

5) Each report includes an action plan to address identified gaps.

iii. The annual review incorporates appropriate elements of The Joint Commission's required Periodic Performance Review (PPR). Any deficiencies identified on an annual basis are immediately addressed by a plan for improvement.

iv. Effective development and implementation of the plans for improvement will be monitored by the EOC ~~Specialist~~/**Safety Manager**.

v. The results of the annual evaluation are presented to the ~~EH&S~~**EHSC** Committee. The Committee reviews and approves the reports. Actions and recommendations of the Committee are documented in the minutes.

vi. The annual evaluation is distributed to the CEO, BOD, organizational leaders, the Patient Safety Committee, the Quality Assurance Performance Improvement Committee, and others as appropriate.
vii. The manager of each EOC Management Plan is responsible for implementing the recommendations in the report as part of the performance improvement process.

l. The hospital analyzes identified environment of care issues. (EC.04.01.03)
i. Identified EOC issues are communicated through the ~~EH&S~~**EHSC** Committee and the ~~ESLT~~**EHSC** to senior leadership, the BOD and the CEO for analysis.
ii. The hospital uses the results of data to identify opportunities to resolve environmental safety issues (EC.04.01.03 EP2)
1) Once the data has been presented to leadership and appropriate committees, a team is appointed to manage the improvement project.
2) The ~~EH&S~~**EHSC** Committee works with the team to identify the goals, establish a timeline, a budget, if needed, priorities, and establish objective measurements of improvement.
3) The ~~EH&S~~**EHSC** Committee also established a schedule for the team to report progress and results.
4) All final improvement reports are summarized as part of the annual review of the overall program and presented to hospital leadership, the performance improvement team, and patient safety leadership.

m. Orientation and Ongoing Education and Training – (HR.01.04.01 EP1 & 3, & EC 01.05.03, EC.03.01.01 EP1 – EP3)
i. Orientation and training addressing the EOC programs is provided to each staff member, contractor, and volunteer.
ii. All Licensed Independent Practitioners (LIP) receive an orientation to the Environment of Care in accordance with the Medical Staff policies and bylaws.
iii. Annual EOC training is provided and documented via NetLearning.
iv. The Human Resources Department with participation from the Education Department coordinates the general New Employee Orientation (NEO) program.
1) New staff members are required to attend the NEO program within 30 days of their date of employment.
2) The Human Resources Department with participation from the Education Department maintains attendance records for each new staff member completing the general orientation program.
v. New staff members are also required to participate in orientation to the department where they are assigned to work.
1) The departmental orientation addresses job related patient safety and environmental risks and the policies, procedures, and processes to minimize or eliminate them during routine daily operations.
vi. The ~~EOC Specialist~~ **EOC/Safety Manager** collaborates with the department managers, the Manager of Risk Management/Quality, the Manager of Regulatory Compliance and Infection Control, the Patient Safety Officer, and others as appropriate to develop content materials for general and job-related orientation and continuing education programs.
vii. The ~~EOC Specialist~~ **EOC/Safety Manager** gathers data during EOC rounds and other activities to determine the level of competency of staff and licensed independent practitioners related to their ability to describe or demonstrate how job-related physical risks are to be managed or eliminated.

viii. The ~~EOC Specialist~~ **EOC/Safety Manager** evaluates the level of competency of staff and LIPs related to understanding and demonstrating the actions to be taken when environmental incidents occur and how to report environmental hazards or incidents.

ix. Information about staff and licensed independent practitioner knowledge and technical skills related to managing or eliminating EOC risks are reported to the ~~EH&S~~**EHSC** Committee.

———When deficiencies are identified, action is taken to improve orientation and ongoing educational materials, methods, and retention of knowledge as appropriate.

E. GOALS/OBJECTIVES:

1. Safety risk assessment for all departments throughout the facility and off-site locations.

~~x.~~2. Continuing educating and raising awareness to Covid-19 protocols.

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

1. Code Adam (Infant Abduction) Policy
2. Code Blue/Pink (Adult/Infant Arrest) Policy
3. Code Caleb Policy
4. Code Dr. Strong (Violent Person) Policy
5. Code Gray (Hostage Situation) Policy
6. Code Green (02 Emergency) Policy
7. Code Orange (Disaster) Policy
8. Code Red (Fire) Policy
9. Code Silver (Active Shooter) Policy
10. Code Yellow (Radiation Disaster) Policy
11. Environment of Care (EOC) Audit Tool – Clinical Rounds
12. Environmental Health and Safety Committee Charter
13. EOC Audit Tool – Non-clinical Rounds
14. EOC Security Management Plan
15. EOC Waste Management Plan
16. **EOC Utility Management Plan**
17. **EOC Fire/Life Safety Plan**
18. **EOC Medical Equipment Plan**
~~15.~~19. **EOC Emergency Management Plan**
~~16.~~20. Hazardous Materials and Waste Management Plan
~~17.~~21. Illness and Injury Prevention Program (IIPP)
~~18.~~22. Security Management Plan

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

1. The Joint Commission for Health Care Organizations Standards
2. Cal/OSHA, Title 8

Tri-City Health Care District	Home Health Care
PROCEDURE:	**LABORATORY ~~PROCEDURES~~ORDERS**
Purpose:	To define the parameters for laboratory ~~procedures~~ **orders for Registered Nurses (RNs) and Licensed Vocational Nurses (LVNs).**

A. **DEFINITIONS:** N/A

B. **POLICY:**

1. ~~No~~ Laboratory ~~procedure~~ **tests are** ~~is~~ performed ~~except~~ on signed order ~~of~~ **from a** person lawfully authorized to give such an order. ~~Such an order may be given by telephone and is signed by the physician within 30 days. Each order must be read back.~~
2. ~~All telephone orders are received by a licensed nurse.~~ Prescriptions from **a physician** ~~MD~~ given to **a** patient may be used **and must be uploaded into the patient's medical record.**
3. All signed orders are incorporated into the patient's medical record.
4. All laboratory tests ordered must be directly related to the management of specific symptoms or discomfort.
5. ~~TCHC~~**Home Health** nurses draw blood, obtain appropriate urine **and stool** specimens for laboratory testing, and deliver to Tri-City Medical Center Laboratory or ~~MD~~**physician** ~~MD~~/insurance company required laboratory for analysis. ~~.~~

C. **PROCEDURE:**

1. The nurse completes the appropriate lab requisition ~~with~~ **and includes** diagnosis code(s) ~~specificity~~ supporting **the** ordered laboratory test**(s).**
   - **a. Clearly indicate** the physician's name**, telephone number,** and fax ~~/telephone~~ number ~~must be clearly indicated~~ so that the lab can **call and/or fax** ~~phone back~~ test results **to the ordering physician**.
   - ~~a.~~**b. Note: For HTLV III testing, a properly executed consent form must accompany the test request.**

2. The nurse selects necessary equipment **for specimen collection.**
   - **a.** ~~and~~ **Checks** ~~the~~ **the expiration dates on all supplies used**.
   - b. Make sure all ~~tubes~~ **specimen containers** are labeled with patient's name, date of birth (DOB), date **and**, ~~,~~ time of collection, and RN's/LVN's initials in patient's presence.

~~2.~~**3.** **Place** the collected specimens ~~are placed~~ in plastic bags with ice, if needed, and transport~~ed~~ in **a** closeable, leak~~-~~proof, puncture~~-~~resistant container that is properly labeled with **a** Biohazard Label.

4. Laboratory personnel ~~phone~~**call and/or** fax the attending physician with the results.
   - a. ~~Confirming~~ Copies **of test results** are sent to the attending physician and **the Agency** ~~TCHC~~.

~~3. A properly executed consent form must accompany requests for HTLV III testing.~~

~~4.~~**5.** Document all laboratory **orders and collection** procedures in the patient's medical **record** ~~chart~~.

~~D. **FORMS: N/A**~~

~~E.~~**D. RELATED DOCUMENTS:**

1. **ADULT Specimen Requirements**

~~F. **EXTERNAL LINKS:** N/A~~

~~G. **REFERENCES:** N/A~~

~~B. **RESPONSIBLE PARTY:**~~

~~1. All RN's/LVNs.~~

Department Review	Pharmacy & Therapeutics Committee	Department of Pathology	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/98, 07/99, 08/00, 10/05, 10/07, 10/09, 08/12, 06/20, **05/22**	n/a	09/20, **08/22**	09/20, **11/22**	10/20, **12/22**	n/a	11/20

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	**10/05**	**SUBJECT:**	**Continuing Medical Education (CME) Speaker & Honoraria Reimbursement**
REVISION DATE(S):	**05/09, 11/12, 12/15, 06/18, 03/19 03/20, 04/21**	**POLICY NUMBER:**	**8710-604**

Medical Staff Department Approval:	~~10/20~~01/22
CME Committee Approval:	~~01/21~~10/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/21~~11/22
Administration Approval:	~~04/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. **PURPOSE:**

1. To outline the process utilized by the Continuing Medical Education CME Committee to determine honoraria, and reimbursement expenses paid to individual faculty, authors, planners, and activity support staff and volunteers.

B. **POLICY:**

1. Tri-City Healthcare District's (TCHD) CME Committee is responsible for approving funds for speaker honoraria.
2. The CME Committee Chairperson/designee is responsible for approving honoraria, and reimbursement expenses greater than $500.
3. Honorarium shall not be paid to the director of the CME activity, CME Committee members, presenters, authors, joint sponsor, members of the medical staff involved with the supported activity, or others involved with the supported activity. No other payment as aforementioned shall be provided.
4. Members of the medical staff, who provide educational presentations, may request reimbursement for their expenses, i.e., development of PowerPoint/slide presentation as outlined in the following procedure.

C. **PROCEDURE:**

1. The CME Coordinator may contact commercial support in an effort to secure an unrestricted educational grant.
   a. All commercial support funds shall be made payable to "TCMC Medical Staff Treasury".
2. The CME Coordinator shall inform the speaker of the approved, offered honorarium.
   a. The CME Coordinator shall obtain a completed W-9 form from the speaker.
   b. Upon completion of the CME activity, the CME Coordinator shall mail the honorarium check, "Thank You Letter", and a copy of the activity "Evaluation Summary" to the speaker.

D. **REFERENCE(S):**

1. ACCME Standards of Commercial Support – Standard 3.7.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 04/12	**SUBJECT:** Credentialing Policy, Mazor Robotic Surgery
REVISION DATE~~(S)~~: 03/13, 03/20	**POLICY NUMBER:** 8710 – 566

Medical Staff Department Approval:	~~07/17~~09/22
Division of Subspecialty & GVS~~Neurosurgery~~ Approval:	~~03/13, 07/18, 09/18, 03/19, 11/19~~10/22
~~**Division of Orthopedics Approval:**~~	~~03/19, 11/19~~
Credentials Committee Approval:	~~03/13, 11/19, 02/20~~11/22
Pharmacy & Therapeutics Approval Committee:	n/a
Medical Executive Committee Approval:	~~03/13, 02/20~~11/22
Administration Approval:	~~03/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/20

A. **PURPOSE:**

1. To provide criteria for use in credentialing physicians who request privileges in Mazor robotic surgery.

B. **INITIAL CREDENTIALING:**

1. All physicians requesting Mazor robotic surgery privileges must be Board Certified in Orthopedic Surgery or Neurosurgery, or be actively pursuing the applicable certification, or be able to demonstrate comparable ability, training and experience.
2. For surgeons with residency or fellowship training which included training in the Mazor Robotics Renaissance Guidance System:
   a. Physicians must have privileges to perform underlying procedure; and
   b. Provide:
      i. Letter from training program director certifying adequate training and current competency for the requested privilege(s) using the Mazor device; and
      ii. The surgical log of a minimum of ten (10) Mazor cases; and
      iii. Proctoring: A minimum of one (1) case must be concurrently proctored by a Mazor robotic-credentialed surgeon.
3. For surgeons with prior Mazor experience at an outside institution:
   a. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
   b. Proctoring: A minimum of one (1) case must be concurrently proctored by a Mazor robotic-credentialed surgeon.*
4. For surgeons without residency/fellowship training or prior Mazor experience:
   a. Privileges to perform the underlying procedure; and
   b. Certification of completion of a Mazor Training Program or comparable program, which includes cadaveric training module and completion and passing of test modules.
   c. Proctoring: A minimum of one (1) case must be concurrently proctored by a Mazor robotic-credentialed surgeon (preferably in their field).*
   d. *Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief of the Division that additional training and/or proctoring be completed.

5. Surgeons who have been granted Mazor robotic surgical privileges may assist in Mazor procedures without separate Mazor assist privileges.
6. For privileges to assist in Mazor robotic surgery (for MD/DO, PA, RNFA/RNFA trained):
   a. Unrestricted surgical assisting privileges.
   b. Documented experience in Mazor robotic assisting (three [3] cases beyond proctoring) or completion of Mazor Training Program.
   c. Proctoring: A minimum of three (3) cases must be proctored by the primary surgeon. Surgeons who have been granted unsupervised privileges to perform Mazor robotic surgery are not required to undergo additional proctoring in the assistant role.

C. **REAPPOINTMENT CRITERIA (MAZOR ROBOTIC SURGEONS):**

1. A minimum of four (4) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present.
2. If less than four (4) but greater than or equal to two (2) cases have been performed successfully during the previous 24-month period, the next two (2) cases must be successfully performed with the assistance of either a Mazor robotic certified surgeon on staff from within the same field, or an outside proctor/preceptor.
3. If fewer than two (2) cases have been performed successfully within the previous 24-month period, additional certified hands-on training must be obtained either by simulator, cadaver or animal lab AND the next one (1) case must be successfully performed with the assistance of either a Mazor robotic certified surgeon on staff from within the same field, or an outside proctor/preceptor.

D. **ONGOING PROFESSIONAL PRACTICE EVALUATION:**

1. Mazor robotic-performed cases may be reviewed on an ongoing basis by the appropriate Division/Department/Committee with the goal of patient safety, and successful performance of the procedure(s). This may include OR time, blood loss, conversion to open procedure, complications, length of hospital stay.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 04/09	**SUBJECT:** Disaster Privileges
REVISION DATE: 09/09, 01/17, 03/20	**POLICY NUMBER:** 8710-553
Medical Staff Department Approval:	~~08/16~~10/~~19~~10/22
Credentials Committee Approval:	~~08/16~~11/~~19~~11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/16~~02/~~20~~11/22
Administration Approval:	~~03/20~~12/22
Professional Affairs Committee Approval:	~~01/17~~ n/a
Board of Directors Approval:	03/20

A. **PURPOSE:**

1. To provide a process to credential and grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners, and/or Allied Health Professionals (AHP's), as appropriate, in the event of a disaster when the HICS plan has been activated, and the hospital is unable to meet immediate patient care needs.
2. SCOPE and RESPONSIBIITY includes the Medical Staff Services Department of Tri-City Medical Center or Designee, and the designated Disaster Coordinator.

B. **DEFINITIONS AND TERMS:**

1. The following definitions shall apply for purposes of this policy and procedure only.
   a. Practitioner: A physician (M.D., D.O.), podiatrist (D.P.M.), dentist or oral maxillofacial surgeon (D.D.S., D.M.D.).
   b. Allied Health Professional or AHP: All health care professionals other than Practitioners, as defined above, who are classified as Dependent practitioners to work as a physician extender under the direction of a supervising physician, and required by law and regulation to have a license, certificate or registration to practice their profession.
   c. Surgical Tech, Orthopedic Tech shall be credentialed as follows:
      i. If a "tech" is employed by another hospital, they will be sent to Human Resources for appropriate credentialing.
      ii. Any "tech" who is not employed by another hospital will be credentialed per this policy.
   d. Volunteer Practitioner or AHP: A Volunteer Practitioner who is not currently a member of the medical staff of Tri-City Medical Center, or an AHP who has not been credentialed as an AHP by the facility.
   e. Disaster Clinical Privileges: Clinical Privileges granted to a Volunteer Practitioner, as defined above, pursuant to this policy and procedure.
   f. Disaster Practice Prerogatives: Practice prerogatives granted to an AHP, as defined above, pursuant to this policy and procedure.

C. **PROCEDURE:**

1. Upon presentation to the hospital, Volunteer Practitioners, and/or AHPs shall be directed to the Hospital Representative responsible for disaster credentialing under the HICS plan.
   a. Volunteer Practitioners and/or AHPs must sign in and present required identification as follows:
      i. A valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport), and at least one of the following:

1) A current hospital photo ID badge that clearly identifies professional designation;
2) A current license, certificate or registration to practice, as appropriate;
3) Identification indicating the individual is a member of a Disaster Medical Assistance Team (*DMAT*), or Medical Reserve Corps (*MRC*), Emergency System for Advanced Registration of Volunteer Health Professionals (*ESAR-VHP*), or other recognized state or federal organizations or groups;
4) 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 deferral state, or municipal entity); or
5) Identification of Volunteer Practitioners by current hospital or medical staff members(s) who possess personal knowledge regarding the Volunteer Practitioner's ability to act as a licensed independent practitioner during a disaster, and of Volunteer AHPs by current hospital member(s) who possess personal knowledge regarding the AHP's qualifications.

b. Required Documentation on the Disaster Privileges/Prerogative Approval Form:
   i. Name of Volunteer Practitioner or AHP (printed and signed)
   ii. Specialty or AHP Category
   iii. Office Address and Phone Number
   iv. Professional License/Certificate/Registration Number and Expiration Date
   v. Driver's License or Passport Number and Expiration Date
   vi. Date of Birth
   vii. Name of Professional Liability Insurance Carrier and Limits of Liability
   viii. Name of Professional School and Year of Graduation
   ix. Hospital Affiliation(s) and Staff Status

c. Verification Process:
   i. The hospital Representative shall verify professional licenses/certificates/ registrations as follows:
      1) Primary Source Verification:
         a) Query the appropriate licensing/certification/registration board on-line, e.g.= Medical Board of California website = *www.medbd.ca.gov* – use for M.D.s, D.P.Ms and PAs; California Osteopathic Medical Board = *www.ombc.ca.gov* – use for D.O.s, California Board of Registered Nursing = www.rn.ca.gov – use for R.N.F.A.s, N.P.s, C.N.M.s and other R.N.s; Board of Behavioral Sciences = www.bbs.ca.gov --- use for M.F.C.C.s and L.C.S.W.s; California Psychology Board = www.psychboard.ca.gov –use for clinical psychologists, and print verification if possible.
      2) If computer access is not available, a copy (if possible) of the Volunteer Practitioner's or AHP's professional license/certificate/registration and driver's license or other identification shall be made and attached to the Disaster Privilege/Prerogative Approval Form. If a copier is not available, the Hospital Representative shall perform a visual verification of the above documents, and document such verification.
      3) If primary source verification of professional licensure/certification/ registration cannot be accomplished at the time of initial credentialing, it must be performed as soon as the immediate situation is under control, and completed no later than seventy-two (72) hours from the time the Volunteer Practitioner or AHP presented to the campus. In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours (e.g., no means of communication or lack of resources), it shall be accomplished as soon as possible. In this

extraordinary circumstance, the following must be documented:
a) Why primary source verification could not be performed in the required timeframe;
b) Evidence of the Volunteer Practitioner's or AHP's demonstrated ability to continue to provide adequate care, treatment, and services;
c) Attempt(s) to rectify the situation as soon as possible.

4) The Medical Staff Services Representative or designee shall query the National Practitioner Data Bank (NPDB) and other sources as needed, as soon as, the emergency situation has been contained.
5) Primary source verification shall not be required if the Volunteer Practitioner or AHP has not provided care, treatment, and services under the Disaster Clinical Privileges, or Practice Prerogatives, as appropriate.

d. Who May Grant Disaster Clinical Privileges/Practice Prerogatives:
i. As described in the Medical Staff Bylaws, the Chief Executive Officer (CEO) or Chief of Staff or their designees may grant Disaster Clinical Privileges or Practice Prerogatives. The option to grant Disaster Clinical Privileges or Practice Prerogatives to Volunteer Practitioners and/or AHPs shall be made on a case-by-case basis in accordance with the immediate needs of the hospital's patients, based on the qualifications of the Volunteer Practitioners and/or AHPs.

e. Temporary Badges:
i. So that they may be readily identified, Volunteer Practitioners and/or AHPs shall be issued badges containing the following information:
1) Name
2) Specialty or AHP category
3) Practicing with Disaster Clinical Privileges or Practice Prerogatives, as appropriate.

f. Oversight:
i. The Medical Staff shall oversee the care, treatment, and services provided by a Volunteer Practitioner or AHP who has been granted Disaster Clinical Privileges or Practice Prerogatives. Oversight shall be accomplished whenever possible by partnering the Volunteer Practitioner or AHP with a current credentialed medical staff member or AHP, as appropriate, to observe or mentor the Volunteer Practitioner or AHP. If partnering is not possible, oversight shall be by clinical record review. A Volunteer Practitioner or AHP may be assigned additional responsibilities by the Medical Staff Officer designated under the *HICS* plan.

g. Termination of Disaster Clinical Privileges/Practice Prerogatives:
i. A Volunteer Practitioner's or AHP's Disaster Clinical Privileges or Practice Prerogatives shall be terminated immediately in the event that any information received through the verification process or otherwise indicates adverse information or suggests the Volunteer Practitioner or AHP is not capable of exercising Disaster Clinical Privileges or Practice Prerogatives. Disaster Clinical Privileges and Practice Prerogatives are time-limited and shall expire automatically at the time the CEO or designee declares the disaster to be over, or that the services of Volunteer practitioners or AHPs are no longer required.

D. **REFERENCE(S)**:
1. The Joint Commission Standards

APPLICATION FOR DISASTER PRIVILEGES

To be completed by the Volunteer Licensed Independent Practitioner/Volunteer Practitioner

Full Name:_____
Cell Phone Number:_____
Social Security Number:_____
Date of Birth:_____
Office Address, City, State, Zip Code:_____
_____
Office Telephone:_____
Photo Identification Type (i.e., driver's license, government I.D.):
_____
Identifying Number:_____
Issuing State/Agency:_____
(If copy not obtained, list other information):_____
_____
License (certification or registration) Number:_____
Issuing State:_____
Expiration Date:_____
(If copy not obtained, list issuing agency name/address/phone/other information):
_____
Malpractice Insurance Carrier Name:_____
Telephone Number (if available):_____

Current Hospital Affiliation(s) – Facility(s) Name(s)
Address(s), City(s), State(s), Zip Code(s)
Telephone Number(s)
_____
_____
_____

LIP/Volunteer Practitioner's Signature:_____

VERIFICATIONS/APPROVAL

Review all documents and attach copies if possible. Conduct verification of information as possible.

License/Certification/Registration:_____

Affiliation(s):_____

Insurance:_____ NPDB:_____OIG:_____Other:_____

On Site Medical Staff Member's Name:_____

Responsibilities (following interview with volunteer Health Care Practitioner):_____

_____

_____

Assigned Partner:_____

Approved by: (Print name, signature, title):_____

CONSENT, ACKNOWLEDGEMENT & RELEASE OF INFORMATION FOR DISASTER PRIVILEGES

I, the undersigned, hereby apply for disaster privileges as requested on this application. I acknowledge and agree to abide by the Medical Staff Bylaws, Rules and Regulations, and applicable hospital policies. By applying for disaster privileges, I accept the following conditions during the processing and consideration of my application and for the duration of my privileges, regardless of whether or not I am granted the privilege requested:

1. I agree the information provided in conjunction with this application is accurate and represents the current level of my training, experience, capability, health status, and competence to practice the disaster privileges requested.

2. I fully understand and agree that any significant misrepresentation, misstatement or omission from this application, whether intentional or not, shall constitute cause for denial of requested disaster privileges. In the event that disaster privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary termination of disaster privileges.

3. I hereby authorize my professional liability insurance carrier to notify the Chief of Staff or his agent, in the event that my insurance coverage is terminated, canceled, modified or otherwise acted upon.

4. I understand and agree that as an applicant for disaster privileges that I have the burden of producing adequate information for the proper evaluation of my professional competence, character, ethics, health status, and other qualifications, and for resolving any doubts about such qualifications. I agree to make myself available for interviews with regard to my application, and any peer review related matters during the time that I hold disaster privileges.

5. I agree to provide continuous care for my patients either personally or through an identified qualified member of the medical staff.

6. Immunity is extended to the fullest extent permitted by law and I release from liability all persons, organizations, committees and their agents from participating in good faith in requesting or supplying information relative, but not limited to: (a) applications for appointment and/or clinical privileges; (b) periodic reappraisals undertaken as part of the peer review process; (c) investigations, reprimands, corrective action, suspension or reduction of clinical privileges, or other disciplinary action; (d) hearings and appellate reviews: (e) reviews before the governing board; (f) case evaluations; (g) utilization reviews: (h) other hospital, medical staff or departmental, service or committees activities relating to the quality of patient care or my professional conduct; (i) inquiries concerning my professional qualifications, character, ethics, physical or mental health status, or behavior; and (j) any other matter that may affect patient care, or the orderly operation of this or any other hospital, and I hereby authorize and consent to the release of such information.

7. I understand and agree that after I submit this application it is my sole obligation to promptly report to the Chief of Staff or his designee of any: (1) change in the contents of this application; (2) change in my physical or mental health that could impair my ability to practice; (3) change in my staff membership or privileges at any other health care facility; (4) investigation or accusation with regard to my license or DEA; or (5) conviction of, or plea of guilty or no contest, or its equivalent, to a felony in any jurisdiction; (6) sanction and/or exclusion from participation in any Federal health care program; or (7) change in the status of my professional liability insurance coverage.

8. I present this application and arrange for the submission of other information with the understanding: (1) that such information is requested by the peer review committee(s) of this hospital as part of the credentialing process; (2) that the confidentiality and privacy of this information will be preserved; and (3) that this information and materials will only be released or disclosed as part of current or future credentialing, peer review or quality improvement processes as described above, and in the medical staff bylaws, rules and regulations.

9. I understand that the completion of this application is my sole responsibility. I declare that the information on this application is true and without omission to the best of my knowledge. I hereby apply for disaster privileges.

SIGNATURE: _____ DATE: _____

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	10/05	SUBJECT:	Joint Providership/Co-Providership
REVISION DATE:	05/09, 08/12, 09/14, 08/18, 03/19 03/20, 04/21	POLICY NUMBER:	8710-602

Medical Staff Department Approval:	10/20
CME Committee Approval:	01/21
Pharmacy & Therapeutics Committee:	n/a
Medical Executive Committee Approval:	~~03/21~~11/22
Administration Approval:	~~04/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. PURPOSE:
1. To outline criteria utilized for Joint Providership or Co-Providership of a CME activity.

B. DEFINITION(S):
1. Joint Providership– A relationship between an accredited CME provider and a non-accredited provider, in which the accredited provider works in partnership with the non-accredited provider to plan and present CME activities in accordance with the mission of the accredited provider.
2. Co-Providership– A relationship between two accredited CME providers to plan and present CME activities.

C. POLICY:
1. The non-accredited organization should have as its primary interest the dissemination of health care information or the findings of medical research.
2. The non-accredited organization agrees to follow all procedures outlined by Tri-City Medical Staff, and contained in the CME Policy Manual.
3. The Course Director should be a physician with an affiliation in the non-accredited organization.
4. The program planning request should be received at least six (6) months before the scheduled date of the activity. Timing for the activity should not conflict with other CME activities sponsored by Tri-City Medical Center.
5. Tri-City Medical Center CME planning forms are to be completed and submitted as part of the course file.
6. All promotional material shall follow Tri-City Medical Center's CME policies, and be submitted for approval to the CME Coordinator before being distributed. Appropriate accreditation statements will be used, and all materials must indicate joint sponsorship with Tri-City Medical Center CME as the accredited sponsor.
7. A course coordinator should be designated by the non-accredited organization to manage the administrative details.
8. All potential joint/co-providership relationships will be examined on their individual merits. Although all CME activities joint/co-providership with Tri-City Medical Center CME must comply with this policy, Tri-City Medical Center CME reserves the right to refuse to enter into a joint/co-providership agreement for any reason whatsoever, regardless of that organization's willingness to comply with this policy.
9. The responsibilities and role of the joint/co-provider will be clearly delineated in a letter of agreement between the joint/co-provider and Tri-city Medical Center CME. Tri-City Medical Center CME has the right to withdraw from any activity if the joint/co-provider fails to meet its

obligations as described in the letter of agreement, or fails to comply with Tri-City Medical Center CME policies and procedures.

10. Tri-City Medical Center CME will charge fees for its services. These fees and the terms for its payment will be mutually agreed upon and delineated in the aforementioned letter of agreement between Tri-City Medical Center CME and the joint/co-provider.
11. All commercial support for Joint/co-provider activities shall be obtained as unrestricted grants, and all aspects of commercial support should be disclosed prior to approval of the activity. The CME Coordinator acting in behalf of the CME Committee will administer commercial support.
12. Joint provider activities shall be consistent with Tri-City Medical Center's CME Mission Statement.
13. Tri-City Medical Center, through its CME Committee, shall participate in the planning and implementation of these activities. A representative from the non-accredited entity should attend the CME Committee meeting to discuss progress.
14. All activity expenses are the responsibility of the organization seeking joint providership. Evidence of a proposed neutral budget is to be completed before expenses are incurred. Tri-City Medical Center will withdraw from an activity if resources are inadequate for the development of a high quality educational product or activity.
15. Attendance information should be submitted to the CME Coordinator within two (2) weeks of the activity, in order to provide timely distribution of CME certificates.
16. The proposed CME activity cannot be advertised prior to CME Committee approval and the designation of CME credit.

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

1. Written Agreement for Joint Providership.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	01/07	SUBJECT:	Ongoing Professional Practice Evaluation: OPPE & FPPE
REVISION DATE:	03/08, 05/08, 06/08, 07/15, 07/17 03/21, 08/21	POLICY NUMBER:	8710 – 509

Medical Staff Department Approval:	07/21
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/21~~10/22
Administration Approval:	~~08/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/21

A. PURPOSE:

1. To provide guidelines for the Medical Staff to identify competency and professional practice trends that impact quality of care and patient safety which may require intervention by the organized medical staff. The information used in the Ongoing Professional Practice Evaluation (OPPE) may be acquired through the following three components:
   a. Ongoing Professional Practice Evaluation (OPPE) (To include Direct Observation)
   b. Individual Case/Peer Review
   c. Focused Professional Practice Evaluation (FPPE)

B. POLICY:

1. The Medical Executive Committee (MEC) has oversight of the Ongoing Professional Practice Evaluation (OPPE) process. The Medical Quality Peer Review Committee (MQPR) is a multi-specialty committee that evaluates and monitors the quality and appropriateness of healthcare services provided to patients and recommends plans for improving and sustaining quality patient care on an ongoing basis to the MEC.
2. Medical Staff members, departments, divisions and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws, Medical Staff Rules and Regulations, Department/Division Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in Federally funded programs. Peer review includes all evaluation activities involving members of the Medical Staff ("Practitioners"), including quality improvement, utilization review, monitoring, proctoring, focused review, Focused Professional Practice Evaluation (FPPE), On-going Professional Practice Evaluation (OPPE) and medical record review. The results of peer review activities are utilized to assess a Practitioner's professional practice as part of the credentialing, privileging, and corrective action processes.
3. Members of the medical staff will receive provider-specific feedback on an ongoing basis via the OPPE process.
4. OPPE information in the individual practitioner's file is available to authorized individuals with a legitimate reason for access based on their assigned responsibilities. Individuals with access to provider-specific information is limited to:
   a. The specific provider
   b. Chief of Staff and Medical Staff Department/Division Chair
   c. Members of the MEC and Credentials Committee for purposes of considering appointment, re-appointment, privileges or corrective action
   d. The Board of Governors for the specific purposes associated with this policy and their

role in approving members of the Medical Staff

e. Specific medical and hospital staff that support the work of the Medical Staff in carrying out the duties associated with this policy

f. Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g. The Joint Commission or state/federal regulatory bodies).

5. MQPR meeting minutes will be reported through the MEC meeting for approval.

C. **ONGOING PROFESSIONAL PRACTICE EVALUATION ("OPPE"):**

1. Definition: A Summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior.

2. Ongoing Evaluation: ~~At eight (8) month intervals~~, Eevery Practitioner will undergo ongoing evaluations defined by each Department/Division. **The review timeframe will not exceed a twelve (12) month period.** Relevant data is collected and assembled for review by the applicable Department Chair/Division Chief, who shall determine whether the Practitioner is performing: 1) well/within desired expectations and that no further action is warranted; or 2) that an issue exists and requires action to address the finding; or 3) that an issue exists that requires a focused evaluation; or 4) recommending revocation of a privilege because it is no longer required, recommending suspension of a privilege; or 5) that there has been zero performance of a privilege thereby triggering focused review (proctoring) whenever the practitioner performs the privilege; or 6) determining that a privilege should be continued without change because the organization's mission is to be able to provide the privilege to its patients. Ongoing evaluations shall be included in the Practitioner's credential file as part of the reappointment process. This process will evaluate a Practitioner's professional performance on an on-going basis, utilizing the following six (6) areas of General Competencies:
   a. Patient Care
   b. Medical / Clinical Knowledge
   c. Practice-based learning and Improvement
   d. Interpersonal and communication skills
   e. Professionalism
   f. Systems / Based Practice

3. **Low or No Volume: In the event a practitioner does not have sufficient activity to allow for and adequate evaluation, the following additional steps shall be taken.**

4. **A professional peer reference, and one of the following shall be collected:**
   a. Clinical activity within the past 2-years from the practitioner's primary hospital where they have significant volume.
   b. Letter from hospital at which practitioner has significant volume, stating status and standing
   c. FPPE or OPPE Data from the practitioner's primary hospital where they have significant volume

~~3.~~**5.** Individual quality measures within the OPPE profiles will have thresholds/benchmarks to guide the department/division chair in determining provider performance. (Department/Division specific quality measures are approved annually by the medical staff). If a concern is identified, the department/division chair will propose actions to address the finding.

~~4.~~**6.** Individual peer review outcomes within the OPPE profiles will have a threshold to guide the department/division chair in determining provider performance. This will be acquired through the following point-based system:
   a. Within Standard of Care & Not Physician Related: 0 Points
   b. Minimal Variance from the Standard of Care & Violation of Hospital Policy (with quality component): 1 Point
   c. Moderate Variance from the Standard of Care: 2 Points
   d. Significant Variance from the Standard of Care: 3 Points

~~5.~~**7.** The total number of points will be added for each provider for the ~~8-month timeframe~~/OPPE cycle **that is not to exceed a 12-month period**. The point threshold per ~~8-month~~ cycle is set by the MQPR Committee and may change as deemed warranted by the MQPR Committee. If a practitioner exceeds the set point threshold (this is referred to as a trigger), the

department/division chair will review further and propose actions to address the finding.

~~6.~~**8.** A summary report will be provided to the MQPR Committee periodically outlining all practitioners that have exceeded thresholds in a specific quality measure or peer review outcome during their OPPE cycle. The report will also track if providers are continuing to perform poorly in subsequent OPPE cycles. Customary actions will occur as follows, but actions may be subject to change at the discretion of the department/division chair:

a. 1st OPPE cycle exceeding threshold: Letter from chair notifying provider area in need of improvement.

b. 2nd OPPE cycle exceeding threshold (consecutive): Letter from chair notifying provider area in need of improvement has exceeded the threshold a second time and has been referred to MQPR. Letter from MQPR **will be sent to the provider** requesting **a** response ~~from provider re:~~ **for a** plan of improvement. **Following receipt of the provider's response, MQPR will make recommendations as deemed warranted, which may include the recommendation to the MEC for FPPE.**

~~c. 3rd cycle concern (consecutive): Letter from chair notifying provider area in need of improvement has exceeded the threshold a third time and has been referred to MQPR for potential FPPE. MQPR will review again and make recommendation to MEC for FPPE as deemed warranted~~.

~~7.~~**9.** Individual professional behavior review outcomes within the OPPE profiles will have a threshold to guide the department/division chair in determining provider performance. This will be acquired through the following point-based system:

a. No Determined Behavioral Issue: 0 Points

b. Minimal Violation of Physician Code of Conduct/Violation of Hospital Policy (without quality component): 1 Point *(HIM suspension, angry outbursts, name calling, loud or inappropriate arguments, inappropriate comments in medical record, etc.)*

c. Moderate Violation of Physician Code of Conduct: 2 Points *(Belittling, berating, intimidating, swearing, shaming others for negative outcomes, discriminatory comments, threat of physical force, etc.)*

d. Significant Violation of Physician Code of Conduct: 3 Points (Physical boundaries violation or sexual harassment, threat of physical force, unwanted physical or sexual contact, throwing objects, etc.)

~~8.~~**10.** The total number of points will be added for each provider for the ~~8-month timeframe~~/OPPE cycle **that is not to exceed 12-month period.** The point threshold per ~~8-month~~ **OPPE** cycle will be set by the Professional Behavior Committee (PBC) and may change as deemed warranted by the PBC. If a practitioner exceeds the set point threshold (this is referred to as a trigger), the department/division chair will refer the trend to the PBC committee/chair to propose actions to address the finding. Behavioral trends will be managed through the Professional Behavior Committee (PBC) and not tracked/monitored through MQPR.

~~9.~~**11.** After OPPE review is completed by the respective Department/Division chair, the Practitioner will receive a letter with the review findings and a copy of the OPPE file is placed in the Practitioner's file.

D. <u>INDIVIDUAL CASE REVIEW/PEER REVIEW:</u>

1. Definition: An assessment of a practitioner's professional performance by other practitioners through the review of individual patient record(s). The review can identify a provider's strengths and opportunities for improvement.
2. The MQPR, a multidisciplinary committee, serves as the formal peer review committee for all departments and divisions. The work of the MQPR does not preclude case discussions at department/division/committee meetings for purposes of shared learning.
3. Case reviews are initiated based on department/division established criteria, reported deviations from expected care, statistical analysis showing (i) important single events, levels of performance, or patterns or trends varying significantly from expected; (ii) performance varying significantly from other organizations; (iii) performance varying significantly from recognized standards, variances from utilization practices, (iv) risk management concerns involving quality of care, complaints from patients/family or staff relating to quality of care, (v) notices from

regulatory bodies, accreditation agencies or third party payors involving quality of care, or (vi) if an appropriate medical staff officer determines a need.

4. Case reviews will be performed by **a physician reviewer from** the applicable department/division (or designee thereof in accordance with the Medical Staff Bylaws or Rules and Regulations). Review findings will be documented and rated in accordance with a system established by the Medical Quality/Peer Review Committee (MQPR). *Refer to attachment A (Quality Case Review Flowchart)* for details regarding review process for cases with suspected or identified quality of care concerns.
5. Case**s found to have moderate or significant departure from the standard of care or determined by the MQPR char to warrant further review will have an additional review performed.** ~~reviews involving a single department/division will generally be reviewed by a first and second line reviewer. If a specialty specific second line peer reviewer is unavailable, the second line review will be assigned to a peer with privileges closest to the specialty being reviewed.~~
6. ~~Case reviews involving multiple departments/divisions will only require a first line reviewer for each department/division involved in effort to minimize the number of reviewers assigned to an individual case.~~
7.**6.** Case reviews found to have been within the standard of care or not physician related: Theses cases will be added to the monthly MQPR Committee agenda as informational cases not warranting discussion. Should the MQPR chair or any other member of the MQPR Committee identify a concern, the case can be re-opened and discussed. No correspondence will go out to the attributing provider for these cases unless there is an educational component involved. (Providers are informed of all case reviews and outcomes every 8 months as part of the customary OPPE process).
8.**7.** Case reviews found to have been in violation of hospital policy or with minimal departure from the standard of care: These cases will be added to the monthly MQPR Committee agenda as informational cases not warranting discussion. Should the MQPR chair or any other member of the MQPR Committee identify a concern, the case can be re-opened and discussed. An educational letter is sent to the attributing provider noting the final review findings/outcome/area(s) of opportunity.
9.**8.** Case reviews found to have moderate or significant departure from the standard of care: A letter will be sent notifying the attributing provider(s) of the initial review findings/concerns/questions and opportunity to provide input on the case. The letter will indicate that if input is not received within the allotted timeframe (generally 2 weeks), the review will proceed accordingly. These cases will be discussed at the MQPR Committee. If the MQPR Committee feels that additional information is warranted, the case will be tabled pending additional provider input/response. An educational letter is sent to the attributing provider noting the final review findings/outcome/area(s) of opportunity.
10. ~~Second line case reviewers/MQPR representation: Most department/divisions have one representative that sits on the MQPR Committee. When feasible, the representative that sits on the MQPR Committee will perform the second line case review for their respective department/division. Case discussions involving a specialty that does not have a seat on the MQPR committee will have an ad hoc representative attend the MQPR Committee on an as needed basis.~~
11. ~~Cases involving a clear violation of hospital policy with no additional quality component will only require a first line review.~~
12. ~~First and second line review discrepancies: If a second line reviewer disagrees with the first line reviewer's adjudication, the two reviewers will deliberate in effort to come to consensus on adjudication. If the two reviewers are unable to come to agreement, the case will be referred to the MQPR Committee for further discussion.~~
13.**9.** Review Timelines: Peer review of a particular matter shall be conducted as soon as reasonably possible based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events

interceded, include but not limited to, focused review or referral to another department/division. Delays in review shall be reported to the MQPR and Medical Executive Committee. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

~~14.~~**10.** Reporting Findings: The findings of peer review activities are reported through the MQPR Committee and on to the Medical Executive Committee following each MQPR meeting.

~~15.~~**11.** Action: Consistent with the provisions of the Medical Staff Bylaws, the department/division/quality review committee/chair/chief may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

~~16.~~**12.** External Peer Review: There are circumstances which can potentially warrant external peer review (e.g. ambiguity, conflict of interest, lack of internal expertise). Cases recommended for external review must be approved by the MEC. External peer review will be performed by a contracted peer review organization that is board certified and in active practice. The external peer review report is forwarded to the MQPR for review, discussion and file case disposition.

E. **FOCUSED PROFESSIONAL PRACTICE EVALUATION("FPPE"):**

1. Definition: Monitoring, proctoring and focused review activities utilized to evaluate the privilege-specific competence of a practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a practitioner's ability to provide quality care.
2. Monitoring: Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review, and concurrent observation.
3. Proctoring:
   a. Concurrent proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present.
   b. Retrospective proctoring is when a Practitioner's provision of care and treatment is evaluated through review of the medical record. In the case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set for the in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and Department/Division Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized.
   c. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.
4. Focused Review: In case where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated. Circumstances which may give rise to focused professional practice evaluation include, but are not limited to, provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with applicable standards; failure to comply with hospital or medical staff policies, procedures, rules, regulations, bylaws, laws, regulations or standards; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.
   a. INITIATION PROCESS: Request for a FPPE must be in writing, submitted to the MQPR Committee and MEC, with supported reference to the specific activities or conduct alleged. Monitoring for the FPPE may include but is not limited to periodic chart review, concurrent chart review, direct observation, monitoring diagnostic and treatment techniques, interviews with staff.

b. Time frame for the FPPE: The Medical Executive Committee will approve the time frame required for monitoring.
c. Monitoring Plan: If the MEC initiates the request for an FPPE, the Practitioner will be notified in writing. The initial written notice shall include a statement of facts demonstrating the request for FPPE was reasonable and warranted. This communication must also include what is wrong with the performance and what improvements are expected.
d. OUTCOME OF FPPE: A summary of findings and conclusion is forwarded to the MEC for review. If actions are recommended, the department/division chair is involved in reviewing the FPPE findings and formulating the proposed action plan. The Practitioner will be notified in writing of conclusions and recommendations following FPPE.

F. **GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:**

1. Participants in the Peer Review Process:
   a. Peer: Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.
   b. Reviewer(s): The Department/Division Chair/Chief shall appoint Practitioners to perform case reviews. The reviewer shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.
   c. Affected Practitioner: A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response or attendance at a meeting, as determined by the Department/Division/Committee. In cases where the peer review process advances to the investigation for corrective action stage, the process shall comply with the provisions of the Medical Staff Bylaws.
   d. Support Staff: Employees of the hospital may be designated to assist the Medical Staff with its peer review activities. Employees acting in such roles shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff confidentiality requirements with regard to peer review materials.
2. Data Sources/Collection: The cases for peer review are derived from quality review reports, patient satisfaction surveys, department specific criteria and reports generated from coded medical records.
3. Criteria shall be reviewed by each department/ division annually. The criteria can be changed before the annual review with request from Department Chair.
4. The MQPR will meet as necessary to conduct business; generally monthly but no less than 10 times per calendar year.
5. Peer Review results are used in the reappointment process and in ongoing performance improvement activities for all members of medical staff.
6. Cases requiring immediate action or intervention are shared directly from Risk Manager to Department Chairman or Chairman of MQPR Committee and may require direct intervention.
7. Systems or Process Concerns identified during a case review/discussion will be noted in the Peer Review minutes and referred to the appropriate personnel for further evaluation and action as appropriate. MQPR will track systems/process issues through completion.
8. For cases of Practitioner comportment, refer to Medical Staff Policy 511.1, Physician Behavior Policy.

G. **CATEGORY OF ASSIGNMENTS:**

1. Not Physician Related
   a. These events are non-physician related. . Trending data from this category would not enhance or identify opportunities to improve physician-specific performance but may

demonstrate trends useful for departmental or hospital wide management.

2. Within The Standard of Care
   a. These events reflect care that is within the contemporary standards of the specialty or expected standards of the department.
   b. These events reflect care that resulted in a complication and or prolonged clinical course, but the care remained within the contemporary standards of the specialty or the department.
3. Departure From The Standard of Care
   a. Minimal Variance
      i. These events reflect care that is minimally outside the contemporary standards of the specialty or expected standards of the department, that may have or did result in temporary or permanent harm to the patient.
   b. Moderate Variance
      i. These events reflect care that is clearly outside the contemporary standards of the specialty or expected standards of the department that may have or did result in temporary or permanent harm to the patient.
   c. Significant Variance
      i. These events represent gross departures from expected standards and raise immediate questions about judgment or technique. These events may have or did result in temporary or permanent harm to the patient.
4. Violation of Hospital Policy (Includes poor communication and- inadequate documentation.
5. No Identified Physician Behavioral Issue
6. Violation of Physician Code of Conduct
   a. Minimal Violation
      i. These events reflect behavior that minimally violates physician code of conduct (HIM suspension, angry outbursts, name calling, loud or inappropriate arguments, inappropriate comments in the medical record.
   b. Moderate Violation
      i. These events reflect behavior that moderately violates physician code of conduct ((Belittling, berating, intimidating, swearing, shaming others for negative outcomes, discriminatory comments, etc).
   b. Significant Violation
      i. These events reflect behavior that significantly violates physician code of conduct (Physical boundaries violation or sexual harassment, threat of physical force, unwanted physical or sexual contact, throwing objects, etc.)

B. **APPEAL PROCESS:**

1. Practitioner(s) asked for information by a reviewing committee with regard to quality events of a particular case(s) must respond within 30 days of receipt of such request. If no response is received within 30 days, the committee will make its determination without that physician(s) input.
2. If the Practitioner disagrees with the category assigned, he/she may request appeal from the committee where the assignment is made. If the appeal is not resolved to the satisfaction of the Practitioner, the MQPR Committee shall serve as the appeal review body and the MEC as the final appeal body.
3. The Medical Staff member may review his/her file on request as outlined in the Medical Staff Bylaws.
4. Any evaluation of a quality event that is not completed within six (6) months of initial review will be reported to the MQPR Committee and may be subject to assessment by the committee chairperson.

C. **REFERENCE(S):**

1. Medical Staff Standards, Joint Commission 2022~~17~~
2. ~~Effective Peer Review A Practical Guide to Contemporary Design, 3rd Edition, Robert Marder, May 2013~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE:	04/09	SUBJECT:	Regularly Scheduled Series (RSS)
REVISION DATE~~(S)~~:	12/09, 11/12, 09/14, 08/18, 03/19 03/20, 04/21	POLICY NUMBER:	8710-606

Medical Staff Department Approval:	~~10/20~~01/22
CME Committee Approval:	~~01/21~~10/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/21~~11/22
Administration Approval:	~~04/21~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. PURPOSE:
1. To outline criteria and process for approving and evaluating outcomes for Regularly Scheduled Series (RSS).

B. DEFINITION(S): A regularly scheduled Series (RSS) is planned to have:
1. A series with multiple sessions.
2. The series occurs on an ongoing basis (offered weekly, monthly, or quarterly).
3. The series is planned by and presented to the accredited organization's professional staff.
4. The series are only offered as directly-sponsored activities to the accredited organization's professional staff.

C. POLICY:
1. RSS conferences such as cancer conferences and cardiovascular conferences are approved on the basis of common needs and goals for each session for a one-year period.
2. Initial RSS Request: Required documentation to be provided to the CME Committee at least 60 days before the first session is scheduled:
   a. Request for AMA PRA Category 1 Credit(s)™
   b. Planner and Faculty disclosure forms.
3. Continuing RSS: For regularly scheduled series conferences currently taking place with Category 1 credit, the planner shall submit on an annual basis to the CME Coordinator the Annual Evaluation and Outcomes form and a new Request for AMA PRA Category 1 Credit(s)™ and Faculty Disclosure form(s). A 60-day time frame for CME Committee review is encouraged.
4. Conference Planner: The conference planner is responsible for providing the following documentation to the CME Coordinator within 30 days of the session date:
   a. Session Case Selection & Outcomes form.
   b. Completed evaluation forms.
   c. Evaluation summary.
   d. CME Reporting Form.
   e. Attendance roster.
   f. Case summaries (if applicable).
   g. Copy of promotion materials (flyer).
5. Regularly scheduled series conferences must be at least 50 minutes in length for one (1) category 1 credit.

D. EVALUATION – IMPROVEMENT:

1. Learners will complete an annual RSS *Learner Evaluation* form. Results will be summarized and provided to the CME Committee.

E. REFERENCE(S):

1. ~~Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2014~~Accreditation Criteria and Policies for Continuing Medical Education (CME) * with annual report.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	05/01	SUBJECT:	Temporary Privileges for Medical Staff
REVISION DATE~~(S)~~:	03/08, 04/09, 09/13, 04/17, 04/20	POLICY NUMBER:	8710-515

Medical Staff Department Approval:	~~02/20~~09/22
Credentials Committee Approval:	~~02/20~~10/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/20
Administration Approval:	~~04/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. POLICY:
1. Temporary privileges may be granted for circumstances and in accordance with procedures as outlined in the Tri-City Healthcare District (TCHD) Medical Staff Bylaws.

B. DEFINITION~~(S)~~:
1. Temporary Privileges: May be granted to a **provider**~~physician~~ who has a particular skill that is needed or desired in the organization for a period of time but not related to a disaster or emergency procedure.

C. PROCEDURE:
1. Temporary Privileges for Medical Staff Applicants:
   a. Refer to Medical Staff Policy #8710-543, Credentialing Policy, Processing Medical Staff Applications, for medical staff applicant credentialing criteria.
   b. In accordance with the Medical Staff Bylaws.
2. Temporary Privileges –Important Care Need and Locum Tenens
   a. The Medical Staff Office shall verify, at a minimum, the following information when temporary privileges are requested for an important patient care, **treatment and services** need and/or locum tenens:
      i. Current California license to practice
      ii. Drug Enforcement Administration registration, **as applicable**
      iii. Current malpractice insurance and claims history
      iv. Current Competence
      v. NPDB
      vi. Peer References (at least one)
      vii. Letter(s) of Hospital Affiliation (at least one)
   b. Other verification may include:
      i. Positive identification
      ii. AMA or AOA Profile (Medicare/Medicaid exclusions)
      iii. Board Certification (Certifacts)

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**BLOOD TRANSFUSION~~PRODUCT ALIQUOT SYRINGES~~, EMERGENCY~~T~~ PROCUREMENT AND PREPARATION OF**
Purpose:	To facilitate rapid preparation of blood ~~aliquots~~ for emergent use at the bedside.
Supportive Data:	Bedside preparation more rapid than procedure required in lab.
Equipment:	1. Neonatal/pediatric **blood filter** syringe set ~~**(150u filter)**~~(150µ~~u~~ filter and 60cc syringe) 2. ~~**Double female leuuer lock**~~Alaris smart site ~~2.~~3. **Additional ~~Appropriate~~appropriately sized sterile syringes and extension tubing. ~~for blood aliquots~~** ~~**Blood/fluid warming system tubing**~~Alaris male/female Luer lock caps 4. ~~3. **Stop cock**~~ ~~4.~~5. ~~Blood warmer~~

A. **PROCEDURE:**

1. Per physician~~/Allied Health Professional (AHP)~~ order, notify lab of emergent need for "O Negative Uncrossed –Matched Blood."
2. Gather equipment.
3. Confirm patient identity using two-identifier system per hospital policy.
4. Perform hand hygiene and don non-sterile gloves.
5. **Verify correct blood product with a second RN prior to ~~administration~~administration.**
   a. **If time allows, use EHR/Transfusion Administration to verify and document.**

~~4.~~6. **Using Neonatal/Pediatric syringe set with 150µ~~-~~ filter and appropriately sized syringe, spike blood bag and draw up transfusion volume.**

~~5.~~a. **If physician requests warming of blood** ~~If emergent blood requires warming, utilize the "Blood Administration Set Neonatal" with 150 micron filter and spinlock, spike the blood bag, and~~ follow the **blood warmer** manufacturer's ~~guidelines~~**instructions** ~~for warming.~~

~~6. Slowly withdraw warmed blood from unit into a 60 ml syringe..~~

7. Multiple syringes may be drawn from the same unit.
8. Label each syringe with patient label.~~;~~ ~~l~~include ~~on label the~~ blood type, unit number, date and time **in the label.**~~.~~

~~9. Refer to Patient Care Services Procedure: Blood Products Administration for administration procedure.~~

~~10.~~9. Once the unit is empty or blood administration completed, discard all components in biohazardous waste. Do not return blood unit to laboratory.

~~11.~~10. Document procedure in patient's **electronic** medical record~~.~~

B. **RELATED DOCUMENTS:**

1. Patient Care Services Procedure: Blood Products Administration

~~1.~~ **~~Laboratory Transfusion Medicine / Transfusion Medicine Procedures / Emergency Release of Blood for Neonates~~**

C. **REFERENCES:**

~~1. Charter Medical Ltd. product information: Neonatal/Pediatric Syringe Sets.~~

1. **Gomella, T. L., & Cunningham, M. D. (2013). *Neonatology: management, procedures, on-call problems, diseases, and drugs* (7th ed.). New York, NY: McGraw-Hill Medical.**
2. MacDonald, M. G. & Ramasethu, J. (Eds.). (2013). *Atlas of procedures in Neonatology, 5th ed.* Lippincott Williams & Wilkins.

NICU Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/07, 6/11, 8/12, 12/16, 9/20, 10/21	01/17, 08/21, 10/21, 09/22	01/17, n/a	n/a	02/17, 11/22	12/22	03/17, n/a	03/17

3. Beauman, S. S., & Bowles, S. (Eds.). (2019). Policies, Procedures, and Competencies (6th ed.). Chicago, IL: Neonatal Association of Neonatal Nurses.

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE:	03/13	SUBJECT:	Adverse Reaction (Medication Event)
REVISION DATE:	03/13, 10/17		

Department Approval:	~~06/16~~02/20
Division of Oncology Approval:	~~03/17~~03/20
Pharmacy and Therapeutics Approval:	~~07/17~~10/22
Medical Executive Committee Approval:	~~08/17~~11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~09/17~~ n/a
Board of Directors Approval:	10/17

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 Outpatient Infusion Center (Center) when a medication error/reaction/event occurs.

B. POLICY:

1. The Center will adhere to the hospitals 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 shall:
   a. Notify the attending and/or onsite physician of the medication event/reaction
   b. If the interventions are ordered by the attending and/or onsite provider fails when patient is having anaphylactic symptoms, the nurse or designee will call 911 for emergency services.
   c. Notify the patient/family of the incident.
   d. Complete the appropriate 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.

D. RELATED DOCUMENT(S):

1. Administrative Policy: **Event Reporting**~~Incident Report—Quality Review Report (QRR) RL Solutions~~ 396

Tri-City Medical Center
Oceanside, California

OUTPATIENT INFUSION CENTER

ISSUE DATE: 03/13

SUBJECT: Hospital Admission from the Center

REVISION DATE: 03/13, 10/17

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~~11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~10/17~~ n/a
Board of Directors Approval:	10/17

A. PURPOSE:

1. This policy delineates the procedure for an unplanned admission to the hospital directly from the Outpatient Infusion Center (Center).

B. POLICY:

1. Patient admissions to Tri-City Healthcare District (TCHD) from the Center will be done in a safe and efficient manner. The Center Medical Director will discuss the recommendation to admit the patient with the patient/family and the patient's physician/Allied Health Professional (AHP).

C. PROCEDURE:

1. Upon evaluation by the Center Medical Director, if admission is deemed necessary, orders for admission will be generated.
   a. The Center Medical Director will contact the patient's physician/AHP to discuss his/her recommendation to admit the patient (if the patient is not triaged to the Emergency Room).
   b. If the physician/AHP concurs, the patient will be admitted under the care of the physician/AHP.
   c. The admitting department/nurse will be notified immediately by the support staff/receptionist about the pending admission.
   d. A copy of pertinent medical, demographic and treatment information will be provided.
   e. The Registered Nurse (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. If the patient is unstable and cannot be admitted immediately to an acute care bed, the patient will be transferred to the Emergency Room (ER) after the ER has been notified.

Tri-City Medical Center
Oceanside, California

PATIENT CARE MANAGEMENT

ISSUE DATE:	10/09	SUBJECT:	Utilization Review Process
REVISION DATE:	04/10, 02/12, 02/13, 02/16, 01/19, 05/22		

Case Management Department Approval:	~~10/21~~10/22
Utilization Review Committee Approval:	~~10/21~~11/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Staff Department or Division Approval:	n/a
Medical Executive Committee Approval:	~~02/22~~11/22
Administration Approval:	~~05/22~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/22

A. PURPOSE:
1. To establish criteria for utilization review process.

B. POLICY:
1. Case Management staff will utilize hospital approved (InterQual®) Severity of Illness/Intensity of Service (SI/IS) guidelines to perform and document admission reviews, observation status and continued stay reviews, discharge disposition review and retroactive review for all patients as stated in this procedure.
2. Case Management staff will identify appropriateness of level of care (i.e. ICU/CCU, DOU/Telemetry, Acute Care, Monitored Med/Surg, NICU, and Women's Care Services).
3. Case Management staff shall review admission criteria for Observation vs. Inpatient.
4. Every reasonable effort shall be made for appropriate admission criteria to be documented within 24 business hours of admission.

C. PROCEDURE:
1. Admission Review
   a. All new Tri-City Medical Center (TCMC) Admissions (Inpatient & Observation Service) and transfers to TCMC shall have an initial InterQual® review performed no later than 24 business hours following admission to TCMC to determine appropriateness of an admission to a Level of Care.
      i. Priority of Initial Review:
         1) Medicare
         2) Medi-Cal & Cash
         3) Commercial Insurance
      ii. Every reasonable effort shall be made to complete Initial CM Reviews within 24 calendar hours of admission to TCMC
      iii. EXCEPTIONS: Routine postpartum, newborn care.
         1) Vaginal Delivery – provide review 48 hours following delivery
         2) Cesarean Section Delivery – provide review 96 hours following delivery
   b. Admission Review shall include a "Patient Status Reconciliation" – the physician order must match the correct level of care- Inpatient vs Outpatient / Observation,
      i. Case manager shall contact the admitting physician to discuss any discrepancy and clarify the physician's intent. The Case Manager ~~shall contact~~**will refer cases to** the Physician Advisor as needed.
   c. Clinical review findings shall be documented in the electronic health record (EHR) within 24 business hours of admission.

i. ~~The following~~**Insurance providers and** medical groups' ~~U~~utilization ~~M~~management staff, **who have access to the EHR** will perform utilization review for their ~~capitated~~ patients per ~~contractual~~ agreement.
~~1) PCAMG (Primary Care Associates Medical Group)~~
~~2) GTCIPA (Greater Tri-City Independent Physician Association)~~
~~3) Graybill Medical Group (except CHG)~~

ii. TCMC Case Management staff and the medical groups' utilization management staff will have ongoing communication regarding cases, issues, problems, on an as-needed basis.

2. California Children's Services (CCS)
   a. Identify all patients under the age of 21 and screen for potential CCS eligible diagnosis (refer to CCS approved diagnoses).
   b. Review all patients under 21 for changes in clinical condition representing a potential California Children's Services (CCS) -eligible condition. If the patient appears to meet the eligibility criteria, a referral is made to the Social Worker and communication is made to the Business Office to generate a referral to CCS.
3. California Department of Correction (CDCR):
   a. Clinical updates shall be provided daily Monday through Friday via pre-scheduled conference call.
4. Continued Stay Review
   a. All inpatients will be reviewed for Continued Stay, Monday – Friday, utilizing InterQual® guidelines' Intensity of Service (IS) and appropriateness of level of care and medical necessity (unless Payor has been granted electronic health record (EHR) Aaccess by TCMC for the purposes of performing their own clinical reviews).
   b. If Continued Stay criteria are not met or the current level of care is no longer appropriate, case is discussed with the attending/treating physician.
      i. ~~NOTE:~~ If attempts to contact/discuss the case with the attending/treating physician are unsuccessful, **or if there continues to be insufficient evidence to justify continued stay,** refer case to the Physician Advisor.
      ~~i.~~**ii. The RN Case manager performs retrospective reviews on cases per payer request**
   c. InterQual® reviews shall be provided to the payer / review organization, **upon request,** via EHR or in manner requested by the payer.
   ~~i.~~**d.** The payer information (including authorization number and days authorized) will be documented in EHR.
   ~~d.~~**e.** When a patient is transferred to another area of the hospital, the ~~transferring~~ case manager / social worker is responsible for:
      i. ~~Hand-Off Communication to accepting Case Manager / Social Worker~~**Following the patient(s) until the end of that days' shift.**
      ~~utilizing SBAR format as adopted by TCMC.~~
      ii. Completing all electronic medical record documentation**/referrals/follow up.**
      ~~ii.~~**iii. Completing hand off communication to next shift case manager/social worker.**

D. **REFERENCE(S):**
1. InterQual Level of Care Criteria, Acute Care - Adult (Annual Edition as appropriate & updated)

Tri-City Medical Center
Oceanside, California

PHARMACY MANUAL

ISSUE DATE: 05/94 SUBJECT: Antidote Stocking

REVISION DATE~~(S)~~: 04/97, 08/00, 05/02, 02/03, 07/06, 07/09, 01/12, 02/15, 01/19

Pharmacy Department Review:	~~09/18~~07/22
Medical Staff Department or Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~11/18~~11/22
Administration Approval:	~~01/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. DEFINITION(S):
1. Antidote: a substance which can counteract a form of poisoning

B. PURPOSE:
1. To ensure supply of antidotes are consistently available, controlled, and secured

C. POLICY:
1. Antidote medications will be primarily stocked in the Pharmacy Department
2. Antidote medications that require immediate administration upon patient arrival shall be stored in the Emergency Department
3. Pharmacy will supply a minimum of an 8 hour supply of antidotes unless mechanisms for more rapid resupply or transfer is in place
4. Pharmacy will supply up to 24 hours for patients likely to be maintained for longer periods or when definitive care is planned
5. A list of antidotes stocked and approved for use at Tri-City Medical Center shall be reviewed and maintained at least annually; available via the Intranet (see attachment)
6. The telephone number of the Poison Control Center shall be posted in the Pharmacy, Emergency Department, and all other patient care areas

D. RELATED DOCUMENT(S):
1. Antidote Information Chart

E. REFERENCE(S)

1. Dart RC et al. Expert Consensus Guidelines for Stocking of Antidotes in Hospitals that Provide Emergency Care. Annals of Emergency Medicine. 2017 doi: 10.1016/j.annemergmed.2017.05.021. [Epub ahead of print]
2. California Poison Control System. Antidote Chart. Last Updated March 2017. Available from: http://www.calpoison.org/hcp/home.html. Date Assessed: October 11, 2017.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/90 SUBJECT: Controlled Substances - Pharmacy

REVISION DATE~~(S)~~: 01/97, 12/97, 02/03, 06/05, 07/06, 07/09, 01/12, 07/15, 12/18

Pharmacy Department Approval:	~~09/18~~07/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~10/18~~11/22
Administration Approval:	~~12/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. POLICY:
1. The Pharmacist in Charge (PIC) is responsible for the proper safeguarding of controlled substances within the Hospital.
2. The PIC is responsible for the purchase, storage, accountability and proper dispensing of controlled substances.
3. All applicable state and federal laws governing the handling of controlled substances will be enforced.
4. The Pharmacy Department utilizes a perpetual inventory system for all Schedule II-V controlled substances. The PIC is responsible for assuring the accuracy and completion of the perpetual inventory system.

B. PROCEDURE:
1. Registration:
   a. The hospital will hold current registration with the Drug Enforcement Administration (DEA) and appropriate state licensure.
   b. The individuals authorized to sign the DEA Form 222 and Controlled Substance Ordering System (CSOS) will include the Director of Pharmacy, Pharmacy Buyer, and anyone else deemed appropriate and necessary.
   c. Only physicians with valid registration numbers may prescribe controlled substances.
2. Pharmacy Receipt of Controlled Substances:
   a. The receipt of all Schedule II-V controlled substances is documented in the perpetual inventory system in the CII safe.
   b. Upon receipt of controlled drugs, the count, condition and identification of the drugs are verified by a pharmacist.
   c. The Pharmacy Buyer shall fill out the retained copy of the DEA Form 222 for all Schedule II drugs, indicating the amount received and date.
   d. For Schedule II, a copy of the wholesaler's invoice, CII Safe Receive Log Sheet, and copy of DEA 222 will be filed separately in a readily retrievable manner and will be maintained for the period required by law.
   e. For Schedule III-V, a copy of the wholesaler's invoice and CII Safe Receive Log Sheet will be filed in a readily retrievable manner and will be maintained for the period required by law.
   f. Discrepancies in shipment that cannot be resolved immediately with the wholesaler shall be reported to the PIC.
3. Pharmacy Storage and Security:

a. All Schedule II-V drugs are stored in the Pyxis cabinet (C-II Safe) or locked cabinet in the refrigerator.
b. Only licensed personnel shall have access to controlled drugs with the hospital.

4. Dispensing and Distribution:
   a. All Schedule II, III, IV and V drugs are dispensed to the patient care units and stored in an automated dispensing machine. Exceptions: See Pharmacy Policy Floor Stock.
   b. Par levels for controlled substances are automated utilizing the C-II Safe and the Pyxis Medication Stations. The Pharmacy Department will re-stock and fill orders on a daily basis.
   c. The Pharmacy Technician fills the order and the order is checked by a second technician or a pharmacist prior to delivery to the nursing unit. Upon refill, a perpetual inventory is updated with the refill amount. Activity reports are generated and reviewed for audit purposes.
   d. Controlled substance discrepancies will be resolved according to Patient Care Services Policy Controlled Substances Management Policy and Pharmacy Policy Automated Dispensing Machine.
5. Inventory System:
   a. In the CII Safe a physical inventory is done monthly and is compared to the computed balance in the perpetual inventory system. Any discrepancy that cannot be resolved will be reported to the PIC immediately.
      i. A physical inventory will be compiled of all Class-II substances stored in the Pharmacy at least every 3 months as required by the California Board of Pharmacy. The Inventory Reconciliation report should be readily available for up to 3 years.
   b. Every two (2) years a complete inventory count of all controlled drugs will be conducted and kept on file in the pharmacy department pursuant to state and federal laws.
6. Destruction:
   a. Destruction of all controlled substances within the pharmacy must be done in the presence of two (2) licensed individuals, one of which must be a pharmacist.
   b. Destruction of patient's own controlled substances left behind after discharge must be wasted in the presence of two (2) pharmacists.
7. Suspected Tampering/Loss:
   a. If tampering with or loss of a controlled substance is suspected the PIC shall be notified immediately and an investigation shall be initiated. (See Employee Theft or Impairment Policy)
   b. All unauthorized losses shall be reported to the appropriate state and federal authorities.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	01/98	SUBJECT:	Discharge Prescriptions
REVISION DATE~~(S)~~:	02/03, 06/05, 07/06, 07/09, 01/12 05/15, 12/18		

Pharmacy Department Approval:	~~07/18~~07/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~10/18~~11/22
Administration Approval:	~~12/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. POLICY:

1. The hospital does not provide discharge medications, unless an extreme emergency exists. Discharge prescriptions may be an important component of the continuum of the patient's care. This hospital is committed to assisting the patient/family in obtaining access to appropriate pharmaceutical care during the discharge process.
2. If an emergency exists, no drugs supplied by the hospital shall be taken from the hospital unless a prescription or medical record order has been written for the medication. The medication must be properly labeled and prepared by the Pharmacist in accordance with state and federal laws, for use outside of the hospital.
3. The patient may be provided printed material describing the effects of the discharge medications ordered by the physician. Drug leaflets for discharge information may be accessed at nursing units using the Micromedex system.
4. Depending on risk and other factors, the patient and/or family may receive education about anticipated discharge medications prior to the day of discharge. Such education will be provided by either the nurse or Pharmacist. Documentation of such education will appear in the discharge instructions area of the medical record.
5. The Hospital may assist in extraordinary cases, hardship cases or when the medication is difficult to obtain elsewhere. It should be noted however, that discharge prescriptions are not a payable benefit of most health care insurance plans. The patient/family holds the financial responsibility for discharge prescriptions.
6. No person other than a pharmacist or an individual under the direct supervision of a pharmacist shall dispense medication for use beyond the immediate needs of the patients.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	01/85	SUBJECT:	Drug Compounding for Medication Not Commercially Available
REVISION DATE~~(S)~~:	06/05, 03/06, 07/09, 01/12, 09/15 01/18, 12/18		

Pharmacy Department Approval:	~~09/18~~10/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~10/18~~11/22
Administration Approval:	~~12/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. POLICY:

1. It is the policy of this institution to allow orders for compounded drugs or drug mixtures not commercially available as appropriate to meet the needs of the patient population, following applicable state and federal law, rules and regulations. Compounded drugs may be prescribed and when the licensed independent practitioner determines, in his/her professional judgment, that the compounded drug's benefits over any approved alternative, justify the risk for a particular patient. The goal is procurement or preparation of safe and effective products using the best available resources and techniques.

B. PROCEDURE:

1. The Pharmacy Department may procure compounded drugs from a contracted Compounding Pharmacy in situations where drug products are not commercially available and/or a suitable alternative does not exist.
   a. The following includes, but may not be limited to reasons for ordering and/or preparing compounded drugs:
      i. The drug required is not manufactured in the needed strength.
      ii. The prescriber requests a different form of the drug to improve patient compliance with prescribed drug therapy (for swallowing or taste purposes, etc.).
      iii. The prescribed drug needs to be combined in forms not available from the manufacturer to improve patient response to prescribed drug therapy.
      iv. The patient is allergic to inactive ingredients (dye, lactose, etc.) in the manufactured form of the drug.
      v. The prescribed therapy requires tailoring to the individual patient (intravenous feeding solutions, chemotherapy, etc.).
   b. Before outsourcing sterile compounding, the pharmacy department will confirm that the vendor to be used can provide evidence of the following:
      i. State pharmacy and/or wholesaler licensure and other appropriate licenses
      ii. Licensure documents if the compounding facility is registered with the FDA as a drug manufacturer or device manufacturer
      iii. Current DEA registration as a manufacturer or wholesaler
      iv. Stability and sterility documents and clinical references, as well as any materials that are used to determine beyond-use date
2. The Pharmacy Department shall not prepare high-risk compounded sterile products which utilize non-sterile ingredients or devices. Refer to Pharmacy Policy Sterile Product Preparation section on High-Risk Level CSPs.

3. Extemporaneously prepared products by the Pharmacy Department must be supported by evidence-based literature and a recipe must exist for the preparation of the product.
4. The drug to be compounded must be individually prescribed for an identified patient.
5. A bulk drug substance (the chemical that becomes the drug's active ingredient) qualifies for use in compounding when:
   a. It is found in a FDA-approved drug.
   b. It is listed in a book of widely used drug substances published by the United States Pharmacopeial Convention (authoritative body).
   c. It is listed in a FDA rule as acceptable for pharmacy compounding.
6. Previously marketed drugs found to be unsafe or ineffective and removed from the market shall not be compounded.
7. If inclusion criteria are met and no exclusion criteria exist, prior to preparing the compounded drug, the Pharmacist will review the medical record of the patient. The risks of the patient receiving compounded drug, along with the benefits, will be weighed in the context of a specific patient's medical condition. If the Pharmacist, in his/her clinical expertise feels the risks outweigh the benefits, the prescriber will be contacted for revision of the order.
8. If the prescriber has ordered a compounded drug that is either found to be unsafe or ineffective and removed from the market, or is listed in the FDA's regulations as difficult to compound the prescriber will be contacted for discontinuation of the order.
   a. If the prescriber refuses to discontinue the order and insists on preparation of the compounded drug, the Pharmacist will contact either the Pharmacy Clinical Manager or Pharmacy Director.
   b. The Pharmacy Clinical Manager or Director will contact the Chairperson of the Pharmacy and Therapeutics Committee to resolve the situation with the prescriber.

C. **RELATED DOCUMENT(S):**
1. Pharmacy Policy: Sterile Product Preparation section on High-Risk Level CSPs

D. **REFERENCE(S):**
1. California Code of Regulations (CCR), Title 16, Division 17 ,Article 4.5, section 1735

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 09/90

SUBJECT: Drug Product Procurement and Inventory Management

REVISION DATE(S): 09/91, 01/97, 02/03, 01/05, 07/06, 07/09, 01/12, 09/15, 12/18

Pharmacy Department Approval:	~~09/18~~05/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~07/22
Medical Executive Committee Approval:	~~10/18~~09/22
Administration Approval:	~~12/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. POLICY:

1. The Pharmacy Department shall be responsible for the procurement, distribution, and control of all drug products used in the hospital for inpatient and ambulatory patients.

B. PROCEDURE:

1. Medication Acquisition:
   a. Pharmacy or Designee (i.e. Materials Management) shall ensure the highest quality of and the best price for drug products through careful consideration and selection of drug product manufacturers and suppliers.
   b. Only those medications approved for formulary use will be procured and stored as delineated in Pharmacy Policy Formulary System.
   c. Whenever possible, only those medications which are commercially available and/or in single-unit packages and in ready-to-administer form shall be procured.
   d. Procurement of medications during emergencies shall be determined and performed as delineated in Pharmacy Policies Medication Shortages and Loaning and Borrowing of Medications for Emergency Purposes.
   e. Antidote medications will be procured and stocked in accordance to Pharmacy Policy Antidote Stocking.
   f. Orders will be made by the Pharmacy Buyer or designee and prepared daily using the wholesaler computerized ordering system or ordered directly from the manufacturer.
   g. After the product is delivered directly to Pharmacy or via Materials Management, the order will be checked against the packing slip and invoice.
      i. If the items received were not accompanied by an invoice, drug products will be put aside until an invoice is obtained and the items are entered into inventory.
      ii. Upon arrival of the order from the wholesaler the pharmacist will confirm the shipment container quantities match the expected quantities.
      iii. If the order is complete, the pharmacist checking the order must initial and date the packing slip as an indication the products were received.
      iv. If the order is incomplete, the Pharmacy Buyer will be notified and shall contact the appropriate wholesaler for rectification.
         1) Receipt of controlled substance medications shall be checked against the controlled substance packing slip for quantity and accuracy, signed and dated by a pharmacist.
         2) Any discrepancies shall be noted and referred to the appropriate person.
         3) The CII Safe Receive Report is compared to the invoice to ensure all ordered products are accounted for and placed in the CII Safe.

h. A copy of each invoice will be forwarded to Accounts Payable.
i. A copy of Schedule II invoices shall be kept with the DEA order form filed for three years. Copies of Schedule III, IV, V invoices shall be kept in a separate file for three years.

2. Storage:
   a. Medications shall be received, stored, and prepared under proper conditions in accordance with State and Federal Regulations, governing agencies, and manufacturer recommendations to ensure medication integrity, safety and security.
   b. Storage of medications outside of the pharmacy shall be done in a secure manner, utilizing automated dispensing devices whenever possible.
   c. Unusable drugs will be removed from stock as delineated in Pharmacy Policy Unusable and Outdated Drugs.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	01/90	SUBJECT:	Emergency Medication Tray for Crash Cart
REVISION DATE:	05/94, 03/97, 10/99, 08/02, 02/03, 06/05, 07/06, 07/09, 01/12, 05/15, 07/18		

Department Approval:	~~04/18~~07/22
~~Medical Staff Department/Division Approval:~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~07/22
Medical Executive Committee Approval:	~~06/18~~09/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. POLICY:

1. This hospital maintains mobile supplies of emergency equipment and medications (crash carts) inpatient care areas of the hospital and at designated off-site clinics. The Code Blue Committee determines which medications will be stocked in these carts and the Pharmacy and Therapeutics Committee approves final recommendations. The Pharmacy Department is responsible for the integrity and security of medications contained in the crash carts.

B. PROCEDURE:

1. The emergency drug supply is stored in a clearly marked portable container. The contents of the container are listed and visible on or within the container and include the earliest expiration date of the drugs within.
2. The emergency medication tray will be filled by pharmacy personnel.
3. The emergency medication tray will be checked by a pharmacist or pharmacist intern.
4. The pharmacy personnel checking the emergency medication tray will verify contents, quantities, and expiration dates, then lock the tray with a lock that must be broken in order to gain access to the medications.
5. The first to expire medication, date of expiration, and lock number of the lock used to seal the tray will be included on a label which will be placed on the crash cart medication drawer.
6. Prior to placing the final lock on the crash cart, pharmacy personal will inspect IV solutions placed in the cart by Sterile Procedures Department personnel.
7. In an effort to confirm the integrity of the crash cart, when performing monthly area unit inspections, the pharmacy personnel performing the inspection will confirm the lock number on the crash cart matches the lock number recorded on the current crash cart checklist. If there is any question of integrity at that time the most appropriate person to address the matter will be notified.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	05/94	SUBJECT: Floor Stock
REVISION DATE:	02/97, 08/00, 02/03, 06/05, 07/06, 07/09, 01/12, 07/15	

Department Approval:	~~04/18~~06/22
~~Medical Staff Department/Division Approval:~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~07/22
Medical Executive Committee Approval:	~~06/18~~09/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. POLICY:

1. Responsibility for control of floor stock medications within this hospital rests with the Pharmacy Department. Policies and procedures are designed to ensure the safe and accurate dispensing of medications throughout the hospital.

B. PROCEDURE:

1. Floor Stock: Medications that are maintained outside of an Automated Dispensing Machine (ADM) in specific areas of the hospital. These medications are intended for use by physician/Allied Health Professionals with appropriate clinical privileges who are responsible for ordering, preparing and administering drugs.
   a. Medications contained in floor stock are stored in a secured, locked cabinet. Responsibility for security of the floor stock rests with the supervising licensed practitioner or nurse overseeing the unit in which the floor stock is stored.
   b. Medications contained in floor stock are stored under the conditions listed by the medication manufacturer to ensure stability.
   c. Medications designated as floor stock are requisitioned from the Pharmacy Department by the nurse or practitioner in quantities sufficient for anticipated needs.
   d. As with all other medications, all floor stock used to prepare medications (i.e diluent bags, diluent vials, etc) are accurately labeled with contents, expiration dates and appropriate warnings.
   ~~e. Controlled substances designated as floor stock are requisitioned according to Pharmacy Policy Controlled Substances, stored in a securely locked, substantially constructed cabinet and inventoried weekly by two licensed personnel.~~
2. Inspection: All floor stock supplies within the hospital will be inspected monthly by the Pharmacy Department. A report of inspection will be maintained by the Pharmacy Department. Reports noting any discrepancies will be reviewed by the pharmacist in charge and shared with the supervising personnel of the unit involved.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 12/11 POLICY: Formulary System

REVISION DATE: 02/12, 05/15, 07/18

Department Approval:	~~03/18~~06/22
~~Medical Staff Department/Division Approval:~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~07/22
Medical Executive Committee Approval:	~~06/18~~09/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. PURPOSE:
1. To address the process for addition, removal, and restriction of pharmaceutical agents at Tri City Medical Center (TCMC).
2. The formulary system is operated under the auspices of the Pharmacy and Therapeutics (P&T) Committee to promote rational, cost-effective use of medications at Tri-City Medical Center.

B. DEFINITIONS:
1. Formulary System: An ongoing process through which a healthcare organization establishes policies regarding the use of medications, therapies, and drug-related devices and identifies those that are most medically appropriate and cost-effective to best serve the health interests of a given patient population.
2. Formulary: a continually updated list of medications and related information, representing the clinical judgment of physicians, pharmacists, and other experts in the diagnosis, prophylaxis, or treatment of disease and promotion of health. A formulary includes, but is not limited to, a list of medications and medication-associated products or devices, medication-use policies, important ancillary drug information, decision-support tools, and organizational guidelines.

C. ROLE OF THE PHARMACY AND THERAPEUTICS COMMITTEE:
1. The P&T Committee is responsible for overseeing the effective and efficient operation of the formulary system. The Committee is responsible to the Medical Staff as a whole, and its policy recommendations are subject to approval by the Executive Committee as well as to the normal administrative approval process. The Committee assists in the formulation of broad professional policies relating to medications in the hospital, including their evaluation, selection, procurement, storage, distribution, administration, and use.
2. It is the responsibility of the P&T Committee to provide integrity to the formulary system by assuring current, consistent prescribing practices of medications designated as "formulary" medications and such medications are routinely stocked in the pharmacy, unless mechanisms for more rapid resupply or transfer is in place.

D. FORMULARY DESIGNATION:
1. Only those considered to be most cost-effective in patient care shall be designated as formulary medications.
2. The P&T Committee shall at minimum evaluate the following before designating a medication as formulary:
   a. Indications for use
   b. Effectiveness

c. Drug interactions
d. Potential for errors and abuse
e. Adverse drug events
f. Sentinel event advisories
g. Population(s) served (e.g., pediatrics, geriatrics)
h. Contraindications and Precautions
i. Costs compared to formulary alternatives

3. The organization shall have the appropriate capability to monitor patients' response to medications before the product will be added to the formulary, dispensed, or administered.
4. These medications are listed in the formulary; only formulary medications are routinely stocked and available from the pharmacy.
5. Only those medications that have been approved by the Food and Drug Administration (FDA) shall be considered for formulary addition. Therefore, investigational medications do not meet criteria for formulary addition.
6. The Department of Pharmacy is responsible for selecting, from available generic equivalents, those medications to be dispensed pursuant to a physicians order for a particular drug product. Generally, this choice is consistent with competitive bids awarded TCMC by group purchasing organizations.
7. Medications designated on the formulary shall be reviewed at least annually based on emerging safety and efficacy information, cost-effectiveness data, and inventory control standards.
   a. Pharmacy shall report the result of the annual review of the formulary to the P&T Committee
8. The Department of Pharmacy shall maintain an approved formulary list in Cerner

E. ADDITION OF PHARMACEUTICAL AGENTS TO FORMULARY:

1. It shall be the responsibility of the requesting practitioner (MD, DO, PharmD) to complete all paperwork necessary for addition of pharmaceutical agents to the TCMC formulary.
2. Pharmacy shall be responsible for determining acquisition costs, costs of therapy, and cost comparisons for therapeutically equivalent agents.
3. Pharmacy shall arrange for the requested pharmaceutical agent to be presented at the Pharmacy and Therapeutics committee in a timely fashion for review and approval to the formulary.
4. The requesting practitioner may provide written recommendations to the P&T committee or be present at the P&T committee when the pharmaceutical agent is being presented for review.
5. Requesting practitioners must disclose any and all "conflicts of interest" related to the pharmaceutical agent being requested to the Pharmacy and Therapeutics Committee.
6. Pharmacy shall notify all affected prescribers and/or departments once a medication is approved through P&T.

F. REMOVAL OF AGENTS FROM THE FORMULARY:

1. Pharmacy shall consult with all necessary practitioners with an expertise related to the pharmaceutical agent before requesting removal at the Pharmacy and Therapeutics Committee.
   a. Pharmacy shall document all communications with practitioners in this matter
2. Pharmacy shall notify all appropriate TCMC committees/departments of the proposal for removal of a medication prior to presentation at the Pharmacy and Therapeutics Committee.
3. Agents proposed by the Department of Pharmacy for removal from the formulary shall be presented at the Pharmacy and Therapeutics Committee.
4. The Department of Pharmacy shall present to the Pharmacy and Therapeutics committee evidenced based reasons for removal of agents from the formulary that include cost savings and pharmaceutical and therapeutically equivalent alternatives already on TCMC formulary.
5. Pharmacy shall notify all affected prescribers and/or departments once a medication is removed from the formulary.

G. RESTRICTION OF FORMULARY AGENTS:

1. The department of pharmacy will work with TCMC physicians to create criteria for use for pharmaceutical agents both formulary and non-formulary.
2. Formulary medications may be considered for restriction by the Pharmacy and Therapeutics Committee when they meet one or more of the following criteria:
   a. The drug has limited therapeutic use that requires expertise in that area
   b. Inappropriate use might result in excessive or unnecessary expenditures
   c. The medication is a high risk agent with potential problems due to adverse effects or toxicity
   d. Other reasons as deemed appropriate by the Pharmacy and Therapeutics Committee
3. Formulary medications may be restricted to use, either by a medical service (e.g., oncology), prescribing criteria (e.g., specific indications), or patient care area (e.g., Intensive Care Unit).
4. A current list of restricted medications will be maintained on the Department of Pharmacy website (Formulary Keeper).
5. Physicians requesting the use of a medication outside its established restriction shall fill out the Pharmacotherapy Utilization form (See Appendix 1).
6. Pharmacy service shall create a method to administer restricted agents outside their restriction when necessary. This may involve one or more of the following:
   a. Case by case review of each request within the pharmacy, and if necessary input a Pharmacy and Therapeutics Committee chairperson.
   b. Obtaining a consult from an authorized prescriber.
   c. Moving a patient to the needed area for proper treatment.
7. Pharmacy shall notify all affected prescribers, TCMC departments and/or committees of the proposal to restrict a pharmaceutical agent prior to presentation at the Pharmacy and Therapeutics committee.

H. **FORMULARY STATUS OF NEW MEDICATIONS:**

1. New medications approved by the FDA, but not yet considered for formulary addition by the Pharmacy and Therapeutics Committee shall be considered non-formulary until the P&T Committee has reviewed these medications. Prior to the P&T Committee deliberation, use of the medications shall conform to the non-formulary medication use process.

I. **OBTAINING NON-FORMULARY MEDICATIONS:**

1. When a non-formulary medication is prescribed, a pharmacist shall contact and inform the prescribing physician that the medication is non-formulary and not stocked in the pharmacy. The pharmacist shall inform the physician of other formulary alternatives available.
2. If the physician determines that the non-formulary medication is needed, approval must be obtained from the ~~Clinical~~ **Director of** Pharmacy **/designee**~~Manager~~. For tracking purposes, the physician or pharmacist must fill out the Pharmacotherapy Utilization form documenting why the medication is needed ~~(See Appendix1)~~. The medication will then be obtained by pharmacy for a specific patient.
3. Non-formulary medications are normally obtained within 24 hours, but may take longer depending on when the order is received and product availability. The P&T Committee may deem some products not to be ordered, dispensed, or stocked, even on a non-formulary request basis.

J. **MONITORING OF NON-FORMULARY MEDICATION PRESCRIBING:**

1. The ~~Clinical~~ **Director of** Pharmacy**/designee** ~~Manager~~ shall compile and analyze data regarding non-formulary medication use as appropriate and report findings to the P&T Committee.
2. The Committee shall determine appropriate action necessary to maintain the integrity of the formulary system. This may include:
   a. Reconsidering a medication formulary addition
   b. Undertaking educational efforts to reduce inappropriate prescribing
   c. Imposing prescribing restriction

K. **FORM(S):**

1. Pharmacotherapy Utilization Form

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	01/72	SUBJECT: Hours of Operation and Authorized Access to the Pharmacy
REVISION DATE:	01/75, 01/80, 01/90, 01/00, 06/05, 07/06, 07/09, 01/12, 05/15, 07/18	

Department Approval:	~~02/18~~07/22
~~Medical Staff Department/Division Approval:~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~07/22
Medical Executive Committee Approval:	~~06/18~~09/22
Administration Approval:	11/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. POLICY:

1. As approved by the medical staff committees and Tri-City Medical Center (**TCMC**) administration, the Pharmacy hours of operation will be seven (7) days per week, 24 hours per day.
2. Access to the Pharmacy is limited to the Pharmacy staff.
   a. Medical staff, nursing staff, administrative, environmental services and other personnel are authorized admission only in conjunction with their duties and under supervision of Pharmacy staff.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	06/05	SUBJECT:	Medication Dispensing/Distribution
REVISION DATE:	06/05, 03/06, 07/09, 01/12, 09/15, 07/18		

Department Approval:	~~04/18~~07/22
~~Medical Staff Department/Division Approval:~~	~~n/a~~
Pharmacy & Therapeutics Committee Approval:	~~05/18~~07/22
Medical Executive Committee Approval:	~~06/18~~09/22
Administration Approval;	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. PURPOSE:
1. To define the policies used to ensure the safe dispensing and distribution of medications that are in accordance with law and regulation, licensure, and professional standards of practice.

B. POLICY:
1. The Pharmacy Department is responsible for the control and distribution of all medications.
2. Medications in patient care areas are available in the most ready to administer forms commercially available or, when possible, in unit-doses that have been repackaged by the pharmacy or a licensed repackager.
3. The Pharmacy makes every attempt to utilize a consistent dose packaging system; however, if a different system is required for use, the Pharmacy staff will provide education about the use of the dose packaging system to the appropriate medication administration staff and patients. This includes dose packaging systems for controlled substances.
4. In response to a new medication order, the Pharmacist shall review the order for appropriateness prior to dispensing or releasing the medication for administration to the patient pursuant to Pharmacy Policy Pharmacist Order Verification and Patient Care Services Policy Medication Administration.
5. If the medication is not in the Automated Dispensing Machine (ADM), the Pharmacy Technician or Pharmacist Intern shall prepare the medication for delivery in accordance with Pharmacy Policies: Medication Preparation, Technician Checking Technician Program, and Automated Dispensing Machine.
6. Only a licensed pharmacist or authorized Pharmacy Department personnel under the direct supervision of a licensed pharmacist shall package medications or make labeling changes in accordance to Pharmacy Policy Labeling Standards.
7. Medications will be dispensed and distributed to patient care areas in a timely manner and in accordance with Pharmacy Policies: Automated Dispensing Machine, Controlled Substances, Floor Stock, and Delivery of Medications Ordered as STAT and at Specified Time Intervals.
8. When delivering medication to nursing units, pharmacy staff shall check return bins to retrieve any discontinued or unused medications that should be returned to the pharmacy.
9. Unused unit-of-use packaging doses may be returned to inventory for reuse and credited to the patient if the package is intact (security and integrity maintained) and within the expiration period.
10. Unusable medications will be removed from storage areas of the hospital pursuant to Pharmacy Policy Unusable Medications.

C. **REFERENCE(S):**

1. The Joint Commission Standards MM. 03.01.01, MM.05.01.01, MM.05.01.11, MM.05.01.19 (2017)

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	06/05	SUBJECT:	Medication Management Program
REVISION DATE~~(S)~~:	06/05, 07/06, 07/09, 01/12, 09/15, 03/19		

Pharmacy Department Approval:	~~09/18~~07/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~10/18~~11/22
Administration Approval:	~~03/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/19

A. POLICY:

1. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff, shall implement a Medication Management Assessment and Evaluation Program to provide a system to ensure medication use within the organization is conducted in a safe and optimal manner. The Medication Management Assessment and Evaluation program requires the routine evaluation of literature for new technologies and best practices that have been demonstrated to enhance safety in other organizations to determine if these practices are conducted successfully within the organization or if they should be implemented to improve the medication management system. The Medication Management Assessment and Evaluation Program identifies risk points (including medication errors and adverse drug reactions) and identifies areas to improve patient safety as well as the overall use of medications throughout the organization.
2. For the purposes of this program the definition of medication includes:
   a. Prescription medications
   b. Sample medications
   c. Herbal remedies
   d. Vitamins
   e. Nutraceuticals (substances not controlled by the FDA, not proven beneficial by authoritative sources, however the public commonly utilizes – example: Ingestible Shark Cartilage)
   f. Over-the-counter drugs
   g. Vaccines
   h. Diagnostic and contrast agents
   i. Radioactive medications
   j. Respiratory therapy treatments
   k. Parenteral nutrition
   l. Blood derivatives
   m. Intravenous solutions (plain, with electrolytes and/or other drugs)
   n. Any product designated by the FDA as a drug
3. The Pharmacy and Therapeutics Committee will maintain oversight for the Medication Management Assessment and Evaluation Program. The program is based on the principles of performance improvement, with a focus on identification and measurement of processes and activities that are high-volume, high-risk, problem-prone and patient safety related. The program includes data collection and measurement of medication management processes, identification of opportunities or areas of improvements, the testing of incremental improvements and the recommendation of improvements to the organization's leaders. The main goal of improving the performance of medication management processes is to

continuously improve patient health outcomes and reduce the occurrence of medication related errors and medication related adverse patient outcomes, including adverse drug reactions. The following essential processes will be conducted to adequately assess and evaluate how medication is managed throughout the institution.

a. Process Design
b. Performance Measurement
c. Performance Assessment
d. Performance Improvement

4. The Pharmacy Director or designee is responsible for reporting medication management processes to the Pharmacy and Therapeutics Committee, whose members in turn are responsible for assessing, monitoring and evaluating the processes and outcomes of the medication management throughout the institution.

B. **PROCEDURE**:

1. The Pharmacy and Therapeutics Committee will collaborate and work together as a team with the Pharmacy Director or designee, and other designated members of the institution, to develop, implement and evaluate the organization wide Medication Management Assessment and Evaluation Program. As appropriate to the setting, individuals involved in the system of medication management include licensed independent practitioners, healthcare professionals and staff involved in medication management processes.
   a. Assessment and Evaluation Process: The following core medication management processes carried out by the organization are measured, assessed and evaluated:
      i. Selection and procurement
      ii. Storage
      iii. Ordering and transcribing
      iv. Preparing and dispensing
      v. Administration
      vi. Monitoring the effects and side effects on patients
   b. Over time, data is collected on all of the above processes.
2. The Pharmacy Department provides fundamental functions as well as key oversight responsibilities and activities in the system of medication management. The Pharmacy Department performs the following functions and activities:
   a. Selection and procurement of medications
   b. Storage of medications
   c. Maintenance of adequate medication inventory
   d. Oversight of ordering and transcribing processes
   e. Preparation of medications
   f. Medication dispensing
   g. Direct and indirect scheduled medication security and control
   h. Drug floor stock distribution
   i. Drug utilization monitoring and evaluation
   j. Provision of drug information to the organization's staff
   k. Patient/family/staff counseling and education
   l. Provision of formal and informal in-service to the nursing and other staff licensed to administer medications
   m. Provision of sterile compounding services
   n. Clinical dosing of specific medications (i.e., aminoglycosides)
3. The Pharmacy Department will be responsible to monitor the outcomes of its important functions and activities through internal performance improvement activities through investigation, data collection and monitoring of the internal processes conducted within, or by, the Pharmacy and its personnel. External performance improvement activities related to medication management will be monitored by the Pharmacy Department through data collection

from a wide variety of sources including, but not limited to, medication error reports (which include real and potential errors), and adverse drug reaction reports.

4. The Pharmacy Department will collect data systematically for improvement priorities and continuing measurement. The process of data collection activities will be (when appropriate and as often as possible) collaborative and interdisciplinary in nature.
5. To adequately monitor and evaluate the medication management system in place within the institution the Pharmacy Department collects data on the following:
   a. Processes and outcomes
   b. Medication errors (real and potential)
   c. Adverse drug reactions
   d. High-risk, high-volume and problem-prone processes
   e. Patient's needs, expectations and department specific patient satisfaction questionnaires and/or surveys
   f. Infection control activities
   g. Patient safety reports
   h. Current literature for new technologies and best practices
   i. Risk management issues and findings
6. Performance Measures:
   a. Administration of medication is of high-risk and therapeutic benefit to the patient. Medication management processes are measured on an ongoing basis. The following are performance measures or categories of measures for which data is collected, aggregated, reviewed and analyzed in an effort to identify risk points and areas to improve patient safety. The list is not exhaustive and may be revised in accordance with data collected, which may indicate the benefit of inclusion or exclusion of a performance measure from the monitoring and evaluation cycle. Measures include, but may not be limited to:
      i. Medication errors - wrong drug, dosage, time, route or rate of administration, wrong patient, omission, duplication or administration without an order, adverse reaction to medication (includes potential errors or "near misses")
      ii. Medication order filled incorrectly
      iii. Medication order prepared incorrectly
      iv. STAT medication not sent within established time frames
      v. Controlled substance missing and/or incorrect count
      vi. Occurrences that have an adverse result on a patient
      vii. Equipment breakage/failure that has an adverse result on a patient
      viii. Equipment not available
      ix. Security incident
      x. Expired, recalled or otherwise unusable drug dispensed
      xi. Formulary management
      xii. Labeling of drugs
      xiii. Education of patients and family
      xiv. Drug recall measures
      xv. Surveillance, prevention and control of infection
      xvi. Research investigational drugs
      xvii. Management of Human Resources (i.e., licensure requirements and entry level qualifications)
      xviii. Patient outcomes; long and short range continuing education
      xix. Technical quality control activities
      xx. Adverse drug reactions
7. Drug Usage Evaluation is an important component of the Medication Management Assessment and Evaluation Program. The Pharmacy and Therapeutics Committee, acting on behalf of the medical staff shall implement as a component of the overall Medication Management Assessment and Monitoring Program a Drug Usage Evaluation Program to ensure the safe,

appropriate and efficacious use of medications throughout the institution. Drug usage will be monitored in a systematic and continuous manner. The Pharmacy and Therapeutics Committee will determine the specific medications to be evaluated as well as the criteria to be applied. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.

8. Priorities for the selection of medications for evaluation shall be based on one (1) or more of the following factors:
   a. The number of patients affected by the medication use (i.e., frequency of medication use)
   b. The significance, including degree of risk, to individual patients
   c. The degree to which use of the medication is known or suspected to be problem-prone
   d. Ability to improve the outcome of a specific disease for which medication is an integral part of the treatment
9. Criteria for evaluation will be developed by the Pharmacy Department, in conjunction with the medical staff, based on objective measures that reflect the appropriate use of the medication as determined by community medical standards, current literature and best practices. The evaluation shall focus on processes that measure:
   a. Prescribing or ordering of medications
   b. Transcribing of medications
   c. Preparing and dispensing
   d. Administration
   e. Monitoring the medications' effects on patients
10. The Pharmacy Department, in conjunction with the medical staff, will conduct the evaluations, obtaining quantitative data and present a written report of findings to the Pharmacy and Therapeutics Committee on a quarterly basis. Reports shall include criteria, findings, causes/conclusions and recommendations.
11. The Pharmacy and Therapeutics Committee will determine actions to be recommended to the medical staff based on an analysis of:
   a. Thresholds or control limits exceeded
   b. Undesired patterns or trends
   c. Opportunities to improve performance or minimize adverse reactions
12. To adequately address the amount of medications that may prove beneficial for drug usage evaluation priorities for ongoing assessment have been developed. These priorities are based upon the following:
   a. The number of patients taking a medication
   b. The balancing of risk with therapeutic potential
   c. Medications known or suspected to be problem-prone
   d. Therapeutic effectiveness, (i.e., use of antibiotics to treat pneumonia)
13. The Pharmacy and Therapeutics Committee shall determine if, and when, a medication evaluation requires discontinuation or needs to be continued as a:
   a. Full evaluation
   b. Limited evaluation
14. Based on the findings of the Drug Usage Evaluation Program, the Pharmacy and Therapeutics Committee will forward recommendations to the medical staff to correct or improve medication use.
   a. The performance assessment process conducted for evaluation of the medication management program, as a whole is systematic, interdisciplinary and interdepartmental. The Pharmacy Department uses a systematic process to assess collected data. Other disciplines will collect data related to medication management processes conducted within their department. The assessment process will include statistical quality control techniques as needed. Data assessment begins with a clear understanding of the medication management processes under review. The framework for systematic

assessment includes the multidisciplinary analysis of data to answer questions about the processes and outcomes that are being monitored throughout the organization. The following issues shall be assessed and evaluated:

i. Current level of performance
ii. Stability of current processes
iii. Identification of areas that could be improved
iv. Identification of improvement priorities
v. Effectiveness of strategies implemented to improve performance
vi. Specifications for new or redesigned processes determined and met

15. An interdisciplinary approach will be made to make comparisons of processes and outcomes over time. The data will be compared and reference databases utilized as needed. Priorities for improvement will be assessed. Improvement activities will be implemented based upon assessment conclusions. The Pharmacy Department as well as the Pharmacy and Therapeutics Committee (as appropriate) will collaborate as necessary with other disciplines throughout the organization.
16. The organization will systematically improve the performance of its medication management system. The Pharmacy and Therapeutic Committee will assess and evaluate data provided and will determine and implement strategies to improve performance. The Pharmacy and Therapeutics Committee will implement actions that result in desired, measurable changes in processes. To achieve improvements and improve patient safety, the Pharmacy and Therapeutics Committee will participate in the following performance improvement activities:
    a. Planning
    b. Testing
    c. Assessing results and redesigning if necessary
    d. Implementing
    e. Assessing the effectiveness of implemented actions
    f. Reevaluation as deemed necessary to assure gains made are sustained

C. <u>ANNUAL REVIEW:</u>

1. The Medication Management Assessment and Evaluation Program will be assessed and measured annually for its effectiveness and consistency within the improving organization performance framework in place within the facility. If the identified improvements are not realized within a defined time period, the organization will reexamine the process within the function that is being monitored. The findings, conclusions, recommendations and actions will be communicated by the Pharmacy and Therapeutics Committee to the following:
    a. Medical Executive Committee
    b. Governing Body

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	01/75	SUBJECT:	Medications Ordered STAT and at Specified Time Intervals
REVISION DATE:	06/05, 03/06, 03/08, 04/08, 07/09, 01/12, 05/15, 07/18	POLICY NUMBER:	8390-3107

Pharmacy Department Approval:	~~04/18~~07/22
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~05/18~~10/22
Medical Executive Committee Approval:	~~06/18~~11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. POLICY:

1. STAT medications from the ~~P~~pharmacy will be delivered to the requesting area within 30 minutes ~~or less~~ from time of receipt of STAT order in the Pharmacy Department.

B. PROCEDURE:

1. The Pharmacy Department will be notified of STAT medications via a CPOE order entered as STAT or via telephone/verbal communication from the ordering prescriber ~~followed by a scanned telephone/verbal or electronic medication order~~.
2. If the medication is not available via Pyxis Medstation, the medication will be delivered to the appropriate patient care area, directly to the primary nurse.
3. Medications ordered at specified time intervals shall be adjusted to standard hours as per "Medication Administration Times" policy as soon as possible, unless ordering prescriber specifies~~d~~ otherwise.
4. For non-formulary ~~orders,~~ back ordered ~~medication~~ and/or out of stock **medications ordered** STAT ~~medication orders~~, the pharmacist will contact the primary RN and the prescriber to explain the delay and offer potential alternatives.

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE:	02/03	SUBJECT:	Patients' Use of Herbals and Natural Remedies
REVISION DATE:	02/03, 06/05, 03/06, 07/09, 01/12, 05/15, 07/18		

Pharmacy Department Approval:	~~02/18~~07/22
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	~~05/18~~10/22
Medical Executive Committee Approval:	~~06/18~~11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~07/18~~ n/a
Board of Directors Approval:	07/18

A. POLICY:
1. Due to clinically significant drug-drug interactions and unproven efficacy, continuation of herbals and natural remedies are not recommended during hospital admission.
2. The admitting nurse shall encourage the patient to send all medications home with a responsible family member or patient representative.
3. If the medication(s) cannot be sent home, they shall be stored in the Pharmacy Department until discharge.
4. If the "natural" remedy is prescribed by the physician and the patient wishes to continue taking the substance while in the hospital, the medication shall be ordered via CPOE as a "Patient Own Med."
5. The medication shall be identified, labeled, and dispensed in accordance to California State Law and Patient Care Services Policy Medications Brought in by the Patient.
6. As with other medications brought from home, herbals are returned to the patient upon discharge.

B. RELATED DOCUMENT(S):
1. Patient Care Services Policy: Medications Brought in by the Patient

Tri-City Medical Center
Oceanside, California

PHARMACY

ISSUE DATE: 04/77 SUBJECT: Unusable Medications

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

Pharmacy Department Approval:	~~07/18~~07/22
Pharmacy & Therapeutics Committee Approval:	~~09/18~~10/22
Medical Executive Committee Approval:	~~10/18~~11/22
Administration Approval:	~~12/18~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/18

A. PROCEDURE:

1. All medication storage areas of the hospital will be inspected for outdated, contaminated improperly stored medications and containers with worn, illegible or missing labels. The Pharmacy staff member conducting the inspection will remove all of these types of medications from the area.
2. The medication storage areas will be inspected by a pharmacist, pharmacist intern, or pharmacy technician on a monthly basis.
   a. The nurse manager or designee will be notified of the inspection findings at the time the inspection is complete.
   b. If the inspection is performed by a pharmacist intern or pharmacy technician, any irregularities found during an inspection will be reported to the Director of Pharmacy or designee within 24 hours.
3. Nursing, or other staff approved by license to administer medications, who note outdated, contaminated, improperly stored medications or containers with worn, illegible or missing labels, will contact the Pharmacy Department to notify them of the drug's existence on his or her unit. Pharmacy personnel will remove the medication from the unit.
   a. Patient specific medications that are used should be placed in the appropriate waste bin on the nursing unit at the time of patient discharge or discontinuation of the physician order.
4. Unusable medications shall be stored in an isolated area within the Pharmacy Department that has been designated for the storage of such unusable drugs. The drugs shall remain there until they can be returned to the manufacturer or picked up by the pharmaceutical reverse distribution company.
5. A record of medications returned to the manufacturer or pharmaceutical reverse distribution company will be maintained. Documentation will include the name of the receiving company, the name, strength and quantity of medications, and the date the medications were removed from the Pharmacy Department.
6. Medications that are to be disposed of within the pharmacy department will be done according to current regulations.
7. Disposal of controlled substances within the pharmacy department must be done in the presence of two (2) witnesses, one of which must be a pharmacist. A record of all controlled substances that are disposed of within the Pharmacy Department will be maintained for three (3) years. The record will consist of the name and strength of the medication, quantity, signatures of witnesses, and date of destruction.
8. Medications from outside the hospital brought in by patients and left in the Pharmacy Department for storage greater than 30 days:

a. Will be destroyed in accordance with current regulations.
b. A record of disposal will be noted on the "Patient's Own Medication Record".
c. Upon destruction, the information on the "Patient's Own Medication Record" will include the name of medication, strength, quantity if a controlled substance, patient's name, date of destruction and signature of person(s) disposing of the medication(s).
d. Controlled substances shall be destroyed in the presence of two (2) pharmacists. .
e. The records shall be kept for three (3) years.

Tri-City Medical Center
Oceanside, California

RADIOLOGY

ISSUE DATE: 11/18 SUBJECT: Policy Statement

REVISION DATE: 08/11

Radiology Department Approval:	08/22
Department of Radiology Approval:	08/22
Pharmacy & Therapeutics Committee Approval;	n/a
Medical Executive Committee:	09/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/11

Tri-City Medical Center	~~Distribution: Imaging Services 7633-100 Radiology~~
~~PROCEDURE:~~	~~POLICY STATEMENT 7633-100~~
~~Purpose:~~	~~Statements, Policies and Protocols contained in this section of the manual are information and represent a collection of guidelines that contribute to patient care services. This portion of the manual is to be used as consultative materials.~~
~~Supportive Data:~~	
~~Equipment:~~	
~~Issue Date:~~	

A. POLICY: ~~Statements:~~

1. The Medical Director of Radiology Services is certified by the American College of Radiology and is a member of Tri-City Medical Center medical staff. The medical director serves the department on a full time basis
2. The American Board of Radiology certifies all radiologists practicing in radiology services. Their credential files, located in the medical staff office, reflect the experience and current competencies required for all aspects of radiology in which they are engaged.
3. Persons licensed by the State of California as Radiologic Technologists or Nuclear Medicine Technologists will use all equipment controlled by radiology services under the direction of the Medical Director of Radiology. All Radiologic Technologists must have their California Fluoroscopy License. Only persons holding a Fluoroscopy license may operate Fluoroscopy equipment. These persons are subject to the rules and regulations of the California Department of Health Services and applicable federal regulations. The department will be open and a licensed radiographer available, in house, 24 hours each day.
4. All policies and procedures will be developed and approved by the Medical Director of Radiology Services. No permanent changes in the policies or protocols will be made until approved, signed and dated by the Medical Director.
   a. Statements, Policies and Protocols contained in this section of the manual are information and represent a collection of guidelines that contribute to patient care services. This portion of the manual is to be used as consultative materials.

~~B. APPROVAL PROCESS~~

~~Radiology Department~~	~~Department of Radiology~~	~~Pharmacy & Therapeutics Committee~~	~~Medical Executive Committee~~	~~Board of Directors~~	~~Administration~~
~~11/18~~		~~n/a~~		~~08/11~~	

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

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	10/88	SUBJECT:	Discharge Criteria
REVISION DATE~~(S)~~:	01/91, 01/94, 04/95, 09/97, 03/00, 01/06, 03/12, 03/16, 12/19		

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Chiefs Approval:	~~10/19~~08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~09/22
Administration Approval:	~~11/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. POLICY:
1. To establish guidelines for discharging patients from Physical Therapy, Occupational Therapy, Speech Therapy, and Therapeutic Recreation Services.

B. PROCEDURE:
1. Criteria
   a. Rehabilitation Services are no longer clinically indicated and medically necessary for the treatment of the individual's illness or injury.
   b. There are no longer valid expectations for significant practical improvement in the level of functioning within a reasonable length of time. Care is at a maintenance level.
   c. Specified goals and/or prior level of function have been met.
   d. With surgery or major medical complication, patient treatment will be put on hold or the patient will be considered for discharge pending physician or non-physician practitioner orders.
   e. The patient's mental function is insufficient to participate or recall information and no family nor caregiver available for training.
   f. Appointment Cancellation or failure to show for two scheduled outpatient therapy visits.
   g. Patient is unable or repetitively refuses to follow through with the established treatment plan as established upon therapy evaluation.
   h. Patient is transferred to another facility, discharged from the hospital, or expires.
2. Process
   a. It is the responsibility of the physician to determine discharge from the Rehabilitation Service the patient is receiving.
   b. In the course of treatment, the therapist may determine the patient no longer requires therapy services, or that intervention for the medical problem for which services were being provided is no longer indicated, and is documented in the Medical Record.
   c. A discharge summary may be documented in the medical chart showing progress or lack of progress made during the therapy sessions. A final progress note or discharge summary is sent to the referring physician for Outpatient Services.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 07/91	SUBJECT: Documentation of Progress Note and Discharge Summary
REVISION DATE~~(S)~~: 02/94, 09/97, 01/00, 01/03, 01/06, 01/09, 05/12, 03/16, 10/19	

Rehabilitation Department Approval:	~~08/18~~08/22
Department of Medicine Approval:	~~08/19~~08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~09/19~~09/22
Administration Approval:	~~10/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	10/19

A. POLICY:

1. All documentation of treatments performed will adhere to Centers for Medicare and Medicaid Services (CMS) Guidelines in accordance with Medicare Benefits Policy Chapter 15 Section 220.0 through 220

B. PROCEDURE:

1. Information regarding progress will be displayed in the patient's medical record. Progress notes or discharge summaries will be documented on the appropriate form and will be provided for referring or treating physicians.
2. Documentation must reflect status regarding the long and/or short-term goals that have been met or which have been modified if necessary, the plan of care for continued treatment, if indicated, or any changes in focus or frequency of treatment, including discharging current services.
3. Each documentation for progress note or discharge summary may include, but is not limited to the following information:
   a. Background information with admitting diagnosis, evaluation date, admitting physician, type of therapy and total therapy visits to date
   b. Objective measure of therapy outcome for current goals.
   c. Assessment of patient's deficits, strengths, and rehabilitation potential, and education provided according to patient/family education needs
   d. Recommended plan of care or termination of skilled therapy services, which may or may not include updating functional short and/or long-term goals, and prognosis
   e. Therapist's signature and/or co-signature for supervised providers as indicated.

C. REFERENCE(S)~~-LIST~~:

1. Centers for Medicare and Medicaid Services. (2014, December 31). *Medicare Benefits Policy, Chapter 15, Section 220.0-220.4.* Retrieved July 3, 2015, from www.cms.gov: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c15.pdf

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 01/09	SUBJECT: Fire and Internal Disaster Drill – Outpatient
REVISION DATE~~(S)~~: 05/12, 05/18	POLICY NUMBER: 1507

Department Approval:	~~003/18~~09/22
Environmental Health & Safety Committee Approval:	09/22
Department of Medicine Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	12/22
Professional Affairs Committee Approval:	~~05/18~~ n/a
Board of Directors Approval:	05/18

A. POLICY:

1. Mock fire and internal disaster drills will be held on a minimum of once every twelve months.

B. PROCEDURE:

1. The Director of Safety/Environment of Care or designee will be responsible for the coordination and implementation of mock fire and internal disaster drills at the Wellness Center.
2. The Director of Safety/Environment of Care or designee will inform a Rehab Services staff member that a mock drill is starting and exactly what and where the mock fire or disaster is.
3. The staff will respond according to the Rehabilitation Services Department's fire or disaster plan.
4. The Director of Safety/Environment of Care or designee will observe and take notes. Any problems or questions will be addressed at the time of the drill. The summary of result will be shared with the Wellness Center Rehab Services staff at the subsequent staff meeting, and any resulting questions will be addressed in that forum.
5. Results of the drill will be sent to Director of Safety/Environment of Care.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 09/91 SUBJECT: Home Evaluation

REVISION DATE~~(S)~~: 01/94, 12/96, 03/00, 01/06, 03/12, 06/13, 04/19 ~~POLICY NUMBER: 504~~

Rehabilitation Department Approval:	~~10/17~~08/22
Department of Medicine Approval:	01/19, 08/22
Pharmacy & Therapeutics Committees Approval:	n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. POLICY:

1. The primary OT, PT and/or SLP (if appropriate) will assess if patient requires a home evaluation. The home evaluation will be conducted while the patient is receiving inpatient acute rehabilitation.

B. PROCEDURE:

1. At least one staff OT or PT will conduct the home evaluation. Other participants may include OTA, PTA, SLP, Rehab Aide or interns
2. Therapist(s) will coordinate the home evaluation time and discuss transportation arrangements for patient with their family member/caregiver prior to the evaluation.
3. Transportation for patient will be provided by the patient's family.
4. A temporary absence release form must be filled out by the patient or representative before the home evaluation. A form is placed in the chart, and a copy is given to the patient.
5. The therapist will leave documentation of their scheduled trip at Rehab Services with address of the Home Evaluation location and an emergency number which includes a work and one personal contact phone number. The therapist will carry a copy of this with them in the car.
6. The therapist(s) will notify the patient's nurse about the patient's absence from the unit due to the Home Evaluation.
7. The therapist(s) are responsible for taking necessary equipment, e.g.: tape measure, bath bench, transfer boards, and appropriate forms, on the home evaluation.
8. The therapist(s) will document results of Home Evaluation in the medical chart and order any specialized equipment.
9. Home Evaluation with concurrent patient discharge from TCMC to their home may occur at times. A discharge home is determined by the patient's physician at TCMC and is based on the patient meeting pre-established functional and medical safety criteria. The physician may reconsider patient discharge home following specific findings of the Home Evaluation.

C. FORM(S):

1. Temporary Absence Release Form -- Sample

Temporary Absence Release Form – Sample

A patient outing (explain activities to occur during patient outing) _____

_____

_____ will occur away from the hospital at

(location) _____

on (date) ___/___/___ and will last approximately (time) _____(AM/PM) to_____(AM/PM).

Patients who participate in the outing are accompanied by hospital employees or agents who are responsible for the supervision of the patients and for providing or arranging, when appropriate, transportation by hospital vehicles or commercial carriers to and from the activity. A patient may participate in the outing if his/her physician deems such participation therapeutically appropriate and beneficial. However a patient may continue to receive other services from the hospital even if permission is not given for participation in the outing, which is a special treatment modality.

Private medical insurance programs and publicly funded programs, such as Medi-Cal and Medicare, may or may not provide hospitalization benefits for the period of the time during and subsequent to the time a patient is away from the hospital. If private or public insurance does not provide such hospitalization benefits, the patient or the person responsible for the patient's hospitalization expenses will remain, to the extent permitted by law obligated to pay the hospital for such expenses in accordance with the hospital's regular rates and terms.

The physicians involved in your care are not employees or agents of the hospital. They are independent medical practitioners. Your signature below constitutes your acknowledgement: (1) that you have read and agree to the forgoing; (2) that the patient outing noted above has been adequately explained to you by your/ the patient's physician and that you have received all the information you desire concerning the outing; and (3) that you authorize and consent to the participation of (patient name) _____in such outing.

_____

Patient/Conservator/Guardian/Other Signature Date / Time

If signed by someone other than patient, indicate relationship: _____

Print name: _____
(Patient/Conservator/Guardian/Other)

Affix Patient Label

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

7790-1014
(Rev 2/13)

CONSENT FOR PARTICIPATION
IN TRI-CITY HOSPITAL
PATIENT OUTING

White - Hospital Yellow -Patient

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE: 08/91	SUBJECT: Outpatient Medical Records
REVISION DATE~~(S)~~: 02/94, 09/97, 10/99, 01/06	~~POLICY NUMBER: 1001~~
REVIEW DATE~~(S)~~: 01/03, 01/09, 04/12, 08/19	
Rehabilitation Department Approval:	~~12/15~~08/22
Department of Medicine Approval:	01/1908/22
Pharmacy & Therapeutics Committee Approval:	..n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~08/19~~12/22
Professional Affairs Committee Approval:	..n/a
Board of Directors Approval:	08/19

A. POLICY:
1. All outpatients accepted for treatment will have a completed medical record compiled and maintained.

B. PROCEDURE:
1. The Office Coordinator, Clerk Receptionist, or Rehabilitation Aide will be responsible for obtaining or creating the file and paperwork necessary for the medical record.
2. Each medical record will contain the following:
   a. Outpatient Admission Form: To include patient's name, address, medical record number, social security number, insurance information, age, sex, marital status, religion, date of admission, admitting physician, initial diagnostic impression, and diagnosis.
   b. Physician's Prescription/Referral Authorization: which includes diagnosis, physician signature, and date signed.
   c. A signed Conditions of Admissions Form: If the patient is under 18 years of age, they must be accompanied by an adult who assumes responsibility for care during therapy sessions. This includes signature for authorization of treatment and completion of Medical History and Physical form.
   d. History and Physical Intake form.
   e. Discharge Summary from other facilities, if available/ appropriate.
   f. Copy of insurance card(s) and authorization as appropriate.
   g. Signed Cancellation/No-Show policy
   h. HIPAA form and workers' compensation release of information form, if applicable.
   i. Signature Log
3. Once the patient has been seen, an evaluation will be documented and placed in Electronic Medical Record (EMR).
   a. The initial evaluation will be faxed to the physician for signature and scanned into the EMR.
4. Progress will be documented after every patient visit.
   a. Progress summaries will be written by each appropriate therapist every 10 visits, or per authorization as appropriate. A copy will be faxed to the referring physician, and scanned into the EMR.
5. A discharge summary including patient/family teaching and continuation of services referral.
   a. A copy is to be faxed to the physician and scanned into the patient's EMR.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	02/97	SUBJECT:	Physical Therapy Assistant Supervision
REVISION DATE~~(S)~~:	01/06, 01/09, 04/12, 05/15, 01/19	~~POLICY NUMBER: 613~~	

Rehabilitation Department Approval:	~~05/18~~08/22
Department of Medicine Approval:	08/22 n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	11/18
Administration Approval:	~~01/19~~11/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. POLICY:

1. To comply with the Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44 for adequate supervision of Physical Therapy Assistants.
2. The Physical Therapy Staff will be responsible to follow the progress of each patient, provide direct care to the patient, and to assure that the physical therapy assistant does not function autonomously.

B. PROCEDURE:

1. Adequate supervision shall include all of the following:
   a. The supervising physical therapist shall be readily available in person or by telecommunication to the physical therapy assistant at all times while the physical therapy assistant is treating patients. The supervising physical therapist shall provide supervision of the assigned patient care rendered by the physical therapy assistant.
   b. The supervising physical therapist shall initially evaluate each patient and document in the patient's record, along with his or her signature, the evaluation and the plan of care.
   c. The supervising physical therapist shall formulate and document in each patient's record, along with his or her signature, the treatment program goals and plan based upon the evaluation and any other information available. This information shall be communicated verbally or in writing by the supervising physical therapist to the physical therapy assistant prior to initiation of treatment by the physical therapy assistant. The supervising physical therapist shall determine which elements of the treatment plan may be assigned to the physical therapy assistant. Assignment of these responsibilities must be commensurate with the qualifications, including experience, education, and training of the physical therapy assistant.
   d. The supervising physical therapist shall re-evaluate the patient if necessary, and modify the treatment goals and plan as needed. The re-evaluation shall include treatment to the patient by the supervising physical therapist. The re-evaluation shall be documented and signed by the supervising physical therapist in the patient's record and shall reflect the patient's progress toward the treatment goals and when the next re-evaluation shall be performed.
   e. The physical therapy assistant shall document each treatment in the patient's record, along with his or her signature. The physical therapy assistant shall document in the patient's record and notify the supervising physical therapist of any change in the

patient's condition not consistent with planned progress or treatment goals. The change in condition necessitates a re-evaluation by a supervising physical therapist before further treatment by the physical therapy assistant.

D. **REFERENCE(S):**

1. Physical Therapy Regulations California Code of Regulations Title 16 Division 13.2 Article 4 Section 1398.44

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	01/91	SUBJECT:	Physical Therapy
REVISION DATE~~(S)~~:	01/94, 09/97, 03/00, 01/03, 01/06, 01/09, 03/10, 04/12, 03/16, 04/19	~~POLICY NUMBER: 603~~	

Rehabilitation Department Approval:	~~03/18~~08/22
Department of Medicine Chiefs Approval:	~~01/19~~08/22
Pharmacy &Therapeutics Committee Approval:	..n/a
Medical Executive Committee Approval:	03/19
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	..n/a
Board of Directors Approval:	04/19

A. POLICY:

1. Physical Therapy is accountable through the Rehabilitation Services Leadership Team and/or Medical Director of the rehabilitation program and/or the referring physician for maintaining a competent level of practice. The Department is also accountable through the appropriate Administrative Executive to the Administrator for carrying out the policies and procedures as approved by the Governing Board.
2. Physical Therapy staff report directly to the Rehabilitation Services Leadership Team in fulfilling duties and/or responsibilities.

B. PROCEDURE:

1. All requests for Physical Therapy services must be in the form of a written prescription from a licensed physician or Allied Health Professional (AHP). AHP must be working in collaboration with a physician.
2. Verbal requests for Physical Therapy services will be accepted, but must be followed by a written prescription.
3. A new signed prescription is required for any change in medical status or treatment ordered.
4. Outpatient appointments are scheduled between 0700 and 1800 Monday through Friday.
5. Inpatients are seen between 0800 and 1630 Monday through Sunday according to prioritization policy.
   a. Therapy provision may occur outside of these time frames on an as needed basis.
6. Physical Therapy evaluations and treatment will be provided as prescribed by a licensed physician or an AHP.
7. Appropriate assessments/tests will be administered to develop a treatment plan.
8. A written treatment plan will be provided with time frames for each individual with designated functional goals, based upon the individual's medical condition, evaluation and test results, and personal goals.
9. Initial and ongoing treatment will be implemented utilizing specific activities or methods to develop or restore function, relieve pain, compensate for dysfunction or minimize debilitation. Treatment may include but is not limited to:
   a. The use of physical agents such as thermotherapy, cryotherapy, hydrotherapy, electrical stimulation, ultrasound, and mechanical traction.
   b. Therapeutic exercise and activities, manual therapy and joint mobilizations.
   c. Neuromuscular re-education, gait training, vestibular integration.
   d. Manual lymphatic drainage and bandaging.

10. Treatment will be modified based upon progression towards therapeutic goals as clinically indicated and medically necessary.
11. Patient treatment and treatment outcomes will be documented in the patient's legal record according to appropriate documentation policies.
12. Patient's physician will be provided with a written summary of the patient's evaluation, progress and designated discharge plan for treatments.
13. All therapy equipment will be maintained in quality condition.
    a. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.
14. 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.
15. Appropriate operational and administrative records will be maintained, may include but not limited to licensure, certifications, timecards, training records, and billing sheets.
16. Reporting and consulting with appropriate healthcare professionals regarding patient's current status will be maintained and documented.

C. **RELATED DOCUMENT(S):**
1. Documentation of Evaluations
2. Documentation of Daily Notes
3. Documentation of Progress Notes
4. Documentation of Discharge Summaries

D. **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

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	08/90	SUBJECT:	Referrals for Rehabilitation Services
REVISION DATE~~(S)~~:	01/91, 01/94, 09/97, 10/00, 01/03, 01/06, 01/09, 03/10, 04/12, 06/13, 04/19	~~POLICY NUMBER: 509~~	

Rehabilitation Department Approval:	~~09/15~~08/22
Department of Medicine Approval:	~~01/19~~08/22
Pharmacy & Therapeutics Committee Approval:	~~--~~n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	~~--~~n/a
Board of Directors Approval:	04/19

A. PURPOSE:

1. Rehabilitation services are rendered according to the written orders of a Physician or an Allied Health Professional (AHP), such as a Physician Assistant, Clinical Nurse Specialist or Nurse Practitioner. The Physician/AHP is to determine the need for therapy, the tolerance and capabilities of the patient and the treatment objectives.
   a. The Physician/AHP, in consultation with the therapist, must prescribe the specific procedures/modalities to be used and the frequency and duration of treatment.
   b. The referring Physician/AHP should then notate the order **under the "orders" tab in the patient's electronic medical record (EMR)**~~on the Physician/AHP order sheet in the patient's chart~~, for inpatients; or complete an appropriate referral form, or his own personal prescription form, with the required information for outpatients.
   c. The dated prescription must include a specified diagnosis or description of the problem, therapy orders, frequency and duration, and a signature.
   d. These forms will then be forwarded to the Rehabilitation Services Department.

B. REQUESTS FOR SERVICE:

1. Verbal orders may be taken by a physical therapist, occupational therapist, or speech and language pathologist from a Physician/AHP.
2. These must be charted and signed by the physical therapist, occupational therapist or speech and language pathologist read back and verified with the ordering Physician/AHP verbatim.
3. A written order shall be obtained from the referring Physician/AHP within a reasonable time frame.

C. HOURS OF SERVICE:

1. Inpatients are seen for an evaluation within 24 hours for PT, OT and high-priority Speech patients 7 days a week.
2. Referrals received after 4 PM on Friday for Speech are evaluated within 72 hours.
3. Outpatients are scheduled as quickly as possible, not to exceed 7 business days.

D. RESPONSIBILITIES:

1. Rehabilitation services must be provided by, or under, the supervision of a Rehabilitation Services staff member who meets the qualifications established by applicable federal, state and local laws and regulations.

2. Whenever a rehabilitation service is given by a person who does not meet these regulations, the qualified therapist shall be immediately available to supervise and/or handle any emergency that may arise during treatment.
3. After the initial assessment is completed, the Physician/AHP will sign off on the therapist's proposed plan of care. The sign-off will be in the form of a clarification order (inpatient) or an updated therapy prescription form (outpatient) or by signing the therapist's evaluation/report and plan of care (outpatient).

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	07/91	SUBJECT: Scope of Services
REVISION DATE~~(S)~~:	01/94, 05/95, 04/97, 10/00, 05/01, 02/03, 01/06, 01/09, 03/12, 03/16, 04/19	~~POLICY NUMBER: 104~~

Rehabilitation Department Approval:	~~03/18~~08/22
Department of Medicine Approval:	~~04/19~~08/22
Pharmacy & Therapeutics Committee Approval:	~~--~~n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	~~--~~n/a
Board of Directors Approval:	04/19

A. POLICY:

1. The Department of Rehabilitation Services includes Physical, Occupational, and Speech Therapies, Audiology, and Therapeutic Recreation. Using a multidisciplinary collaborative team approach, services and programs are available to meet the needs of all patients with a wide variety of diagnoses, including physical and psychosocial disabilities. The overall objective of the Department is to foster a healing environment for patients to regain their functional independence in all areas of daily life as rapidly as possible. Assessment identifies the patient's physical, cognitive, behavioral, communicative, emotional and social status and identifies facilitating factors that may influence attainment of rehabilitation goals. Problems may include:
   a. Emotional, behavioral or mental disorders
   b. Cognitive disorders
   c. Communicative disorders
   d. Developmental disabilities
   e. Vision or hearing impairments or disabilities
   f. Physical impairments or disabilities
   g. Pain interfering with optimal level of function or participation in rehabilitation
2. Each patient, inclusive of neonatal through geriatric ages, will be treated with dignity and respect. Optimal health care services will be delivered to each patient regardless of gender, size, disability, race, creed, or ethnic origin.
3. Physical Therapy - The goals of Physical Therapy are to relieve pain, minimize disability, prevent deformities, develop, improve and restore functioning. Physical Therapy Services shall include, but are not limited to, evaluation/assessment, development of treatment plans and goals, instruction, education and consultation services.
4. Occupational Therapy - The role of Occupational Therapy is to provide assessment, therapy and education for patients who demonstrate deficits in skills required for daily living activities. Services include evaluation and treatment for impairments of physical, psychosocial, cognitive, developmental and sensory-integrative functioning. The goal of treatment is to improve or restore function, prevent or minimize dysfunction, and compensate for or cope with disabling conditions.
5. Speech Pathology - Speech-Language Pathology Services include assessment, therapy and education for patients who demonstrate communication or oral-pharyngeal function disorders. These include, but are not limited to, impairments of articulation, language comprehension and

expression, cognition, fluency, voice, reading, writing and swallowing. Education and counseling for families of patients exhibiting the aforementioned disorders are also provided.

6. Audiology Services – Audiology Services include assessment of hearing acuity and status in patients who may be at risk for changes in hearing due to medical or treatment issues, including medication, age or diagnosis. Instruction and education of patients and family members is provided to increase the involved person's understanding of their deficits.
7. Therapeutic Recreation - Therapeutic Recreation Services provide goal-oriented programs that promote wellness and improve the patient's quality of life through leisure. Therapeutic Recreation treatment may be individual or done in groups. Services include, but are not limited to, leisure assessment and evaluation, skill development, social programs, special events, leisure education, leisure counseling and resource development. Family education and counseling are included to improve patient's attitude, skill level and socialization.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	01/07	SUBJECT:	Supervision Requirements of Minors During Outpatient Treatment
REVISION DATE~~(S)~~:	01/09, 10/15, 12/19		

Department Approval:	~~05/18~~08/22
Department of Medicine Approval:	08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~09/22
Administration Approval:	~~11/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. POLICY:

1. Parent/Guardian shall accompany their minor child for all outpatient treatments until the child reaches the age of 18 years. Parent/Guardian shall be present at the child's session or remain in the waiting area for the duration of the session. The level of parent participation depends on the child's age and prior agreement with the treating therapist.
2. Exceptions may be made to this rule with prior signed consent by the minor's parent authorizing treatment in absence of the parents' presence. This may apply to teenagers that are driving themselves to their appointments (i.e. minor children age 16 and older). Other limited (single-visit) exceptions may be considered for emergencies and would have to be arranged between the parent and therapist for agreement on feasibility of the treatment session without the parent's presence at the facility.

Tri-City Medical Center
Oceanside, California

REHABILITATION SERVICES

ISSUE DATE:	09/91	SUBJECT:	Therapeutic Recreation Department Policy
REVISION DATE~~(S)~~:	01/94, 09/97, 01/06, 01/09, 04/12, 05/12, 04/19	~~POLICY NUMBER: 901~~	

Rehabilitation Department Approval:	~~09/15~~08/22
Department of Medicine Approval:	~~01/19~~08/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/19~~09/22
Administration Approval:	~~04/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/19

A. POLICY:

1. Patients referred for therapeutic recreation will be evaluated, and recommendations will be established as clinically indicated. Therapeutic recreation is accountable through the leadership structure of rehabilitation services and the referring physician/Allied Health Professional (AHP) 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. Therapeutic recreation staff reports to the leadership structure in fulfilling duties or responsibilities.

B. PROCEDURE:

1. Requests for Service:
   a. All requests for therapeutic recreation services must be in the form of a written prescription from a licensed physician/AHP.
   b. Verbal requests for therapeutic recreation services will be accepted, but must be followed by a written prescription.
   c. A new requisition is required for any change in treatment ordered.
2. Hours of Service:
   a. Inpatient care: Monday through Sunday, 0800 to 1630.
      i. Therapy provision may occur outside of these time frames on an as needed basis.
3. Responsibilities:
   a. Provides therapeutic recreation evaluations and treatment to rehabilitation unit, behavioral health inpatient unit, and acute care, as prescribed by a licensed physician/AHP.
   b. Administers appropriate assessments and tests prior to the initiation of treatment.
   c. Provides a written plan for each individual with designated goals based upon the individual's medical condition, age-appropriate considerations, evaluation and test results, and personal goals.
   d. Implements initial and ongoing treatment programs while maintaining patient privacy, utilizing leisure education that focuses on assisting the patient in learning new leisure skills, redeveloping past leisure skills, and establishing an awareness of self and leisure opportunities. Assists the patient and family in adjustment to disability and a change in lifestyle patterns through the use of recreational activities.

e. Modifies treatment program based upon medical status, progress/lack of progress, or as requested by the patient's physician/AHP.
f. In the acute care setting patients will be seen at bedside unless otherwise indicated. Leisure materials may be left for unsupervised individual to use at bedside with nursing informed of any safety concerns and program continuity.
g. Documents patient treatment and treatment outcomes in patient's record.
h. Identifies safety hazards and equipment in disrepair, removes hazard or equipment and inputs work order.
i. 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.
j. Maintains appropriate operational and administrative records; may include but not limited to licensure, certifications, timecards, training records, and billing sheets; as per department guidelines.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY EQUIPMENT

ISSUE DATE:	11/93	SUBJECT:	Authorized Security Department Uniforms and Safety Equipment
REVIEW DATE:	12/95, 10/97, 06/00, 02/01, 05/03, 06/09, 06/11	POLICY NUMBER: 401	
REVISION DATE:	02/01, 07/03, 06/09, 09/15, 11/20, 04/22		

Department Approval:	~~03/22~~08/22
Environmental Health & Safety Committee Approval:	~~03/22~~09/22
Administration Approval:	~~04/22~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/22

A. PURPOSE:
1. To establish guidelines for the wearing and issuing of approved Security Department attire, uniforms and safety equipment by all security personnel.

B. POLICY:
1. All on duty Security Department personnel will wear only approved professional attire, uniforms and safety equipment items while acting in the capacity of security officer. In addition, uniform items are to be issued in accordance with this policy.

C. APPROVED UNIFORM APPAREL:
1. Required Uniform Items (department issued)
   a. Uniforms will be clean and pressed with visible vertical creases on the pant legs and on shirt sleeves.
   b. Boots **or plain black** will be clean and polished, **footwear is required but is at the officer's expense.**
   c. A supervisor**, lead security officer** or designee will routinely check uniforms and equipment to verify compliance.
   d. Department patches are to be worn on both sleeves of any approved shirt, sweater, and jacket and in the center of approved ball cap **or beanie-caps**.
   e. Department issued security badge will be displayed in plain sight in an appropriate manner.
   f. Medical Center photographic identification badge will be worn in plain sight with the photograph showing.
   g. Duty Belt will be made of nylon ~~with plastic buckle~~ and black in color.
   h. Four Belt keepers matching duty belt.
2. Additional Uniform Items (officer's expense).
   a. One Key Ring matching duty belt.
   b. Footwear will consist of any of the following and will be maintained in a clean and neat condition.
      i. Military style boots or shoes~~, with plain toe,~~, black in color~~, and having plain type sole~~.

ii. High Tech brand (or equivalent) style uniform boot or shoe, black in color ~~with standard sole~~.
1) All low-cut style footwear will be worn with plain black or dark blue colored socks. High top boots may be worn with white, black, or blue socks (sock color will not be visible while wearing boots).
2) Prior approval from the Security Supervisor must be obtained for the wearing of any other style of footwear.

3. Optional Uniform Items (officers expense)
~~a. Approved plain navy blue or black ball cap style security hat with approved security patch centered on the front.~~
~~b.~~**a.** Crew style tee shirt. Color will be Black, White, or Blue only.
~~c.~~**b.** The wearing of appropriate insignias. Insignias must be approved by the Security Supervisor prior to being worn and can only be worn in a manner displaying proper respect and protocol.

4. Safety Equipment (Hospital Issued)
a. Non-latex medical exam gloves (or equivalent)
b. Safety glasses
c. Spit sock~~.~~
d. Surgical or N95 mask
e. Disposable gown
~~c.~~**f. Safety shield**
~~d.~~**g.** Department furnished Two-Way Motorola radio.
i. Officer will be issued their own ~~personal~~ radio for use while on duty. The Officer will be solely responsible for maintaining their issued radio and keeping it in good operating condition. Any damage to the Officer's radio must be immediately reported to his supervisor. Damage due to neglect will be the responsibility of the assigned Officer.

5. Optional Safety Equipment (Officer expense)
a. Mini style flashlight with case matching duty belt.
~~b. Plain black colored gloves. Gloves will only be worn with uniform during night shifts or inclement weather.~~

6. While on duty, security officers will only wear the appropriate uniform items as described.
7. While on duty, Security Department personnel will only be allowed to wear the following personal affects: appropriate wristwatch. ring(s) to be limited to wedding band or one ring per hand and not bulky or excessive or would not allow the officer to perform their physical-contact duties safely. The wearing of any necklaces will be done in such a manner to be kept from plain sight. Earrings to be limited to stud type and one per ear.
8. Light-Duty security officers are not authorized to be in Security Department~~.~~ uniforms and must wear black or dark-blue professional business attire such as shoes or boots, pants and collared shirt.

D. ISSUANCE OF UNIFORMS:

1. Full Time New-Hire
a. Number of issued uniforms to be received by full time new-hire Security Department officers will be determined by the Security Department Leadership (lead officer, supervisor, manager or director) based on Department needs.

E. REPLACEMENT OF DAMAGED UNIFORMS:

1. Any replacement of required Security Department uniform items that have sustained work-related damage will be subject to approval and will be replaced in accordance with the uniform procedure to be determined by the Security Department Leadership (lead officer, supervisor, manager or director).

F. NON-COMPLIANCE:

1. Non-Compliance with any portion of this policy may result in disciplinary action leading to, and or including termination.

Tri-City Medical Center
Oceanside, California

SECURITY
EMERGENCY PREPAREDNESS

ISSUE DATE:	04/03	SUBJECT:	Emergency/Staffing Situation ~~Officer Recall~~
REVIEW DATE:	12/96, 05/03, 11/06, 03/09, 06/11, 11/20	POLICY NUMBER: 803	
REVISION DATE:	07/03, 07/10, 10/10, 09/15		

Department Approval:	~~05/20~~08/22
Environmental Health and Safety Committee Approval:	~~08/20~~09/22
Administration Approval:	~~10/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. PURPOSE:

1. To establish guidelines to be utilized in the event of an ~~E~~emergency ~~S~~situation or ~~D~~disaster ~~A~~alert, or for the immediate recall of additional Security Department personnel due to ~~Emergency or~~ a staffing need.

B. POLICY:

1. All Medical Center Security Officers are required to maintain in good working order a telephone or telephone message system that allows for contact within 2 hours, in the event of an emergency or Security Department **staffing** need.

C. PROCEDURE:

1. In the event of an emergency situation or ~~D~~department need requiring the recall of additional Security Department personnel during off hours, the ~~S~~shift ~~L~~lead ~~O~~officer or ~~D~~designee will use the chain of command to notify the ~~Security~~**SD** Supervisor, **Manager or Director** prior to activating the ~~O~~officer ~~R~~recall chart.
2. The ~~Security~~ ~~S~~shift ~~L~~lead ~~O~~officer or ~~D~~designee will go down the list calling each **off-duty** ~~O~~officer starting with the ~~O~~officers on the shift needing to be filled first, followed by other shift ~~O~~officers as needed and recording the results of each call. If necessary, the ~~Security~~**SD** Supervisor, **shift lead officer, Manager or Director** ~~Designee, or Shift Lead Officer~~ will appoint another ~~S~~security ~~O~~officer or Medical Center ~~E~~employee call each ~~O~~officer.
3. Each ~~O~~officer called will be informed of the need for additional ~~Security Department personnel~~**officers**, and that ~~he is~~ **they are** being recalled. The ~~O~~officer will be briefed on ~~his~~ **their** duties for the situation or ~~E~~emergency when ~~he~~**they** arrives on post.
4. Each ~~O~~officer called is required to respond or return the phone call no later than 2 hours from the time the message was left and documented.

Tri-City Medical Cen
Oceanside, California

RETIRE – follow Administrative Policy Dress and Appearance Philosophy

SECURITY
PERSONNEL

ISSUE DATE:	04/91	SUBJECT:	Hair and Grooming Standards for Security Officers
REVIEW DATE:	06/94, 12/96, 03/02, 05/03, 11/06, 03/09, 06/11	POLICY NUMBER:	302
REVISION DATE:	03/02, 07/03, 09/15		

Department Approval:	~~05/20~~08/22
Environmental Health and Safety Committee Approval:	~~08/20~~09/22
Administration Approval:	~~10/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

~~A. PURPOSE:~~

~~1. The Medical Center has a right to expect Security Department officers to present a neat, clean, and well-groomed appearance whether in a Tri-City provided uniform or personal attire. Both hairstyle and personal dress style are recognized as an individual matter; however, when an officer interacts on duty, they will follow the below criteria.~~

~~B. POLICY:~~

~~1. All Security Officers will conform to the hair and grooming guidelines while they are on duty and on the Medical Center Campus.~~

~~C. PROCEDURE:~~

~~1. Regardless of style, the officer's hair shall not in any way interfere with proper and efficient performance of their duties.~~

~~2. Male Grooming Standards:~~

~~a. Front and side hair length may be worn at any length on the front and sides as long as it can't~~**~~cannot~~** ~~be extended into eyes and interfere with the officer's vision.~~

~~b. Back hair may be worn at any length and style as long as it doesn't~~**~~does not~~** ~~extend below the top of the shirt collar.~~

~~c. Hair shall be kept neat, clean, and well groomed at all times.~~

~~d. Sideburns shall be trimmed so that they don't extend below the mid-ear. The bottom portion of the sideburn will be trimmed and at no time wider than one inch in width.~~

~~e. Facial hair in the form of a mustache,~~ **~~beard and sideburns~~** ~~is permitted, but will be kept neat, clean, and well-trimmed at all times~~ **~~in coordination with Administrative Policy 415 Dress and Appearance Philosophy~~**~~. The mustache will not exceed lower than one-quarter inch past the smile crease line.~~

~~f. Beards and goatees are permitted with a medical note and per approval of the Manager or Supervisor.~~

~~3. Female Grooming Standards.~~

~~Hair shall be kept in a neat, clean and well-groomed manner and will either be cut in length or worn in a style which doesn't extend below the top of the collar. The length or style also pertains to the hair extending in the officer's eyes in such a manner as to interfere with their vision.~~

~~Tattoos and Piercings~~

a. ~~Security Officers are only allowed to have their ears pierced so as to uphold a professional look and to keep the officer safe while not interfering with proper and efficient performance of their duties; all tattoos must be covered when possible by wearing long-sleeves, turtlenecks or opaque hose by all security officers.~~

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

ISSUE DATE:	06/91	SUBJECT: Post Positions
REVIEW DATE~~(S)~~:	05/94, 10/97, 05/03, 11/06, 03/09	POLICY NUMBER: 202
REVISION DATE~~(S)~~:	05/94, 07/03, 06/11, 04/13, 11/20	

Department Approval:	~~05/20~~08/22
Environmental Health and Safety Committee Approval:	~~08/20~~09/22
Administration Approval:	~~10/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. PURPOSE:
1. To assist each Security Officer with guidelines of activities, details, and assignments for all Security Department post positions.

B. POLICY:
1. It is the policy of the Security Department that each Security Officer be familiar with and able to demonstrate proficiency in assuming the assignment of any post position.

C. PROCEDURE:
1. The following is an overall breakdown of the basic responsibilities and responsibilities of each Security Department post position. All positions include other duties as identified and assigned by the Security Department Manager, Supervisor, and S.D. Leadership members to enhance overall productivity and Department efficiency.
   a.
   b. The following post orders include but are not limited to the following guidelines and procedures.
   c. Eastside Main Entrance: engage passers-by and stay aware of Main Lobby, Level 1 Hallways, exterior-side of East Main Entrance [Sector 8], provide directions for customers and visitor badges, assist with reviewing C.C.T.V., notifying the Legal Department and lead security officer of subpoenas, and responds to all emergency calls on property.
   d. Westside Emergency Department Lobby and Weapons' Scanner: inventory personal items and persons' body that enter into the Lobby [visually or physically with flashlight, drumstick, or metal-detector / wand], be aware of high-risk persons near the E.D. area, and assist with reviewing C.C.T.V.
   e. Emergency Department Station B: in the best possible position to stop elopements, stop combative patient, to monitor all high-risk activity, ensure that all high-risk patients are congregated together and not dispersed throughout the E.D., and is able to respond to emergency calls on property if authorized by Supervisor, Lead, or designee.
   f. E.D. Rover: responsible for patrolling all E.D. patient care areas, hallways, Ambulance Bay and Unloading / Loading Zone outside the E.D. [Sector 15], assist the scanner officer in the E.D. Lobby, assist the E.D. Station B officer with authoritative presence and watching high-risk patients, responsible for coordinating Station B and E.D.S.O.

operations i.e. enforcement reports, C.C.T.V. checks, and visitors' badges, and responds to all emergency calls on property.

g. Interior Rover: responsible for patrolling all patient care areas, stairwells, lobbies, bathrooms, hallways, Cafeteria, departments, and roof-top access points, checking/confirming the whiteboard information e.g. purple horseshoe patients, custody patients, closed floors, and hold patients, assist with all internal calls for assistance as well as relieve other security officers for assistance, and responds to all emergency calls on property.

h. Exterior Rover: responsible for providing mobile presence throughout all parking lots, giving escorts to different access points of the hospital, directing outside agencies [i.e. law enforcement or fire department] to access points / departments within the hospital, responsible for identify possible threats or incidents around the hospital's perimeter e.g. Thunder Drive, Vista Way, and Waring Court streets, and responds to all emergency calls on property.

i. Any non-adherence to these guidelines / procedures will incur discipline up to possible termination.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

ISSUE DATE:	10/92	SUBJECT:	Release of Security Department Information
REVIEW~~ED~~ DATE:	05/94, 10/97, 05/03, 11/06, 03/09, 06/11, 05/13, 11/20	POLICY NUMBER:	108
REVISION DATE:	07/03		

Department Approval:	~~05/20~~08/22
Environmental Health and Safety Committee Approval:	~~08/20~~09/22
Administration Approval:	~~10/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. PURPOSE:
1. To establish the proper procedure to be utilized when a request is received for the release of any Security Department reports or information.

B. POLICY:
1. It is the policy of the Security Department **(S.D.)** that all ~~Security Department~~ **S.D.** information, ~~reports, memos, correspondences, and e-mails~~ will be considered confidential and as a result will not be released unless authorized in accordance with this policy.

C. PROCEDURE:
1. Security Department ~~reports and~~ information are to include but are not limited to **all** any ~~Crime Report, Incident Report, Accident Report~~**RL Reports**, Daily Security Report, **Enforcement Reports, Pass-Down forms, Checklist forms, Lost/Found, Valuables, Property Custody, Whiteboard Communications, recorded or live CCTV, photographs and images,** ~~Correspondence~~, Memo E-Mail, Written Notes, Witness Statement, **Employee Information, dept schedule, any incident where S.D was involved** or any other **S,D. involved**/~~Security Department~~ related Information.
2. All ~~Security Department~~ **(S.D.)** ~~reports and~~ information will be considered confidential and will not be released by any officer. **Only** ~~T~~**t**he approved **S.D.** leadership member (**Director,** Manager or Supervisor) may release ~~the~~**any** information upon consideration **and based on a need-to-know status**.
3. During the course of each ~~S~~security ~~O~~**o**fficer's shift, the ~~O~~**o**fficer will ensure that all actions and investigations are properly documented on the appropriate Security Department report form in accordance with the current report format.
4. Any interested party not associated with the Medical Center requesting the release of any Security Department information must submit their request to the Risk Management, Legal, or Human Resources Departments. (i.e. a copy of a vehicle accident report). Only a Security Department Leadership ~~Member~~ **(Director,** Manager or Supervisor) may release the requested information after receiving approval from the above-mentioned departments.
5. Any request for Security Department information made by a member of the Medical Center regarding the Medical Center will be forwarded to the Risk Management, Legal, or Human Resources Departments. The Security Department Leadership Member also has the authorization to release information. If approved, the information will be released to the

requesting party. (i.e. request for a copy of a report about an employee issue made by a Director or Supervisor)

6. Any request for Security Department information made by a member of the Medical Center regarding a personal issue will be forwarded to the Risk Management, Legal, or Human Resources Departments.
7. Any non-adherence to this policy could lead to discipline up to termination.

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

1. Administrative Policy: Hospital Records Retention 237

Tri-City Medical Center
Oceanside, California

SECURITY
PERSONNEL

ISSUE DATE: 04/91 SUBJECT: Scheduled Time Off

REVIEWED DATE~~(S)~~: 04/94, 10/97, 05/03, 11/06, 03/09, 06/11, 07/15, 09/15 POLICY NUMBER: 303

REVISION DATE~~(S)~~: 07/03, 07/09, 09/15

Department Approval ~~Date(s)~~:	~~07/15~~05/20
Environmental Health and Safety Committee Approval ~~Date(s)~~:	~~08/15~~09/22
Administration Approval:	12/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~09/15~~ n/a
Board of Directors Approval ~~Date(s)~~:	09/15

A. PURPOSE:
1. To provide a uniform procedure for the request of Scheduled Time Off (Vacation, Holiday, Excused Time Off, Etc.) by Security Department personnel

B. POLICY:
1. All Security Officers shall follow the below listed procedure for requesting of excused time off.

C. PROCEDURE:
1. Due to the necessity of providing coverage for patient care twenty-four hours a day, seven days a week, it is necessary to set guidelines for submission of scheduled time off requests. These are guidelines only and special circumstances will be handled on an individual basis as they arise.
2. Employees wishing scheduled time off must complete the proper request form no less than two weeks (14 days) prior to the requested start date.
3. Employees wishing to trade shifts must complete the proper request form and notify the Security Manager no less than two weeks (14 days) prior to the requested start date, and will be subject to the Manager's approval. If the shift trade is due to an emergency, documentation of the emergency will be required for verification purposes.
4. Urgent and Emergency situations will be handled on an individual basis.

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY OPERATIONS

~~TRI-CITY MEDICAL CENTER~~	~~POLICIES AND PROCEDURES~~
~~Formulation: February 23, 2004~~ ~~Reviewed: 2/04, 11/06, 6/11~~ ~~Revision: 2/04~~ ~~Approvals: Director of Security~~ ~~_____~~	~~Subject: Solicitation and Union Activity on Medical Center Campus~~ ~~_____~~ ~~Page 1 of 2~~
~~Submitted By: Security Department~~	~~Procedure Manual: Security Department~~ ~~SDPPM - # 236~~

ISSUE DATE: 02/04~~February 23, 2004~~ SUBJECT: Solicitation and Union Activity on Medical Center Campus

REVIEWED DATE~~(S)~~: 02/04, 11/06, 06/11 POLICY NUMBER: 236

REVISION DATE~~(S)~~: 02/04, 06/11

Department Approval: ~~07/15~~05/20
Environmental Health and Safety Committee Approval: ~~08/15~~08/2009/22
Administration Approval: 12/22
Professional Affairs Committee Approval: n/a
Board of Directors Approval: 06/11

A. PURPOSE:
1. This ~~P~~policy is to establish a set of guidelines for Security Department personnel to utilize when making contact with Solicitors or Union Representatives. Refer to Administrative Policy # 210 Solicitation and Distribution of Literature on District Property.

B. POLICY:
1. It is the policy for the Security Department to utilize the following guidelines when interacting with Solicitors or Union Representatives

C. PROCEDURE:
1. Solicitors
   a. When Security **Department (SD)** is informed or observes ~~S~~solicitation on the Medical Center Property, the responding Officer will make **verbal** contact with the person **and** ~~asking if they are here as a patient or visiting a patient~~ **for their business on property**.
   b. Once it is determined that the ~~S~~solicitor is not here for a legitimate patient care reason, they will be informed that they are in violation of Tri-City District ~~P~~policies regarding ~~S~~solicitation and the ~~D~~distribution of **unauthorized** ~~M~~materials and that they are required to leave the property.
   c. If the ~~S~~solicitor refuses to leave, ~~contact~~ **inform** the Oceanside Police Department to have the person removed as a ~~T~~trespasser.
   d. A ~~Crime/Incident~~ **daily security** report **entry is required or an electronic incident report per Security Department Leadership (lead officer, supervisor, manage or**

director) should be completed if the ~~P~~police ~~D~~department was called to have the person removed or if there are any unusual circumstances regarding the ~~S~~solicitor.

2. Union Representatives
   a. When Security is informed or observes a Union Representative on the Medical Center Property, the responding Officer will make **verbal** contact with the person ~~asking if they are here as a patient or visiting a patient.~~**by asking for their business on property as the Union Representative must have informed and received authorization from the Head of Human Resource (HR)** ~~Department's Director~~**.**
   b. Once it is determined that the Union Representative is not here for a legitimate patient care reason **and had not previously informed the H.R. Director**, they will be informed of Tri-City District ~~P~~policies regarding ~~S~~solicitation and the ~~D~~**d**istribution of **unauthorized** ~~M~~**m**aterials prohibits ~~S~~**s**olicitation and ~~D~~**d**istribution or ~~P~~**p**rinted ~~M~~**m**aterials on the ~~D~~district ~~P~~property or ~~P~~property in the ~~D~~**d**istrict's control.
   c. If the Union Representative continues to ~~S~~**s**olicit or ~~D~~**d**istribute ~~M~~**m**aterials on the Medical Center Property ~~they will be asked to leave the property.~~**, the responding Officer will inform the Supervisor, Lead or Designee of the activity and follow-up with the Human Resources Department's Director for further instructions.**
   ~~d. If the Union Representative refuses to leave, contact the Security Supervisor or Director and inform them of the Union Representative's actions. If approved Contact the Oceanside Police Department to have the Union Representative removed from the property as a Trespasser.~~
3. Restricted Areas
   a. At no time should any Solicitor or Union Representative be in any Patient Care or Restricted area of the Medical Center. Only Authorized Personnel or Authorized Patients or Visitors may be in a Patient Care or Restricted Area.
   b. Anytime a Solicitor or Union Representative is in a Patient Care or Restricted area they are to be removed immediately ~~and addressed with the appropriate fore listed procedure~~.
   c. Union Representatives may only be allowed in the East side Main Lobby or the Cafeteria upon approval from the H.R. Director; specifically, employees' break-rooms are not an authorized locations unless authorized by the Head of HR.
   ~~b.~~**d. Employee break-rooms' communication boards are allowed to display union material, but the material must have the Head of H.R.** ~~Director's~~ **initials.**

Tri-City Medical Center
Oceanside, California

SECURITY
SECURITY ADMINISTRATION

ISSUE DATE:	04/91	SUBJECT:	Work Schedule and Mandatory Overtime
REVIEW DATE:	05/94, 12/96, 03/02, 05/03, 11/06, 03/09, 05/11, 03/12, 05/13	POLICY NUMBER:	106
REVISION DATE:	~~303~~/02, 07/03, 05/11, 11/20		

Department Approval:	~~05/20~~08/22
Environmental Health and Safety Committee Approval:	~~08/20~~09/22
Administration Approval:	~~10/20~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	11/20

A. PURPOSE:
1. To establish a standard departmental procedure **and information exchange** for the department's**, shifts,** schedule and mandatory overtime **because of safe-staffing requirements**.

B. POLICY:
1. All Security Department Personnel shall follow the below listed ~~procedure~~**procedures** to ~~insure~~**ensure** that safe staffing ~~levels~~**requirements** are maintained.

C. PROCEDURE:
1. **Shift**~~Schedule.~~
2. ~~It will be the responsibility of each officer to check the provided department schedule on a routine basis~~
   a. **Because of established department standards, policies and procedures as well as to immediately address TCMC's patient and operational safety and security needs, all Security Department. personnel is required to and will remain clocked-in and remain on-property in order to maintain continuity of safety; this procedure will work in coordination with breaks and lunches as authorized by the Security Department. Director, Manager, Supervisor and lead officers in addition to department. standards.**
   b. **The Security Department's. lead officer, supervisor, manager or director may change or modify a shift's start and ending time range in order to uphold optimal and safe staffing requirements or assist with a patient and operational safety and security need.**
   c. **Each security officer is required to and will check their shift's post-orders or shift information found on the department's/ communication whiteboard in the Security Department. at least on a shift because of its change or updates and due to safe staffing requirements.**
3. Schedule
   a. **Each officer is required to and will check the provided department schedule- at least once a shift** because of its changes due to safe staffing requirements.

b. The schedule is projected one month in advance and is established so as to provide the optimal amount of officers on property for safe- staffing ~~levels~~. There will ~~be~~ no accommodations made for any ~~one single~~ security officer.

c. The Security Department's Leadership ~~[~~**(Director,** Manager ~~or~~, Supervisor~~]~~ **or lead officer)** has the authority to update or change the schedule on a safe-staffing ~~level~~ needed basis.

~~2.~~**4.** Mandatory Overtime Rotation

a. In order to minimize **liability, negligence,** health and safety ~~risk to~~**risks for** all **physicians, volunteers, contractors,** staff, patients and visitors ~~to the facility, a~~ mandatory ~~four hours~~ overtime ~~from the proceeding~~**, or a pre-determined security officer, must stay over their scheduled** shift ~~will be enacted~~ when **safe** staffing ~~falls below the minimum number needed to safely man fixed mandated posts as required~~**requirements** and ~~the capability to respond to emergency calls of service throughout the facility or parking areas.~~**patient and operational safety and security needs are identified in advance or when discovered.**

b. A staff list will be created determining which ~~staff member~~**security officer** will be next to work the mandated overtime **or safe-staffing coverage** when necessary, but volunteers will be accepted first.

c. If / when the designated staff has worked their mandated overtime **or safe-staffing coverage shift,** their name will automatically be placed on the bottom of the list, and the second officer on the list will be moved to the top position to work the overtime **or safe-staffing shift** on a rotating basis.

d. ~~The~~**. Each** security ~~officers are responsible for knowing who~~**officer** is ~~scheduled for~~**required to and will check** the mandatory overtime ~~and are encouraged to review~~**or safe staffing rotation information found within** the **department's** schedule ~~daily.~~**at least once a shift because of its changes due to safe staffing requirements.**

~~e. A security officer may only work 12 hours total and no more.~~

e. Only the Security Department. Director, Manager of Supervisor may approve overtime or any additional shifts and hours outside of an officer's regular schedule.

f. Any non-adherence to this policy may lead to discipline up to termination.

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

ISSUE DATE: 10/94 SUBJECT: Discharge Process

REVISION DATE~~(S)~~: 01/00, 06/03, 02/10, 06/13, 12/19

Women and Newborn Services Department Approval:	~~10/18~~07/22
Department of OB/GYN Approval:	~~06/19~~07/22
Department of Pediatrics Approval:	~~02/19~~11/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~10/19~~11/22
Administration Approval:	~~11/19~~12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

A. DISCHARGE PRIVILEGES:

1. P~~Only those p~~hysicians with active privileges at Tri-City Medical Center are able to discharge patients.

~~1.~~2. Discharge orders will be placed electronically by the provider.

~~2. Problems arising about such privileges should be referred to the medical staff office or the administrative coordinator during off hours.~~

B. DISCHARGE PLANNING:

1. Discharge planning begins upon admission.
2. Social Service referrals are~~should be~~ implemented for the following (including but not limited to):
   a. Adoptions
   b. Infants going into foster care
   c. Patients with no prenatal care
   d. Teen moms
   e. Positive toxicology results
   f. Mothers of newborns in the Neonatal Intensive Care Unit (NICU) or in another facility
   g. All mothers and families experiencing perinatal loss
   ~~2.~~h. High risk mother or newborn, as defined by the provider

~~a. Patients presenting Tri-City Medical Center with no prenatal care.~~
~~b. Adolescent mothers.~~
~~c. Mothers not living in the family home, (e.g. a recovery center).~~
~~d. Mothers admitted as antepartum patients.~~
~~e. Actual or potential NICU admission of infants.~~

~~3. Depending on the prenatal care provider, patients may be evaluated by case managers, discharge coordinators, etc. from either Tri-City Medical Center or an outside agency.~~

~~C. DISCHARGE NOTIFICATION:~~

~~1. Notification of a transfer within the facility, pending discharge, and actual discharge is done via the hospital information system.~~

~~D.~~C. DISCHARGE CRITERIA:

1. Maternal Ddischarge Ceriteria ~~incorporates~~:
   a. Physical Assessment and Lab Results
      i. Vital signs are within normal limits
      ii. Uterine involution and lochia are appropriate
      iii. Signs and symptoms of wound or incisional infection are absent

iv. Urinary output is appropriate
v. Pertinent laboratory tests are documented and assessed

b. Maternal Readiness
i. The mother can ambulate without difficulty
ii. The mother's pain is adequately controlled
iii. The mother can eat and drink without difficulty
iv. The mother can verbalize and demonstrate readiness to care for herself and for her newborn

c. Care Plan Outcomes
i. Ensure that the mother is aware of care team members, including personal support systems and professional care providers, and ensure that necessary contact information is provided in writing
ii. Ensure that postpartum follow-up visits have been arranged, and that written instructions have been provided
iii. Validate that mothers with hypertension know that they should be assessed within 72 hours and assessed again between 7 to 10 days postpartum
iv. Mother can verbalize signs of postpartum complications such as preeclampsia, and about the importance of glucose screening, for women whose pregnancies were complicated by hypertension or diabetes

d. Emotional and Mental Health
i. Social Service consult has been completed as necessary
ii. Information about postpartum depression and postpartum anxiety has been provided
iii. Complete and document an assessment for depression and anxiety
1) Follow-up information and referrals have been provided, as needed

e. Anticipatory Guidance
i. The mother has received education about caring for herself following discharge, including how to recognize deviations from "normal," and is prepared to recognize and to respond to warning signs of potential complications
~~1.~~ii. The mother has received information about activity, exercise, common discomforts, and relief measures for the postpartum period

~~a. Stability of physiologic parameters.~~
~~b. Readiness of the home environment.~~
~~c. Psychological coping ability and readiness for independent functioning of the parent/caregiver.~~
~~d. Psychological coping ability and readiness for independent functioning after discharge.~~

2. Newborn Ddischarge Ceriteria ~~incorporates~~:
a. Physical Assessment and Lab Results
i. Vital signs within normal limits
ii. Newborn has had a physical assessment by a provider
iii. Newborn has passed at least one stool and is urinating regularly
iv. Newborn blood type and direct coombs test completed, if indicated
v. Newborn has been evaluated for jaundice
1) If at risk, further evaluation has been completed and follow-up plans are in place
vi. Newborn has been evaluated for sepsis based on maternal risk factors and it is determined the infant is not at risk
vii. Newborn metabolic screen has been completed

b. Care Plan Outcomes
i. Ensure that the parent(s) are aware of care team members, including professional care providers, and ensure that necessary contact information is provided in writing

ii. Ensure that newborn follow-up visits have been arranged, and that written instructions have been provided

c. Newborn Care
   i. Newborn shows no signs of distress with feedings
   ii. Newborn has received all immediately necessary vaccines and medications
   iii. Newborn has passed a hearing screen or a follow up outpatient appointment has been scheduled
   iv. CCHD screen or echocardiogram has been completed

d. Parent(s) Education
   i. The parent(s) can verbalize and have received written education about the following:
      1) Caring for the newborn following discharge, including how to recognize deviations from "normal", and is prepared to recognize and to respond to warning signs of potential complications
      2) Frequency of feeds, positioning, latch-on, and adequacy of swallowing, if the infant is breastfed
      3) Frequency of feeds, amount, formula preparation, if the infant is formula fed
      4) Frequency of stooling and urination
      5) Infant safety measures
      6) Bathing
      7) Signs and symptoms of illness or jaundice
      8) Safe sleep practices
      9) Care of cord, skin and genitals
      ~~2.~~10) California car seat law

~~a. Stability of physiologic parameters.~~
~~b. Readiness of the home environment.~~
~~c. Psychological coping ability and readiness for independent functioning of the parent/caregiver.~~

~~E.~~D. DISCHARGE ORDERS:

1. Maternal Discharges
   ~~a. Transfer/discharge orders are to be electronically entered by the obstetrician.~~
   ~~b. Minimum content for orders for transfer of service within the facility will include:~~
      ~~i. Transfer to (e.g. ICU).~~
      ~~ii. Designate the physician to whom care is being transferred, if applicable.~~
   ~~c. Minimum content for transfer to other facilities will include:~~
      ~~i. Transfer to (name of facility)~~
   ~~d.~~a. Minimum content for discharge will include:
      i. Discharge to (i.e., home, recovery center)
      ii. ~~Time frame for f~~Follow-up ~~care~~**appointment date and time or time frame for appointment**~~.~~
      iii. Diet~~.~~
      iv. Medications ~~(if applicable)~~ **(home medications and new medications)**~~.~~
      v. Self-care and/or treatments~~.~~
2. Newborn discharge
   ~~a. Transfer/Discharge orders are to be electronically entered by the pediatrician/family practice physician:~~
   ~~i. Transfer orders may also be written by the neonatologist.~~
   ~~b.~~a. Minimum content for discharge will include:
      i. Discharge to (e.g., home, foster care)~~.~~
      ii. ~~Time frame for f~~Follow-up ~~care~~**appointment date and time or time frame for appointment**~~.~~
      iii. **Diet and feeding instructions** ~~Feedings and diet.~~

iv. Medications (if applicable)~~.~~
v. Treatments (if applicable)~~.~~

~~F. DISCHARGE DOCUMENTATION:~~
~~1. Intra/Interfacility transfer~~
~~a. Transfer within the facility will include the medical record.~~
~~b. Refer to:~~
~~i. Women and Newborn Services (WNS) Standardized Procedure: "Medical Screening Exam to Rule Out Labor".~~
~~ii. TCMC Administrative Policy 506: "EMTALA: Emergency Medical Screening" for required documentation for a maternal transfer to another facility.~~
~~2. Discharge of newborn to parent(s)/caregiver(s):~~
~~a. Copy of completed newborn discharge instructions.~~
~~b. Discharge instructions include:~~
~~i. Signs and symptoms of potential complications.~~
~~ii. Educational information.~~
~~iii. Instructions for follow-up appointment(s).~~
~~iv. Instruction in use of equipment and/or treatments.~~
~~3. Discharge of mother~~
~~a. Copy of completed maternal discharge instructions.~~
~~b. Discharge instructions include:~~
~~i. Signs and symptoms of potential complications.~~
~~ii. Educational information.~~
~~iii. Instructions for follow-up appointment(s).~~
~~iv. Instruction in use of equipment and/or treatments.~~

~~G.~~E. DISCHARGING A PATIENT(S) FROM WOMEN AND NEWBORN SERVICES (WNS):

1. Patient's discharged from WNS must be accompanied to their vehicle by a WNS staff member or Tri-City volunteer.~~All patients to be discharged from Tri-City Medical Center must be accompanied by WNS services staff or volunteer.~~
2. Mode of discharge:
   a. Adults are to be discharged via wheelchair
   b. Newborns/Infants will be discharged via car seat or in caregivers' arms and placed in car seat when at vehicle.

F. RELATED DOCUMENT(S):

1. Referrals to Social Services for Patients Identified to be High Risk
2. Discharge Planning, Homeless Patient Policy
3. Newborn Identification Banding and Electronic Alarm Device

G. REFERENCE(S):

1. Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. ObstetGynecol 2018;131: e140-50.
~~1.~~2. Suplee, P.D. & Janke, J. (Eds.) (2020). AWHONN Compendium of postpartum care, (3rd Ed). Washington, DC: Association of Women's Health, Obstetric and Neonatal Nurses.
~~a. Refer to infant security policy.~~
~~2. Mothers are discharged via wheelchair.~~
~~3. Newborns are discharged:~~
~~a. a. In the arms of mother/caregiver seated in wheelchair .~~
~~i. Held by the mother and/or banded significant other (SO) or father of the baby (FOB) .~~
~~4. Instruct the person providing transportation to move the vehicle to the designated entrance.~~
~~a. If family/caregiver does not have transportation to their residence after the discharge order is processed, contact the WNS clinical manager/charge nurse, social worker, case manager, or administrative coordinator for further assistance in obtaining transportation.~~

~~i. Transport of mothers and/or infants to their homes is NOT to be done by staff members.~~

Tri-City Medical Center	Women and Newborn Services (WNS)
PROCEDURE:	SKIN TO SKIN CONTACT AFTER BIRTH
Purpose:	To define the provision of skin to skin contact between mother **(or designee)**~~, father and/or identified individual by the family~~ and **newborn**~~infant~~ following birth.
Supportive Data:	Early skin-to-skin contact (STS) is a recommended best practice for healthy term newborns~~.because STS provides both newborns and mothers with numerous health benefits.~~ Evidence shows that placing **newborns**~~infants'~~ skin-to-skin with their mothers immediately after birth increases the success and lengthens the duration of breastfeeding, promotes bonding, and facilitates thermoregulation. STS can also be accomplished with another individual identified by the family, if the mother is unable to experience this~~ for whatever reason~~.

A. POLICY~~CONTENT~~:

1. Initiation of STS as soon as possible after birth (vaginal or cesarean birth) shall be supported as a standard of practice if the ~~infant is asymptomatic, no contraindications are present, and~~ mother and **newborn**~~infant~~ are medically stable.
2. **If the mother has tested positive for a blood borne pathogen or is currently infected with a sexually transmitted disease the newborn should receive a bath after delivery prior to STS or the administration of medications/vaccines**~~If the mother is Hepatitis B or Human Immunodeficiency Virus (HIV) positive, infant should be bathed as soon as possible and receive necessary medications per protocols prior to implementing STS~~.
3. Contraindications to immediate skin to skin include, but are not limited to:
   a. A mother who received general anesthesia
   b. A mother who has postpartum hemorrhage concerns
   c. A **newborn**~~n infant~~ with a ~~five minute~~**five-minute** APGAR score of 6 or less
   d. A **newborn that is**~~premature infant~~ less than 35 weeks **in** gestation.

B. PROCEDURE:

1. Dry and stimulate **newborn**~~infant~~ following Neonatal Resuscitation Program (NRP)~~ protocol~~. ~~and~~
~~1.~~2. ~~p~~Place **the newborn**~~infant~~ prone on the mother's chest wearing~~ only~~ a hat~~, and/or~~ diaper **and a warm blanket over both of them.**~~.~~
~~2.~~3. The mother will **not** have **any**~~on no~~ clothing/sheets/blankets between herself and the **newborn**~~infant~~ to **prevent** disruption **of** ~~the~~ STS. ~~The infant should be able to access the~~
~~3. mother's breasts with no interference from any bras, gowns, etc.~~
~~A warm blanket will be laid over the infant and mother once the infant is placed skin to skin.~~
4. Continue uninterrupted STS **contact for the first hour of life and/or** until the first ~~breast~~feeding occurs.~~ (First breastfeeding should occur within the first hour of life).~~
   a. **Encourage the mother or designee to be in STS contact for every feed and whenever desired.**
   ~~b. After the first breastfeeding, STS will continue as long as mother desires and is feasible for the infant.~~
~~5. In the case where the mother chooses to formula feed, the initial period of STS will last at least one hour. (The infant should still feed within the first hour of life).~~
~~6.~~5. In the case of Cesarean (C/S) birth, the **newborn**~~infant~~ will be placed skin to skin with the mother in the Operating Room (OR) ~~as soon as possible after birth and~~ after the initial resuscitation and **assessment**~~evaluation~~ at the warmer by the resuscitation team. ~~The infant will not go from C/S birth directly to STS without assessment from the resuscitation team.~~
   a. Mother's arm**s** will be unsecured from arm board at the initiation of STS and **the** ~~infant~~ **newborn will** ~~should~~ be positioned in a way that does not interfere with **mom's**~~her~~ airway **or** ~~and the~~ surgical site.

Department Review	Department of OB/GYN	Perinatal Collaborative Practice	Department of Pediatrics	Department of Anesthesiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
08/16, 05/22	06/17, 08/22	07/17	08/17, 11/22	03/18	n/a	05/18, 11/22	12/22	06/18	06/18

b. STS will continue in the OR as long as mother is able to maintain contact and **newborn**~~infant~~ remains stable.

c. The ~~t~~Transitional care nurse will remain with the **newborn**~~infant~~ during STS and is responsible for ~~removing~~ the **newborn**~~infant~~ if the mother or **newborn**~~infant~~ becomes unstable.

d. Upon arrival to the recovery room, uninterrupted STS will continue until the first ~~breast~~feeding occurs.

e. If **the** mother is unable to provide STS in the OR, she may designate **a** ~~the father, a family member, or other~~ support person to provide STS.

~~i. If anyone other than the mother is to provide STS, it must be done in the recovery room on Labor and Delivery in a stationary chair.~~

~~ii.~~**i.** The individual identified, will be offered a hospital gown to wear with gown opening to the front and asked to remove shirt~~, bra, etc.~~ to ensure **the newborn**~~infant~~ is able to be positioned skin to skin**, with a warm blanket placed over them.** ~~.~~

~~iii.~~**ii.** Efforts should be made to ensure privacy with a privacy curtain, portable screen, and/ or individual seated in a position facing away from traffic patterns.

~~7.~~**6.** ~~Routine newborn procedures (measurements, initial assessment, medications, bathing) will be postponed until after the first feeding.~~ **Newborn**~~Infant~~ monitoring, vital signs (temperature, heart rate, respiratory rate), and assessment can continue **during** ~~while the infant is~~ skin to skin with the mother/**designee** ~~identified support person~~.

~~8.~~**7.** If mother and **newborn**~~infant~~ require initial separation, staff shall ensure skin to skin **occurs** and **feeding is initiated/resumes** ~~initiations of breastfeeding begin/resume~~ as soon as medically possible.

~~9.~~**8.** If **the newborn** ~~infant~~ demonstrates any signs of distress, requires further assessment/interventions, or if mother is unable to provide STS and no one has been identified to provide STS, the **newborn**~~infant~~ shall be brought to the warmer ~~by delivering provider or nurse~~ and the "Care of the Newborn Standardized Procedure **will**~~should~~ be implemented.

C. REFERENCE(S):

1. Beiranvand, S., Valizadeh, F., Hosseinabadi, R., & Poumina, Y. (2014). The effects of skin to skin contact on temperature and breastfeeding success in full term newborns after cesarean section delivery. International Journal of Pediatrics, Vol 2014, p 1-7.

~~2. Carmichael, A., Matoulionis, B. (2014) Implementing the gentle c-section: A birth experience more like a vaginal delivery. *JOGNN (43)* S1, S13~~

~~3.~~**2.** Elliot-Cater, N., Harper, J. (2012) Keeping mothers and newborns together after cesarean. *Nursing for Women's Health (16)* 4, 290-295

~~4.~~**3.** Grassley, J. and Jones, J. (2014). Implementing skin to skin contact in the operating room following cesarean section birth. Worldview on Evidence Based Nursing, 11:6 414-416.

~~5.~~**4.** Haxton, D., Doering, J., Gingras, L., Kelly, L. (2012) Implementing skin-to-skin contact at birth using the Iowa model. *Nursing for Women's Health (16)* 3, 220-230.

~~6.~~**5.** **Rice Simpson, K., Creehan, P., O'Brien-Abel, N., Roth, C., Rohan, A. (2021) Perinatal Nursing, 5th edition. Philadelphia, PA.** ~~Stevens, J., Schmid, V., Burns, E., & Cahlen, H. (2014) Immediate or early skin to skin contact after cesarean section: A review of the literature. Maternal and Child Nutrition, 10, pp 456-473.~~

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE: 06/14 SUBJECT: Standards of Care – Newborn

~~ISSUE DATE: 06/14~~
REVISION DATE~~(S)~~: 02/17

Department Approval ~~Date(s)~~:	03/22~~07/16~~07/22
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Administration Approval:	12/22
Professional Affairs Committee Approval ~~Date(s)~~:	~~02/17~~ n/a
Board of Directors Approval ~~Date(s)~~:	02/17

~~A. PREAMBLE:~~

~~1. Nursing practice in the care of Women's and Newborn's Services (WNS) is delivered in an environment that respects the goals, preferences, and patient rights of the unique dyad of the maternal-fetal unit and/or mother-baby couplet and the family from admission, through the episode of care, to discharge. The Women and Newborn nursing staff shall use established TCMC and unit specific policies and procedures, and shall adhere to the standards and guidelines set forth by the California Nurse Practice Act, American Nurses Association (ANA), Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN), and National Association of Neonatal Nurses (NANN). Couplet care is based on a philosophy that embraces the family's spiritual and cultural values, is ethically relevant and is grounded on evidence-based practices.~~

~~B. DEFINITIONS:~~

~~1. Standards of Professional Nursing Practice: "Authoritative statements of the duties that all registered nurses, regardless of role, population or specialty are expected to perform competently (American Nurses Association (ANA), 2010, p.2).~~

~~1. Scope of Nursing Practice: "describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2010)".~~

~~2. Standards: "Authoritative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2010, p. 67).~~

~~a. "Standards of care are Standards of Professional Nursing Practice."~~

~~3. Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient focused care. The nursing process as outlined by the ANA 2016 includes the following:~~

~~a. Assessment: A systematic, dynamic way to collect and analyze data about a client i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life-style factors". An assessment includes subjective and objective data.~~

~~i. Subjective what the patient says~~

~~ii. Objective observation based on assessment findings~~

~~iii. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items needed reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to : sleep/alert status, cry reflexes, tone, movement, respiratory symptoms, respirations, respiratory pattern, room air/oxygen, abdominal description, skin color, skin temperature and neonatal skin integrity.~~

~~b. Diagnosis: A nurses' clinical judgment about the client's response to actual or potential health conditions or needs.~~

~~c. Outcomes/Planning: "Based on the assessment and diagnosis. Outcomes are measurable and achievable short and long range goals".~~
~~i. Planning: (Care Plan i.e., Plan of Care): A comprehensive outline of care to be delivered to attain expected outcomes.~~
~~d. Implementation: "Nursing care is implemented to the care plan. This is "continuity of care" from the patient during hospitalization and in preparation for discharge needs".~~
~~e. Evaluation: The process of determining both "The patient's status and the and the effectiveness of nursing care. It is a process that involves continuously evaluation of the patient and the modifications to the Plan of Care".~~
~~4. Patient: Recipient of nursing care.~~
~~5. Health Care Providers: Individuals with special expertise who provide healthcare services or assistance to clients.~~
~~6. Significant Others: Family members and/or those significant to the client.~~
~~7. Reasonable and a Timely Manner: Defined as within 4 hours after completion of assessments or care provided.~~

~~B. REGISTERED NURSES:~~
~~1. Use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence based knowledge of human experiences and responses to collaborate with patient and her fetus or newborn to assess, diagnose, identify outcomes, plan, implement, and evaluate care. Nursing interventions are intended to produce beneficial effects, contribute to quality outcomes, and above all, do no harm. Nurses evaluate the effectiveness of their care in relation to identified outcomes and use evidence based practice to improve care (ANA, 2010)."~~

~~C. WNS NEWBORN STANDARDS OF PRACTICE:~~
~~1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.~~
~~2. A comprehensive and dynamic database shall be maintained on all patients admitted to the hospital.~~
~~3. The patient can expect to have appropriate confidentiality maintained at all times.~~
~~4. The patient can expect that the RN shall ensure the optimal desired level of privacy.~~
~~5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.~~
~~6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the healthcare team to establish an integrated plan of care.~~
~~7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interview, patient medical records, and from other members of the healthcare team.~~
~~8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.~~
~~9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.~~
~~10. An appropriate plan of care shall be formulated for each patient.~~
~~11. The plan of care will be implemented according to the priority of identified problems or needs.~~
~~12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.~~
~~13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.~~

~~D. GENERAL NEWBORN NURSING ASSESSMENT:~~

A. GENERAL NEWBORN ASSESSMENT:

1. ~~STANDARDS OF CARE:~~ Vital Ssigns (VS):
   a. **Vital signs shall include: axillary temperature, apical heart rate, respiratory rate, SpO2 (prn) and pain level.**
      i. **The initial set of VS will be taken within 30 minutes of birth, then VS every 30 minutes until a total of 4 sets obtained.**

1) If the mother and newborn are stable, VS may be assessed while infant is skin-to-skin or breastfeeding.

ii. After two hours of age, VS will be performed every 4-hours until 12 hours post birth.

iii. After 12 hours, VS will be performed every 6-hours for the remainder of admission and within 1-hour of discharge.

iv. Pain assessment will be done on admission, with the initial shift system assessment, with each set of VS and as needed.

1) Neonatal Infant Pain Scale (NIPS) will be used for the pain assessment of the neonate.

b. Normal range VS for Newborns:

i. Temperature: 36.5°C-37.5°C (97.5°F-99.5°F)

ii. Pulse: 110-160 beats per minute (may be lower due to sleep status).

iii. Respirations: 20-60 breaths per minute (may be lower due to sleep status).

iv. Any deviation from the normal range, will result in a reassessment within 20-60 minutes.

~~1.~~

~~a. Vital sings with the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age, upon transfer of care, then every 4 hours until 12 hours post-birth, then if stable, every 6 hours until discharge with vital signs, prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients, or per provider's orders.~~

~~2. Vitals shall include:~~

~~a. Axillary temperature documented in Celsius.~~

~~b. Apical Heart Rate (AHR).Respiratory Rate (RR). SpO_2, prn spot check when clinically indicated.~~

~~c. Pain level.~~

~~3. If mother and infant stable, vital signs will be assessed while infant is skin-to-skin or breastfeeding within the first 30 minutes of birth, at one hour, then every 30 minutes until 2 hours of age.~~

~~a. After two hours of age, the vitals will be taken every 4 hours until 12 hours post birth, then if stable after the 12 hours, every 6 hours until discharge (unless condition warrants more frequent vital signs or per provider order) and prior to discharge per Patient Care Services (PCS) procedure, Discharge of Patients.~~

~~b. Any deviation of temperature, pulse, respirations and/or normal limits should warrant reassessment within 30-60 minutes.~~

~~c. Notify provider if reassessment outside of normal limits.~~

~~d. Any deviation from normal limits warrants further assessments, documentation, appropriate intervention and provider notification as needed.~~

~~e. Oximetry spot checks may be considered based on vital signs and clinical assessments.~~

~~f. Normal ranges for newborns after transition (a few hours after birth).~~

~~g. Temperature range: 97.5°F – 99.5°F (36.5°C – 37°5C).~~

~~h. Pulse range: 110-160 bpm (may be lower due to sleep status).~~

~~i. Respirations: 30-60 per minute (may be lower due to sleep status).~~

~~E. STANDARDS OF CARE: NEWBORN PAIN ASSESSMENT:~~

~~1. Assessment: Pain per Pain Management Policy~~

~~a. The Neonatal Infant Pain Scale (NIPS) is used for pain assessment of the neonate. The infant shall be assess on a scoring system based on 5 parameters, (Behavioral and one physiologic parameter):~~

~~i. Facial expression~~

~~ii. Cry~~

~~iii. Breathing patterns~~

~~iv. Arms~~

~~v. Legs~~

~~vi. State of arousal~~

~~2. Pain assessment will be done on admission at the initial shift assessment with vital signs, and as needed.~~

~~3. Patient may have fussiness due to delivery or handling versus pain. Reassessment does not need to occur in these instances.~~

~~4. Pain will be assessed and assigned a score as follows:~~

~~Assessment of Pain~~	~~Intervention~~
~~No pain~~	~~NIPS 0~~
~~Mild pain~~	~~NIPS less than 2~~
~~Mild to moderate pain~~	~~NIPS 2-4~~
~~Moderate to severe pain~~	~~NIPS greater than 4-7~~

~~F.~~2. ~~STANDARDS OF CARE:~~ Intake and Oeutput:

~~1.~~a. Intake and output shall be monitored ~~as ordered and~~ as follows:

~~a.~~i. Intake:

1) Parents will be educated~~taught~~ that the breastfeeding newborn~~infant~~ should be put to breast ~~Encourage breastfeeding of the baby~~ at least 8 ~~to~~ ~~12~~ times in a 24-hour period.

a) The mother will keep a record of the newborn feedings while admitted to the hospital, and the RN will record the length, in minutes, of feedings in the newborns EHR each shift.

b) Evaluate and document LATCH assessment every shift.

2) If a mother requests her infant be supplemented with a breastmilk substitute(formula) staff will:

a) Explore and address the mother's concerns

b) The mother will be given the Risks of Formula Supplementation handout for review

c) Education to the risks of formula and informed decision of the patient will be documented

d) The mother will be given supplies and education (see Elsevier Online Skill: Formula Feeding Education)

e) The mother will keep a record of the newborn feedings while admitted to the hospital, and the RN will record the volume, in milliliters, of formula in the newborns EHR each shift.

ii. Output:

1) Document the number of wet and/or stooled diapers reported by the parent each shift.

b. Notify provider for the following:

i. Newborn has not urinated in the first 24 hours.

ii. Newborn has not stooled or passed meconium plug in the first 24 hours.

3. Measurements and Allergies:

a. Newborns will be weighed with the admission system assessment.

i. Daily weights will be performed after midnight until discharge.

b. Length, occipital frontal (largest point), abdominal and chest circumference will be measured during the admission system assessment.

c. Ballard assessment will be performed within 24 hours post-birth.

d. Newborn allergies will be monitored and documented upon admission as No Known Allergies (NKA).

4. Patient Safety:

a. Patient safety shall be assessed per the following:

i. All newborns shall have identification bands and an electronic alarm device placed at birth and be identified per WCS procedure: Newborn Identification Banding and Electronic Alarm Device

~~i.~~

~~1) In the first 24 hours, infant may be sleepy and requirements and demands may be less than the 8-12 feedings.~~

2) Evaluate and document LATCH assessment every shift until discharge.
3) A lactation consult is a separate evaluation and shall be assessed and documented as needed and/or for infants in the NICU.

ii. Formula should only be given per mother request or physician recommendation. Refer to Infant Feeding policy.

If a mother requests her infant be supplemented with a breastmilk substitute staff will:

Explore and address the mother's concerns
The mother will be given the Risks of Formula Supplementation handout for review
If mother's request for formula still persists the provider will be called for an order for breastmilk substitute
Education to the risks of formula and informed decision of the patient will be documented
The mother will be given supplies and education (see Elsevier's skills Formula Feeding Education)

b. Output:

i. Urine – the baby should have **wet diapers according to the Infant Feeding Policy**:
1) 1 wet diaper in the first 24 hours.
2) 2 wet diapers on the second day of life.
3) 3-5 wet diapers on the third-fifth day of life.

ii. Stooling:
1) Ensure the infant is passing meconium a minimum of 1 stool per day **or greater than 2 on the 2nd day**

iii. Stools will change color, consistency, and texture after meconium passed on day 1-3 (green to yellow).
1) Breastfed infants may appear to have stool that is runny and seedy once milk supply is in.

iv. Document number of wet and/or stooled diapers per shift.
v. Document color and consistency of stooled diapers per shift.

c. Notify provider:
i. Infant has not urinated in the first 24 hours.
ii. Infant has not stooled or passed meconium plug in first 24 hours.
1) Terminal meconium may have occurred after delivery. Ensure that this was reported and documented.

G. **STANDARDS OF CARE: HEIGHT AND WEIGHT/OTHER MEASUREMENTS:**
1. Weight and length will be measured and documented after birth. Daily weight will be measured and documented until discharge.
a. Weights shall be documented in grams and length in cm.
2. Occipital frontal circumference (OFC) will be measured at birth and/or when ordered by a provider.
3. Abdominal (ABD) and chest circumference will be measured at birth.
a. ABD, chest, and OFC measurements shall be documented in centimeters (cm).
b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.
c. Ballard assessment for gestational age shall be performed on all newborns within 12 hours post-delivery.

H. **STANDARDS OF CARE: ASPIRATION ASSESSMENT:**
1. Maintain aspiration precautions for newborns in transition.
a. Keep bulb syringe in clean dry area close to newborn's head for use PRN.
i. Do not use bulb suctioning for oropharyngeal and nasal malformations

b. Some newborn infants may have increased or thick secretions and may require deep suctioning.
c. Chest physiotherapy requires a provider order and is contraindicated for newborns with history of meconium fluids.
i. Chest physiotherapy when ordered shall be performed by a respiratory clinical practitioner (RCP).

I. STANDARDS OF CARE: PATIENT SAFETY:
1. The healthcare team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother-baby couplet.
2. Patient safety shall be assessed per the following:
a. The RN shall observe the patient's physical condition on admission at transfer to their unit, prior to and after procedures and as needed.
b. All newborns shall have identification bands placed at birth and be identified per WCS procedure: "Identification/Banding of Newborns."
i. Newborns admitted to TCMC following delivery outside the labor and delivery unit shall be banded with mother present prior to separation for evaluation of current condition per procedure as referenced above.
c. Newborn allergies will be monitored and documented upon admission as No Known Allergies (NKA).
i. Any known medication or food allergy shall be documented as follows:
1) The patient allergy band.
2) Allergy sticker placed on the front of the chart.
3) Medication Administration Record.
d. Orders shall be obtained, reviewed, and implemented per PCS: Provider Orders policy.
e. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
f. Patient's specimens shall be handled per PCS: Specimen Handling Procedure or by selecting the appropriate Mosby**Elsevier**'s Online Specimen Collection Procedure.
g. Electronic or medical equipment brought to TCMC shall be evaluated, used, and store per PCS: Medical Equipment brought into the Facility, policy.
h. Hand-off communication shall be provided per PCS: Hand-off Communication policy and unit specific hand-off policies.
i. Medication shall be reconciled per PCS: Medication Reconciliation policy.
j. All alarms shall be reviewed for appropriateness based on patient's status and maintained in the ON position with the volume at an audible level.

J. SYSTEM REVIEW:
1. All newborn patients will have a general system review in all systems completed and documented. Detailed system assessments shall be completed and documented as indicated by the patient's condition.

K.B. STANDARD OF CARE NEWBORN: ASSESSMENT:
1. All **newborn infants** patients admitted to WNS nursing units shall be assessed by a registered nurse **immediately after delivery to determine the best location for care.**
a. **If the infant's condition is stable and the infant does not require further interventions, immediate and sustained skin-to-skin contact between the mother and her infant should be provided for the first hour of life and/or after the initial feed.**
b. **Infants who require interventions in the delivery room will be taken to the radiant warmer.**
1.**i. Newborns who are stabilized, and determined to not need NICU admission, will be placed skin-to-skin with the mother and routine newborn care will resume.** per the following:
a. Admission and/or Transfer: Assessment.

~~i. Infant should first have skin to skin contact with mother and time to breastfeed for as long as possible according to infant stability. Complete physical exam by 2 hours of age.~~

~~ii. Upon admission to couplet care~~

2. Admission Assessment ~~– Patient History~~ (post-delivery):
   a. All inpatients shall have the **a**Admission **a**Assessment **and** ~~–~~**p**~~P~~atient **h**~~H~~istory completed within 2 hours of delivery.
   ~~b. After delivery: Vitals will be done q30 minutes times four with one assessment being a complete head to toe.~~
3. ~~Initial~~ Shift Assessment:
   a. An RN shall perform a ~~n ongoing~~ **system**~~head to toe~~ assessment **within 2 hours of the start of each shift and documented within 4 hours.**
4. **Focused Assessments will be obtained with each set of routine VS, from birth until discharged home.**
   a. **Focused assessments will include evaluation of airway, skin color; auscultation of the heart and lungs, muscle tone, and level of consciousness.**
   ~~a. as follows:~~
      ~~i. Transition RN: within 2 hours of the start of the shift.~~
      ~~ii. Newborn couplet: within 3 hours of the start of the shift.~~
      ~~b. Reassessment (Focused assessment)~~
      ~~i. After completion of an admission or an initial shift assessment, all patients shall have focused reassessment performed and documented as assessment completed and no changes since last assessment. See definition section.~~
      ~~ii. Guidelines for reassessment are as follows:~~
      ~~1) Transition RN: every 6hours until stable newborn returned to couplet care (if applicable) or more frequently if treatment or condition warrants.~~
      ~~2) Newborn couplet: after transitional assessments are complete, every 4 hours until 12 hours post birth, then if stable, every 6 hours until discharge or more frequent if treatment or condition warrants.~~
5. If the patient's guardian refuses **an** ~~a re~~assessment, document their refusal in the **EHR**~~medical record~~.

C. SYSTEM ASSESSMENT:

1. Head and neck
   a. Description/condition of head, eyes, nares, mouth, ears, neck, anterior fontanel and posterior fontanel.
2. Neurologic
   a. Facial symmetry, cry description and reflexes
3. Cardiovascular
   a. Heart rhythm and sounds, capillary refill, brachial and femoral pulse.
      i. Murmurs are to be reported to MD upon discovery.
4. Respiratory
   a. Respirations, pattern and breath sounds
      i. Keep the bulb syringe in a clean dry area close to the newborn's head for use as needed.
      ii. Do not use the bulb syringe for oropharyngeal and nasal malformations.
      iii. Chest physiotherapy requires a provider order and will be performed by a respiratory clinical practitioner (RCP).
5. Gastrointestinal
   a. Abdominal description and palpation, emesis description, bowel sounds, stool color/description and anus description.
6. Genitourinary
   a. Urinary elimination and genital description
7. Musculoskeletal
   a. Tone, movement, clavicles, arms, palmar creases, hands/fingers, back/spine, inguinal/buttock crease, hips, legs and feet/toes.

8. Integumentary
   a. Skin color, integrity, moisture, temperature, turgor and mucous membrane.
   b. After a minimum of 24 hours of life, a stable newborn should receive an initial bath.
      i. Earlier bathing may be considered per specific parental request, meconium stained infant, or malodorous fluid, provided the newborn's temperature is within normal range.
      ii. The newborn whose mother is infected with a blood borne pathogen or current sexually transmitted disease should receive a bath as soon as possible after delivery and prior to administration of medications/vaccines.
9. Umbilicus
   a. Umbilicus description, vessel count and drainage.
   b. Keep the cord dry and clean if cord becomes soiled with urine or stool, cleanse with water and gauze.

~~L.~~

~~M. STANDARDS OF CARE 1.1: ADMISSION ASSESSMENT NEUROLOGICAL SYSTEM REVIEW:~~
~~1. Neurological: System Review.~~
~~2. Assess for the following:~~
~~a. Periods of alertness.~~
~~b. Symmetric features and movements~~
~~c. Posture~~
~~d. Tone~~
~~e. Tremors or jitteriness~~
~~3. Seizure activity.~~
~~a. Facial nerve paralysis.~~
~~b. Newborn reflexes (Moro/startle, reflex, rooting, grasp, plantar, and Babinski reflexes).~~
~~c. Assess if reflexes are symmetrical.~~
~~i. Birth trauma of the head, assess for risk factors.~~
~~ii. Operative assist during delivery process.~~
~~d. Molding or bruising of head, presence of.~~
~~i. Abrasions.~~
~~ii. Caput succedaneum.~~
~~iii. Cephalohematoma.~~
~~e. Eyes:~~
~~i. Sclera – clear, redness, hemorrhage.~~
~~ii. Drainage.~~
~~4. Abstinence scoring needs continuous monitoring by RN to assess for signs and symptoms of withdrawal. See Neonatal Abstinence Scoring policy.~~

~~N. STANDARDS OF CARE 1.2: ADMISSION ASSESSMENT CARDIOVASCULAR SYSTEM REVIEW:~~
~~1. Cardiovascular System Review.~~
~~a. Assess heart sounds in all auscultatory areas; note regular or irregular apex or point of maximal impulse (PMI) at left third or four intercostal space.~~
~~i. Murmurs should be reported to MD with notification of birth.~~
~~ii. Murmurs that are present after 12 hours of life should be reported and evaluated to rule out underlying structural abnormalities.~~
~~1) Notify provider immediately if infant is symptomatic.~~
~~2) Notification of the stable infant during provider rounds the next morning is appropriate or notification via the well baby line.~~
~~b. Check capillary refill.~~
~~c. Check edema location and grade.~~
~~d. Palpate bilateral brachial and femoral pulses of the newborn.~~
~~e. Assess peripheral perfusion; skin warm and dry.~~
~~f. Assess newborn's fontanels – anterior and posterior.~~
~~i. Flat, depressed, bulging.~~

ii. Soft, tense.

O. STANDARDS OF CARE 1.3: ADMISSION ASSESSMENT PULMONARY SYSTEM REVIEW:
1. Pulmonary: System Review.
a. Check oxygen delivery devices if applicable.
b. Check amount oxygen flow/FiO_2 if applicable.
c. Assess respiratory effort.
d. Auscultate breath sounds all lobes.
e. Assess sputum amount, color, and consistency.
f. Assess for presence of cough.
g. Assess for presence of artificial airway, tubes, and drains.
h. Assess chest expansion for symmetry.
2. In addition to above:
a. Expected findings for chest/lungs:
i. Patency of airway.
ii. Patency of nares.
1) Presence of congestion or drainage.
2) Symmetric, barrel shaped, with equal anteroposterior and lateral diameters.
3) Slight subcostal and intercostal retractions are common during transition
4) Bilateral bronchial breath sounds. Fine crackles and transient hoarseness are normal during transition.
5) Respiratory rate and effort.
b. Document all findings, notify provider for abnormals. Assess for:
i. Tachypnea – persistent respiratory rate greater than 60 per minute.
ii. Grunting.
iii. Significant retraction.
iv. Questionable color.
v. Lack of breath sounds in one or more lobes.
vi. Oximetry spot checks based on vital signs and clinical assessments.

P. STANDARDS OF CARE 1.4: ADMISSION ASSESSMENT GASTROINTESTINAL (GI) SYSTEM REVIEW:
1. GI: System Review
a. Assess contour/tone of abdomen.
b. Assess for vomiting.
c. Auscultate for presence of bowel sounds in all four quadrants.
d. Assess bowel function including or last stool.
2. In addition to above assess for:
a. Maternal risk factors:
i. Polyhydraminios.
ii. Cesarean delivery.
iii. Maternal intrapartum bleeding.
iv. Meconium stained fluid.
b. Warning signs:
i. Green bilious emesis.
ii. Presence of blood in emesis or stools.
iii. Tense or tender abdomen.
iv. Abnormal distention.
v. Notify provider immediately for presence of warning signs.

Q. STANDARDS OF CARE 1.5: ADMISSION ASSESSMENT GENITOUTINARY SYSTEM REVIEW
1. Genitourinary (GU) System Review
a. Assess urine color and frequency.
b. Assess for bladder distension if no urination in 24 hours.
c. Assess external anatomy as applicable.

2. In addition to above, assess for:
   a. Females:
      i. Presence of labial skin tags and/or edema.
      ii. Presence of discharge.
      iii. Presence of ambiguous genitalia.
   b. Males:
      i. Location of meatus (hypospadias, epispadias).
      ii. Condition of foreskin.
      iii. Presence of descended testes.
      iv. Condition of scrotum (hydrocele, hernia, etc.).
      v. Presence of ambiguous genitalia.
      vi. Assess circumcision site when applicable.

R. **STANDARDS OF CARE 1.6: ADMISSION ASSESSMENT MUSCULOSKELETAL SYSTEM REVIEW:**
1. Musculoskeletal System Review.
   a. Presence of joint or musculoskeletal abnormalities.
   b. Full range of motion against gravity, some to full resistance of all extremities.
   c. Movement appropriate for age.
2. In addition to above, assess for presence of:
   a. Symmetry of extremities.
   b. Head/neck:
      i. Full range of motion of neck without torticollis.
      ii. Sutures.
      iii. Mouth, lips, and palate (patent, fused, cleft, intact, precocious teeth).
      iv. Nares
   c. Muscle tone.
   d. Intact clavicles with no tenderness, swelling, or crepitation.
   e. All ten fingers and toes present without webbing, extra digits.
   f. Spine intact without openings, masses, curves, dimples, or hairy tufts.
   g. Gluteal folds/creases, palmar creases, or hip click.

S. **STANDARDS OF CARE 1.7: ADMISSION ASSESSMENT INTEGUMENTARY SYSTEM REVIEW:**
1. Skin Assessment.
   a. Admission exams.
      i. Temperature.
      ii. Color
      iii. Warmth.
      iv. Turgor.
      v. Moisture.
      vi. Edema.
      vii. Transient mottling.
      viii. Vernix
      ix. Lanugo.
      x. Milia.
      xi. Port wine stain.
      xii. Capillary hemangiomas: "stork bite," "angel kiss."
      xiii. Mongolian spots.
      xiv. Skin tags.
      xv. Newborn Rash (erythema toxicum): pink popular rash with vesicles on chest, arms, back, or abdomen.
      xvi. Petechiae.
      xvii. Ecchymosis
2. The infant should be dried per Neonatal Resuscitation Guidelines without wiping all the vernix from the skin. Visible blood should be cleaned from the infant. After 24 hours of life, the stable infant may receive an initial bath upon parent's request.

~~a. If the infant is bathed during the hospital stay, familial participation should be encouraged.~~
~~b. A sponge bath may be given to the infant in the crib and then the infant should be placed skin to skin with mother.~~
~~c. Earlier bathing may be considered per specific parental request, meconium stained infant, or malodorous fluid.~~
~~d. The infant whose mother is infected with a blood borne pathogen or current STD should receive a bath as soon as possible after delivery.~~

~~3. Cord Care/Assessment.~~
~~a. Assessment to include:~~
~~i. Number of vessels.~~
~~ii. Condition – moist, drying.~~
~~iii. Drainage.~~
~~iv. Clamp.~~
~~b. Initial: clean the cord and surrounding skin surface during the initial bath with cleansing solution, rinse thoroughly and then allow to air dry folding the diaper away from the umbilical cord.~~
~~c. Ongoing: every shift and as needed, inspect cord for degree of moisture or dryness, drainage and odor. Keep the cord dry and clean if cord becomes soiled with urine or stool, cleanse with water.~~

~~T. STANDARDS OF CARE 1.8: ASSESSMENT PSYCHOLOSOCIAL SYSTEM REVIEW:~~
~~1. Psychosocial assessment will be done with the mother and social service consultation ordered as needed.~~

D. OTHER PROCEDURES:

1. **Newborn admission orders will be entered and implemented as "Protocol/Standing Order w/co-sign" per Care of the Newborn Standardized Procedure.**
2. **Critical test values shall be reported to the provider following the Critical Results and Critical Tests-Diagnostic Procedure.**
~~U.~~3. **Home medications will be reported as "No Home Medications" and reconciled per the Medication Reconciliation Policy.**
~~1.~~4. Newborn will have blood glucose performed per Blood Glucose Newborn Monitoring Standardized Procedure.
~~2.~~5. Toxicology urine specimen will be obtained if the mother has a positive toxicology screen, a positive history of substance abuse, is suspected of substance abuse or with diagnosis, has had less than or equal to three prenatal visits or suspicion of placental abruption and on all babies **admitted to the NICU.**~~assigned to Neonatology.~~
~~3.~~6. Prophylactic eye ointment and Vitamin K will be given per ~~PCS Standardized Procedure:~~ Administration of **Vitamin K**~~Aquamephyton~~ Injection and Erythromycin Ophthalmic Ointment to the Newborn**s Standardized Procedure**.
~~4.~~7. Hepatitis B vaccination or Hep B vaccine and HBIG immunuglobin injection will be given per ~~PCS Standardized Procedure:~~ Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns **Standardized ~~.~~Procedure.**
~~5.~~8. Newborn Hearing Screen prior to discharge, but at least 12 hours post-delivery per **Newborn Hearing Screening Procedure.**~~hospital procedure: Hearing Screening Newborn and Infant.~~
~~6.~~9. Serum bilirubin screening for assessment of jaundice will be done at **approximately** ~~round~~ 24 hours **of age**~~, prior to discharge~~ or **sooner** if baby ~~-~~visually **appears to have** jaundiced.
~~7.~~10. Newborn metabolic screen will be done prior to discharge per ~~PCS Procedure:~~ Newborn Screen**ing**, Collection of Specimen **Procedure**.
~~8.~~11. Universal Screening for Critical Congenital Heart Disease will be done after 24 hours of life **but before** ~~or prior to~~ discharge per Standardized Procedure: Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD).
~~9.~~12. Car seat challenge will be performed on infants meeting criteria per WNS/NICU Procedure: Care Seat Challenge Test.

~~10.~~13. Neonatal Abstinence Scoring will be performed on all infants meeting criteria per WNS/NICU Procedure: Neonatal Abstinence Scoring.

~~V.~~ ~~NURSING PROCESS:~~

~~1. Standards of Care: Assessment.~~
- ~~a. An RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.~~

~~2. Standards of Care: Diagnosis.~~
- ~~a. An RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift, and PRN.~~

~~3. Standards of Care: Outcome Identification.~~
- ~~a. An RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.~~

~~4. Standards of Care: Planning.~~
- ~~a. An RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions which may be implemented to attain expected outcomes.~~

~~5. Standards of Care: Implementation.~~
- ~~a. An RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned task appropriately.~~

~~6. Standards of Care: Evaluation.~~
- ~~a. An RN shall evaluate the patient's progress forward obtaining their outcomes in the POC per TCMC policy.~~
- ~~b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.~~
- ~~c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds or as soon as possible within the shift the changes were identified.~~

~~7. Standards of Care: Documentation.~~
- ~~a. It is recommended that all shift assessments, reassessments, PRN assessments and/or care provided be documented after completion of the care in a timely manner.~~
- ~~b. When it is not possible to document shift assessments, reassessments, PRN assessments and/or care provided due to unforeseen circumstances such as urgent or emergent situations, changes in assignment or increased patient acuity, document the nursing care and assessment as soon as reasonably able to do so.~~
- ~~c. Reasonable and a timely manner may be defined as within 4 hours after completion of assessments or care provided.~~

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

1. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. (2017~~2~~). *Guidelines for Perinatal Care* ***Eighth*** ~~*Seventh*~~ *Edition.* Washington, DC.
2. American Academy of Pediatrics (2010). *Policy Statement – Hospital Stay for Healthy Term Newborns. Retrieved* on 01/12/2011: *http:aapolicy.aappublications.org/cgi/reprint/pediatrics;125/2/405.pdf.*
3. American Nurses Association (ANA). (200**21**~~10~~). *Nursing scope and standards of practice.* Silver Spring, MD: Nursesbooks.org.
4. American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org
5. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns,* Sixth Edition.
6. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (202~~1~~44). 54th Edition.

~~7. California Board of Registered Nursing. (2010). Nursing practice act business and professions code. Chapter 6 Nursing: Section 2725. Retrieved March 2010 from http://111.rn.ca.gov/regulations/rn.shtml.~~

~~8. California Board of Registered Nursing. (2010). Standards of competent performance. California code of regulations, title 16, section 1443.5. Retrieved March 2010 from http://111.rn.ca.gov/regulations/rn.shtml.~~

~~9. California Board of Registered Nursing. (2010). California code of regulations, title 22, section 70125. Retrieved March 2010 from http://111.rn.ca.gov/regulations/rn.shtml.~~

~~10.~~**7.** Mattson, S., & **S**smith, J.E. (Eds). (201~~6~~**6**). *Core Curriculum for Maternal-Newborn Nursing* ***5****4th Edition)* (**5**4th Ed.). Philadelphia, PA: Saunders.

~~11. Lund, C. (2001). Neonatal Skin Care; Clinical outcomes of the AWHONN/NANN evidence-based clinical practice guideline. JOGNN. 30, 41-51.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
~~POLICY MANUAL~~

ISSUE DATE: NEW

SUBJECT: Skin Substitute/ Cellular Tissue Products Inventory and Storage Process

REVISION DATE~~(S)~~:

Department Approval:	~~02/20~~08/22
~~Medical Staff~~ Department of Pathology ~~/Division Approval~~:	10/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	11/22
Administration Approval:	12/22
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE:

1. The intention of this policy is to ensure a standardized process for Tissue used at the Clinic. The process involves the:
   a. Ordered and Inventory of Cellular Tissue Products,
   b. Storage and issuance of Cellular Tissue Products,
   c. Traceability of tissue from source to recipient, and
   d. The ability to investigate any case of an adverse event.

B. POLICY:

1. All tissues used in the Wound Care Center will be ordered, inventoried, stored and issued in the standardized procedure outlined.
   a. Oversight of the Clinic Tissue Utilization is under the Tissue Supervisor, an assigned role in the clinic.
   b. Tissues include any cellular based elements such as human tissue, ~~ammonic~~**amniotic** membrane or tissue, stem cells, cord tissue, bovine or porcine tissue. Cellular Tissue Products covered under CMS will be managed as tissue including collagens.
   c. The Clinic will assure at least yearly validation that tissue suppliers are registered with FDA, and licensed by CA. They are required to comply with 3 FDA standards:
      i. "Good Tissue Practices"
      ii. Registration of Tissue Establishments
      iii. Donor Screening
   d. Package Integrity and acceptable controlled Temperature of Tissue will be verified upon the arrival of product to the clinic. See procedure.
   e. Tissues that must be frozen can only be accepted by Tissue Providers who use validated temperature control packaging. No tissue freezer is kept at the clinic.
   f. All **shelf** tissue packages must be able to be stored at "ambient temperatures".
   g. Ambient Temperature is ensured by a thermometer that tracks temperatures and alarms when above or below identified range. This record will be kept with tissue log. The log will be observed for variances prior to beginning the clinics daily patient flow and engineering will be notified if temperatures need adjustment. See Procedure.
   h. All movements of Cellular Tissue Products through the clinic will be logged in the Tissue Log by Lot number, including arrival condition, time and temperature, through application including verification of product Id, Patient identification and identification of staff that inspected or prepared tissue. The lot numbers of tissue used are returned to the Tissue

supplier to allow for traceability of tissue and the ability to follow up on any adverse events. See Procedure

i. Bidirectional flow of information on adverse events occurs when the clinic can receive information from the Tissue Supplier or when we report events that may occur in the clinic to the Supplier.

C. PROCEDURE:

1. Ordering ~~Freeze-Dried Tissue:~~ **cellular tissue products:**
   a. ~~The Tissue Supervisor will complete~~ ~~a~~**A** Non-Stock Supply Purchase Requisition for all tissue orders **is sent through Materials**. ~~If the tissue is ordered for a specific patient, the requisition must have the patient's name, the physician's name and the date and time of surgery. The completed requisitions are then sent to the Materials Department. All special orders should be placed 48 hours before the scheduled procedure to assure delivery.~~
   b. Tissues must only be ordered from Tissue Banks or Tissue Distribution Centers licensed by the State of California Department of Health Services and **coly** registered by the FDA. The Wound Care Center and TCMC Tissue Bank maintains a list of approved vendors **licenses**. See ~~Attached Vendor List~~**tissue bank licenses** in Tissue Log.
2. Receiving Freeze-Dried Tissue:
   a. The Cellular Tissue Product will be delivered to the clinic from the approved Tissue Vendor.
   b. The person receiving the tissue is responsible for the following:
      i. Verify the shipping container is labeled with the names and addresses of the distributor, TCMC, and any special warnings and/or storage requirements.
      ii. Verify that the distributor is licensed with the State of California and registered by FDA.
      iii. Verify the packing list has the name and address of the tissue supplier, shows TCMC as the recipient and has a P.O. number.
      iv. Compare the packing list to the tissue package to verify identification numbers, expiration dates and storage temperature requirements.
      v. Inspect the outside of the tissue package for signs of contamination of the tissue, such as a tear in the package, breakage or discoloration of the tissue.
         1) The package must not be damaged or altered.
         2) Damaged tissue must not be used.
         3) Return damaged tissue to the supplier.
      vi. The receiving staff verifies package integrity was met, ~~then stamps the package list with the stamp that states, "I inspected the Cellular Tissue Products package upon receipt and determined that~~ the product appearance was acceptable, the container was intact and the label was complete, affixed and legible", and ~~initials the stamp~~**signs and dates each receiving slip**.
      vii. The Receipt for tissue will be returned to Purchasing for validation that the product was received by the Wound Care Clinic.
3. Tracking Cellular Tissue
   a. The product is entered into the Tissue log by name, size and lot number.
   b. The date of product arrival is entered into the Tissue log. The Expiration date of tissue is entered into Tissue log.
   c. The temperature at time of arrival is entered into Tissue log.
   d. The initials of the staff member who inspected the product and assured its integrity is entered into the tissue log. All Wound Clinic Staff have signed the Signature log to confirm their initials and staff status. See Signature log.
4. Temperature Monitoring
   a. Manual temperature readings are to be recorded daily.
   b. Notify the Clinical Manager or Inventory Supervisor immediately if the thermometer readings are outside of the 59-86°F temperature range.

c. Date, initial and indicate the readings are acceptable or that the Engineering was notified and what actions were taken.
d. Arrange immediately to move ~~freeze-dried~~ **cellular tissue products** to an area of acceptable temperature if out of range.
e. The Daily Temperature Log is to be reviewed by the ~~charge person~~ **appointed staff** then dated, signed and maintained in the tissue log at the end of each month.
f. No tissue will be stored past the tissue expiration date as stated on the tissue package. If a tissue has expired, send the tissue and the completed Tissue Tracking Card to the originating facility. Contact the Product Representative for transport if required and credit to hospital account.

5. Obtaining And Implanting **CTP**~~Freeze-Dried Tissue~~:
a. The clinic staff will remove the tissue from the cleanroom and inspect the tissue package for visible signs of contamination. The documentation accompanying the tissue must be reviewed for the results of non-reactive serologic testing for the appropriate infectious diseases.
b. If no insert is found, call the facility and ask if the appropriate testing has been performed and has non-reactive results. The package insert must also contain instructions for proper handling, storage, transport and use/reconstituting of the tissue. If no insert is found, call the supplier and ask them to fax the required testing results and instructions STAT.
c. If the supplier cannot FAX the required documentation, the tissue must be returned to the supplier. Tissues received without required negative testing results or with reactive test results, will not be used for implantation at TCMC.
d. The clinic staff will enter the lot number and/or serial number into the Tissue log. The validated temperature controlled box shall not be opened until the time of procedure. All tissue will be transported, handled, stored and used according to the source facilities or manufacturers written directions stored in the Tissue Log.
e. Tissue will be prepared for procedure following the written instructions provided by supplier stored in the Tissue Log.
f. After implantation of tissue into the patient, the Clinic staff and Physician complete the procedure note in medical record. Documentation under the Procedure section, Skin Substitute.
~~g. The staff will complete the tissue tracking form from the Tissue Supplier, attach a copy of the lot numbers and return the paper work to the Inventory Supervisor for mailing to Tissue Supplier.~~
~~h. A weekly report is generated of all tissue implanting and the lot and serial number tracking. This report remains in the tissue log.~~
~~i.~~**g.** If the tissue is opened but not used, the Clinic staff will ~~complete a Tissue Tracking Card and dispose of the tissue in the biohazard sharps container in the "dirty utility" room at the end of the case~~**contact**.

6. Returned **CTP**~~Freeze-Dried Tissue~~:
a. ~~Freeze-dried room temperature stored tissue~~**CTP** may be returned to the cleanroom for reissue if the tissue is in its original unopened, sterile container and the storage temperature requirements of the tissue have been maintained.
b. Inspect the tissue package to ensure that it is still sealed and sterile and all documentation issued with the tissue has also been returned.
c. If the tissue package has been opened, appears to have been contaminated, or if the storage temperature has not been maintained, the Clinic staff will **contact.**~~complete a Tissue Tracking Card and return the card with the tissue to Supplier~~.
d. Wasted tissue is disposed in the biohazard **red bin.**~~Sharps containers~~ in the Dirty Utility Room.
e. ~~Inventory Supervisor and/or Designee~~ **AN** will run a weekly report to tract all tissue implanted ~~and verify tracking card was received~~**monthly**.

7. Reporting Of Adverse Reaction ~~To Freeze-Dried Tissue~~**to CTP**:

a. All adverse outcomes of tissue implantation must be reported to the Supplier.
b. These adverse outcomes may include, but are not limited to:
   i. Infections
   ii. Tissue failures
   iii. Other complaints by the clinic staff or the surgeon.
c. The following information must be acquired from the person reporting the adverse outcome and sent ~~to the Supplier Source Tissue Bank~~ within 24 hours of notification on ~~a Quality Review Report (QRR)~~.:**RL report.**
   i. Patient name
   ii. Patient Medical Record Number (M RN)
   iii. Implanting physician's name
   iv. Type of tissue implanted
   v. Date of the implant
   vi. Date the adverse outcome is being reported
   vii. Patient symptoms
   viii. Name of the person reporting the adverse reaction
   ix. Name of the person obtaining the information
   x. Date the report was obtained
d. ~~Clinic Staff promptly reports post-transplant infections or adverse events to the Source Facility.~~

8. Recall of ~~Freeze-Dried Tissue~~**CTP**:
   a. The Tissue ~~Source~~ Supplier will notify TCMC when a tissue has been recalled.
   b. If the tissue has not been issued, send the tissue to the Tissue ~~Source~~ Supplier immediately for quarantine.
   c. If the tissue has been issued, obtain the following information and ~~send to the Clinical Laboratory Tissue Bank~~ within 24 hours of notification ~~and~~ complete ~~an Quality Review Report~~.**RL report.**
      i. Patient name
      ii. Patient Medical Record Number CM RN)
      iii. Implanting physician's name
      iv. Type of tissue implanted
      v. Date of the implant
      vi. Date the recall was received
      vii. Reason for the recall
      viii. Patient symptoms, if any
      ix. Name of the company issuing the recall
      x. Name of the person obtaining the information
   d. Recipients of tissue from donors who are subsequently found to have infectious agents known to be transmissible by tissue are identified and informed of infection risk by the ~~Clinical Laboratory Tissue Bank. Refer to the Clinical Laboratory Tissue Bank Procedures Manual Policy "Recall of Tissue"~~.**tissue supplier.**

9. Record Keeping:
   a. The hospital's records, including storage temperature logs, are retained for a minimum of ten (10) years.**?**
   b. The hospital's records/patient records document the source facility. The original numeric or alpha numeric donor and lot identification, all recipients or other final disposition of each tissue and applicable expiration dates and are retained for a minimum of ten (10) years beyond the date of distribution, transplantation, disposition or expiration of tissue (whichever is latest).

D. <u>REFERENCE(S):</u>
1. California Health and Safety Code section 1635.
2. Standards for Tissue Banking," American Association of Tissue Banks, 2002"

3. Comprehensive Accreditation Manual for Hospitals: The Official Handbook, Joint Commission on the Accreditation of Health Care Organizations

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
November 17, 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 November 17, 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 Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director Gleason

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 Sanchez and unanimously passed to approve the agenda as presented by a roll call vote (6-0-0-1) with Director Gleason absent.

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Chavez read the Public Comments section listed on the November 17, 2022 Regular Board of Directors Meeting Agenda.

   Edmundo Garcia, CNA Labor Relations Representative, Doris Turner, RN and Linda Slater requested to speak under Public Comments.

5. Reports – Information Only

a) Foundation Report – Jennifer Paroly

Ms. Jennifer Paroly, Foundation President reported on the Foundation's Jazzy Jubilee and stated it was one of the best events to date and exceeded the Foundation's expectations in bringing in new sponsors. She expressed her appreciation to all who the attended and thanked the District for their generous sponsorship.

Ms. Paroly reported on the plan to launch the Corporate Council in a big way. She stated our success depends on everyone working together and putting the community first.

b) Chief Nurse Executive – Candice Parras

Ms. Candice Parras, Chief Nurse Executive reported on our New Grad program which will begin in February. There are currently 65 applicants and interviews will begin the week after Thanksgiving. Ms. Parras stated we do have a good complement of educators throughout the hospital that will help make this a successful program and improve our staffing.

Ms. Parras stated we struggle with our staffing on a daily basis. Despite the lower census we have on-boarded staff every month with 15-20 new hires, some of which include sign-on and referral bonuses. As a result, staffing should be good on every unit, however the biggest issue is the large number of sick calls, most recently, 10 RNS on Saturday and 9 on Sunday, not including ACTs, techs, etc. She stated incentives are offered consistently, however sometimes it is not enough.

Directors asked questions related to the New Grad program and indicated their support.

6. September, 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 – $81,767
- Operating Expense – $89,436
- EBITDA – ($1,877)
- EROE – ($5,435)

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

- Average Daily Census – 122
- Adjusted Patient Days – 22,901
- Surgery Cases –1,432
- ED Visits – 13,571

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

- Net Operating Revenue – $26,673
- Operating Expense – $29,500
- EBITDA – ($987)
- EROE – ($2,185)

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

- Average Daily Census – 127
- Adjusted Patient Days – 7,648
- Surgery Cases – 453
- ED Visits – 4,488

Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

Mr. Rivas also answered questions related to the "Flash Report".

7. New Business

a) Board Swearing in Ceremony

Board Chairperson Chavez stated by law, Board members may be sworn in on the first Friday in December after 12:00 noon. He stated he has reached out to Assemblywoman Laurie Davies who has offered to perform the Swearing in for him and would be pleased to swear in all re-elected Board members. Directors Coulter, Mizell and Younger were also agreeable.

The Board's Swearing In Ceremony will be held on Friday, December 2, 2022 at 1:30 p.m. at the hospital's front entrance near the flag pole.

8. Old Business - None

9. Chief of Staff - None

10. Consideration of Consent Calendar

It was moved by Director Mizell and seconded by Director Younger to approve the Consent Calendar.

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

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

11. Discussion of items pulled from Consent Calendar - None

12. Comments by Members of the Public

Chairperson Chavez invited comments from the public. Comments were received from the following persons:

- Doris Turner, RN
- Diane Chappell, RN (in lieu of Edmundo Garcia)
- Linda Slater, President of DEMCO

13. Comments by Chief Executive Officer

Mr. Steve Dietlin, CEO reported mental health as been central to Tri-City's mission and on October 17, 2022 the ground breaking was held for the Psychiatric Health Facility. Mr. Dietlin stated construction will begin soon and we anticipate opening the unit in the first quarter of calendar year 2024.

Mr. Dietlin thanked Ms. Paroly for her report. He also thanked the Foundation staff and donors for putting on the wonderful event. He stated the primary purpose of the event is to elevate our Emergency Room with our ED renovation project and the Board has just recently placed the contractor for that project.

Patient and staff safety remain the utmost priority at our medical center. Nurses, physicians, and all Tri-City team members, are an integral part of our healthcare system and their work is valued and greatly appreciated. Nation-wide workforce challenges are well-documented and Tri-City is not immune to these challenges. Like other healthcare providers across the country, we are aggressively recruiting for nursing and other qualified healthcare professionals from a highly competitive pool. He stated the past three years have been unprecedented but we remain steadfast in our commitment to advance the health and wellness for our community. We have invested millions in contract labor, premium pay and COVID pay. Mr. Dietlin stated he is very excited about the New Grad program as we look for long term sustainable solutions. We cannot be successful without people working together and we are committed to moving forward in a positive fashion.

Mr. Dietlin congratulated incumbent Board members Chavez, Coulter, Mizell and Younger.

14. Board Communications

Director Younger thanked today's speakers for their comments.

Director Mizell commented on the recent groundbreaking for the Psychiatric Health Facility as well as the Jazzy Jubilee.

Director Mizell also acknowledged the comments made by staff and concerns of the public made by Linda Slate. He stated the Board remains concerned about staffing and knows how hard the executive team, RNs and staff are working.

Director Chaya congratulated fellow Board members on their re-appointments.

Director Chaya congratulated the Foundation on the successful Jazzy Jubilee and looks forward to the Foundation's events for 2023.

Director Coulter commented that staffing is a concern across the country and not unique to Tri-City. He thanked everyone for all their continued efforts.

Director Sanchez gave "kudos" to the Foundation for the great event.

Director Sanchez encouraged collaboration between staff and management to come up with good ideas and continue to be the best providers for our community. She also encouraged additional communication out in the community to let everyone know about the good things we are doing at our hospital.

14. Report from Chairperson

Chairperson Chavez acknowledged today's speakers and stated the Board is committed to keeping staff and the community as informed as possible.

Chairperson Chavez commented on his personal experience with a family member at a much smaller hospital across the country and stated they too have nursing shortages and healthcare is truly a national issue.

Chairperson Chavez also commented on the annual Auxiliary's Scholarship program and encouraged participation.

Chairperson Chavez commented on the importance of the hospital's image in the community and the need to work quietly and collaboratively.

17. Adjournment

There being no further business, Chairperson Chavez adjourned the meeting at 4:35 p.m.

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Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary