TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
February 23, 2023 – 3:30 o'clock p.m.
Assembly Rooms 2 & 3 – Eugene L. Geil Pavilion
4002 Vista Way, Oceanside, CA 92056

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

	Agenda Item	Time Allotted	Requestor
1	Call to Order	3 min.	Standard
2	Roll Call / Pledge of Allegiance		
3	Approval of Agenda	2 min	Standard
4	Public Comments – Announcement Members of the public may address the Board regarding any item listed on the Board Agenda at the time the item is being considered by the Board of Directors. Per Board Policy 19-018, members of the public may have three minutes, individually, to address the Board of Directors. NOTE: Members of the public may speak on any item not listed on the Board Agenda, which falls within the jurisdiction of the Board of Directors, immediately prior to Board Communications.	2 min.	Standard
5	Reports – Information Only a) Foundation Report – Jennifer Paroly, Foundation President	10 min.	Foundation President
6	January 2023 Financial Statement Results	10 min.	CFO
7	New Business - None		
8	Old Business – None	-	-
9	Chief of Staff - a) Consideration of February 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on February 21, 2023	5 min.	COS

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

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

	Agenda Item	Time Allotted	Requestor
10	Consent Calendar –	10 min.	Standard

a) Consideration to approve the renewal of the agreement for Cardiovascular Institute Co-Management for a term of 36 months, beginning March 1, 2023 and ending February 28, 2026, for an annual cost, not to exceed $870,000 and a total cost for the term not to exceed $2,610,000.

b) Consideration to approve an agreement with HealthSearch Partners to conduct the Executive Search for the Chief Executive Officer.

c) Administrative Committees

A. Policies

1. Patient Care Services Policies & Procedures

a) Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns Standardized Procedure
b) Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure
c) Central Venous Access Devices, Adults Procedure
d) Code Blue and Emergency Care Standardized Procedure
e) Computerized Axial Tomography (CT) Downtime Response Procedure
f) Emergency Department Standardized Procedure
g) Identification, Patient Policy
h) Physician/Allied Health Professionals (AHP) Inpatient Orders Policy
i) Plan for Nursing Care
j) Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure
k) Radial Artery Compression Band Procedure
l) Rigid Laryngoscope Reprocessing Procedure (RETIRE)
m) Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)
n) Venipuncture for Specimen Collection Procedure

2. Administrative 200

a) Authorized Access Medications Policy 298

3. Employee Health & Wellness

a) Bloodborne Pathogen Exposure Protocol Grid
b) General Guidelines
c) Guidelines for Reporting Exposures (RETIRE)
d) HIV Guideline Grid
e) Occupational Exposure Blood/Body Fluid Secretions
f) TB Surveillance
g) Work Restrictions for Personnel with Infectious Disease

4. Engineering

a) Lockout Tagout Procedures
b) The Operation of the Hospital Electrical Distribution System (RETIRE)
c) Use of Extension Cords
d) Utility Management Plan 4003

5. Environment of Care

a) Emergency Management Plan
b) Environmental Health & Safety Committee Charter 1001
c) Waste Management

	Agenda Item	Time Allotted	Requestor

6. **Home Care**
   a) Hazardous Infectious Materials Management (RETIRE)

7. **Infection Control**
   a) Aerosol Transmissible Diseases and Tuberculosis Control Plan
   b) Bloodborne Pathogen Exposure Control Plan
   c) Cleaning, Disinfection and Sterilization Policy
   d) Infection Prevention Program Plan
   e) Standard and Transmission Based Precautions

8. **Mammography Women's Center**
   a) Communication of Results Women Center
   b) Completion of Diagnostic Report
   c) Diagnostic Mammography Policy
   d) Distribution of Mammography Reports Policy
   e) Mammography Image/Data Retention, Check-Out and Copying
   f) Mammography QA Plan DIT Policy
   g) Scheduling of Self Referring Mammography Patients Policy
   h) Screening Mammography Policy
   i) Staff & Personnel Listing Women's Center Policy

9. **Medical Staff**
   a) Appropriate Use of Commercial Support and Exhibits 8710-603
   b) Conflict of Interest for Medical Staff 8710-555
   c) Conflict of Interest Resolution 8710-605
   d) Conflict Resolution Medical Staff 8710-522
   e) Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds 8710-522
   f) Influenza Vaccination of Physicians and Allied Health Professionals (AHP) 8710-547
   g) Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500
   h) Name Tags for Health Practitioners 8710-521
   i) Physician Orders Family Members 8710-529
   j) Physician's Well Being Committee Policy 8710-571

10. **Ultrasound & Vascular Imaging**
    a) How to Report a Critical/Stat Read

11. **Women & Newborn Services**
    a) Partners in Care for WNS
    b) Standards of Care Antepartum

12. **Wound Care**
    a) Decontamination & Sterilization of Instruments (RETIRE)
    b) Infection Prevention and Control Activities

13. **Wound Hyperbaric Oxygen Therapy**
    a) Cardiac Arrest
    b) Complications of HBOT
    c) Consent to Treatment
    d) Contraindications to HBOT
    e) Ear Exam (RETIRE)
    f) Ear Pressure Equalization

	Agenda Item	Time Allotted	Requestor
	g) Emergency Evacuation h) Emergency Shutdown i) Fire Alarm j) Fire in Treatment Area k) Gas & Pressure Safety l) HBOT Treatment Guide m) HBOT Treatment Schedules n) Inspection of HBO Chambers o) Management of Oxygen Toxicity Seizure p) Oxygen Supply Failure q) Patient Screening, Contraindications r) Patient Family Orientation s) Physician Credentialing t) Pneumothorax u) Pre-Treatment Assessment v) Reporting Structure w) Safety Committee x) Transcutaneous 02 Monitoring y) Vacuum-Assisted Closure Device d) Minutes 1) Regular Meeting – January 26, 2023 2) Special Meeting – January 26, 2023 3) Special Meeting – February 13, 2023 e) Meetings and Conferences – None f) Dues and Memberships – None g) Reports – (Discussion by exception only) 1) Lease Report – January, 2023) 2) Reimbursement Disclosure Report – January, 2023		
11	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
12	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard
13	Comments by Executive Leadership and Chief Executive Officer	10 min.	Standard
14	Recognition of Steve Dietlin, CEO	`10 min.	Standard
15	Board Communications (three minutes per Board member)	18 min.	Standard
16	Report from Chairperson	3 min.	Standard
17	Total Time Budgeted for Open Session	1 hour	
18	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
February 8, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/24/2023 – 1/31/2025)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 2/24/2023 through 1/31/2025:

- **ANSARI, Taha MD/ Telepsychiatry(Array)**
- **COYLE, Dustin MD/Anesthesiology (ECHO)**
- **FERNANDEZ, Janice MD/Anesthesiology (ECHO)**
- **GHARIB, Sayed MD/Anesthesiology (ECHO)**
- **IIBRIL, Deanah DO/OB/GYN (TeamHealth)**
- **KUO, James DO/Internal Medicine (Sound)**
- **PAAS, John MD/OB/GYN (TeamHealth)**
- **PORTER, Douglas MD/Neurology (Real Time Neuromonitoring)**
- **SHAPIRO, Robert MD/Urology (North Coast Urology)**
- **UDANI, Vikram MD/Neurosurgery**
- **TADLAOUI, Karim MD/Critical Care Medicine (Vituity)**
- **WALKER, Christopher MD/Teleradiology (StatRad)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
February 08, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 03/01/2023 -02/28/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 03/01/2023 through 02/28/2025, 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:

- ASSELIN, Lynette, DO/Pediatrics/Active
- BARCO, Eric, MD/Internal Medicine/Active
- BINIUS, Tracy, MD/Telepsychiatry/Provisional
- EVANS, Jamie, MD/Telepsychiatry/Provisional
- FURUBAYASHI, Jill, MD/Teleradiology/Active Affiliate
- GOELITZ, Brian, MD/Interventional Radiology/Active
- GRANT, Colette, MD/Pediatrics/Active
- GREIDER, Bradley, MD/Ophthalmology/Active
- HELTON, Derek, MD/Oncology/Active
- IKELHEIMER, Douglas, MD/Telepsychiatry/Provisional
- KLEIN, Michael, MD/Teleradiology/Provisional
- LEAN, Eva, MD/Radiation Oncology/Active
- LIZOTTE, Paul, DO/Internal Medicine/Refer and Follow
- MacEwan, Jennifer, MD/Otolaryngology/Active Affiliate
- MELLS, Cary, MD/Emergency Medicine/Active
- NEWMAN, Jeffrey, MD/Family Medicine/Active
- QUAN, Maria, MD/Obstetrics & Gynecology/Active
- SAHAGIAN, Gregory, MD/Neurology/Active
- SHAFQAT, Jon, DDS/Oral & Maxillofacial Surgery/Refer and Follow

Attachment B

- **SMITH, Mark, MD/Ophthalmology/Active**
- **SMITH, Richard, MD/Infectious Disease/Active**

CHANGE OF STATUS:

- **BAKSHI, Ankur, MD/Cardiothoracic Surgery/Provisional**

RESIGNATIONS: (Effective date 02/28/2023 unless otherwise noted)

Automatic:

- **DESADIER, Laura, DO/Neurology**
- **MANGINANI, Sridevi, MD/Telemedicine**
- **MANY, Sherin, MD/Telemedicine**
- **OTTINO, Jennifer, DO/General Surgery**
- **PERKOWSKI, David, MD/Cardiothoracic Surgery**
- **VAGHA, Sahil, DO/Internal Medicine**

Voluntary:

- **BERMAN, Blake, DO/Neurosurgery**
  Voluntary resignation as requested by physician effective 10/24/2022.
- **DOUGHERTY, Colin, MD/Emergency Medicine**
  Voluntary resignation as requested by physician effective 12/27/2022.
- **EBRAHIMI ADIB, Tannaz, MD/Obstetrics & Gynecology**
  Voluntary resignation as requested by physician effective 02/28/2023.
- **FREDERIKSEN, Ryan, MD/Teleradiology**
  Voluntary resignation as requested by the practitioner effective 02/28/2023.
- **HAWLEY, Daniel, MD/Diagnostic Radiology**
  Voluntary resignation as requested by the practitioner effective 12/01/2022.

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- **KANG, Jason, MD/Orthopedic Surgery**
  Voluntary resignation as requested by physician effective 11/14/2022.

- **KALOOGIAN, Harold, DPM/Podiatric Surgery**
  Voluntary resignation as requested by physician effective 02/28/2023.

- **MCGAHAN, Michele, MD/Diagnostic Radiology**
  Voluntary resignation as requested by physician effective 02/28/2023.

- **MITCHELL, Charles, MD/Diagnostic Radiology**
  Voluntary resignation as requested by the practitioner effective 12/08/2022

- **PATEL, Cecil, MD/Diagnostic Radiology**
  Voluntary resignation as requested by physician effective 10/05/2022.

- **SCHMITTER, Stephen, MD/Diagnostic Radiology**
  Voluntary resignation as requested by physician effective 12/11/2022.

- **SHIH, Jimmy, MD/Diagnostic Radiology**
  Voluntary resignation as requested by the practitioner effective 08/25/2022.

- **VORA, Roshni, MD/Anesthesiology**
  Voluntary resignation as requested by the group effective 03/31/2023.

- **WAILES, Robert, MD/Pain Medicine**
  Voluntary resignation as requested by physician effective 10/31/2022.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
February 08, 2023

PROCTORING RECOMMENDATIONS

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

- **BINIUS, Tracy , MD** — **Telepsychiatry**
- **CARPINELLO, Matthew , MD** — **Telepsychiatry**
- **HANRAHAN, David , MD** — **Telepsychiatry**
- **IKELHEIMER, Doug , MD** — **Telepsychiatry**
- **NIEDZWIECKI, Matthew , MD** — **Telepsychiatry**
- **VADAKARA, Tom , MD** — **Telepsychiatry**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
February 14, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 2/24/2023 – 1/31/2025)

Any items of concern will be "red" flagged in this report. Verification of licensure, specific training, patient care experience, interpersonal and communication skills, professionalism, current competence relating to medical knowledge, has been verified and evaluated on all applicants recommended for initial appointment to the medical staff. Based upon this information, the following physicians have met the basic requirements of staff and are therefore recommended for appointment effective 2/24/2023 through 1/31/2025.

- **COLE, Jason CRNA/Allied Health Professional (ECHO)**
- **GOHL, Mark CRNA/Allied Health Professional (ECHO)**
- **GRYSKA, Jennifer Aud/Allied Health Professional (Specialty Care)**
- **LAU, Yufei PA-C/Allied Health Professional (Vituity)**
- **MEGALI, Nicole PA-C/Allied Health Professional (The Neurology Center)**
- **NIZAMOV, Mikhail CRNA/Allied Health Professional (ECHO)**
- **SENGUPTA, Pushpa NP/Allied Health Professional (Vituity)**
- **SERRA, Natalie CRNA/Allied Health Professional (ECHO)**
- **SZULAKOWSKI, Mary CRNA/Allied Health Professional (ECHO)**
- **THAM, Janice NP/Allied Health Professional (Vituity)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – Part 1 of 1
February 14, 2023

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 3/1/2023 – 2/28/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 3/1/2023 through 2/28/2025, 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:

RESIGNATIONS:

Voluntary:

- **PREGERSON, Heather, PAC/Physician Assistant**
- **RENNE, Brittany, AuD/Neurophysiologic Intraoperative Monitoring**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT– Part 3 of 3
February 14, 2023

PROCTORING RECOMMENDATIONS

- **GREEN, Kyle PAC** — **Allied Health Professional**

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: February 23, 2023
Cardiovascular Institute Co-Management Agreement Renewal

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

Vendor's Name: TCMC Cardiovascular Institute, LLC

Area of Service: Tri-City Cardiovascular Institute

Term of Agreement: 36 months, Beginning, March 1, 2023 – Ending, February 28, 2026

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

Base Management Fee		
Monthly Cost	Annual Cost	Total Cost
$35,000	$420,000	$1,260,000
Performance Improvement Incentive Fee		
Monthly Cost	Annual Cost	Total Cost
$37,500	$450,000	$1,350,000
	Total Term Cost:	**$2,610,000**

Description of Services/Supplies:

- Provides structure that is consistent with the Institute's guiding principles of Hospital Physician Collaboration and integrated leadership
- Established an entity that is consistent with integrated delivery and provides a foundation for business and payer initiatives
- The management fee and incentive fees are unchanged from the original agreement

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

Person responsible for oversight of agreement: Eva England, Senior Vice President / Dr. Gene Ma, Chief Medical Officer

Motion:
I move that the TCHD Board of Directors authorize the Cardiovascular Institute Co-Management agreement for a term of 36 months, beginning, March 1, 2023 and ending, February 28, 2026 for an annual cost not to exceed $870,000 and a total cost for the term not to exceed $2,610,000.

EXECUTIVE SEARCH AGREEMENT

This Executive Search Agreement ("Agreement") is entered into by and between Tri-City Healthcare District ("District"), a public agency organized and operating pursuant to California Health and Safety Code section 32000 et seq., and HealthSearch Partners, ("Consultant") as follows:

R-E-C-I-T-A-L-S

1. District would like to retain the professional services of Consultant to provide a search for a new CEO at Tri-City Medical Center.

2. Consultant possesses extensive executive search experience with healthcare and non-profit organizations and has the knowledge, skill, and expertise, necessary to provide the professional services ("Services") as more specifically outlined in the attached Exhibit "A" ("Consultant Proposal").

C-O-V-E-N-A-N-T-S

1. CONSULTANT'S SERVICES.

1.1 Services. Consultant shall provide all labor, materials, equipment, and incidentals necessary to provide the District fully and adequately with the professional services described in the Consultant Proposal. All Services shall be performed by Consultant to the reasonable satisfaction of the District.

1.2 Compliance with Laws. In performing the Services, Consultant shall, at all times comply with all applicable laws, rules, regulations, codes, ordinances, and orders of every kind whatsoever issued, adopted, or enacted by any federal, state, or local governmental body having jurisdiction over the Services.

1.3 Performance Standard. Consultant shall perform the Services with efficiency and diligence and shall execute the Services in accordance with the standards of Consultant's profession, generally described as that degree of skill and care ordinarily exercised by professionals providing similar services as Consultant practicing in California.

1.4 District and Foundation's Representative. For purposes of this Agreement, the District's Representative shall be Board Chairman, Rocky Chavez. Any amendments to this Agreement shall require the approval of the District Board of Directors.

2. FEES AND PAYMENTS.

2.1 Compensation for Services. As outlined in the Fee Arrangement section of the Consultant Proposal, the professional fees for the executive search services shall be $149,000, a $3,000 communication fee, plus out-of -pocket expenses of approximately $15,000.

2.2 Payment. Fees are payable in six equal monthly installments invoiced at the initiation of the assignment and the beginning of each of the four subsequent months. The final payment is due upon completion. The parties shall expeditiously resolve the subject of any disputed amounts by way of negotiation or, if necessary, mediation or litigation. Any such dispute shall not relieve Consultant of its obligation to continue diligently performing the Services.

3. PRESENTATION OF RECOMMENDED CANDIDATES

A final group of candidates, typically six to eight will be formally presented to the full Board in a face-to-face meeting. This confidential discussion will provide detailed information on each candidate's background, qualifications, and strengths/weaknesses. At this meeting the Board will select candidates to invite for first-round interviews.

4. INDEPENDENT CONTRACTOR.

District has retained Consultant to provide, and Consultant shall perform, the Services as an independent contractor maintaining exclusive direction and control over its employees; and, no personnel utilized by Consultant to perform the Services are employees of the District.

5. LIABILITY INSURANCE.

All all times during the performance of services by consultant for District, Consultant shall maintain General Liability insurance in a form and in the amounts as set forth in the Exhibit "A" Consultant Proposal.

6. NOTICES.

All notices to be given under this Agreement shall be in writing and shall be deemed effective upon receipt when personally served or two days after mailing by certified, return receipt requested, to the following addresses:

To: District
Tri-City Medical Center
Attention: Rocky Chavez, Board Chairman
Administration
Oceanside, California 92056

To: Consultant
HealthSearch Partners
Attention: Neill Marshall
13355 Noel Road Ste. 1100
Dallas, Texas 75240

7. MISCELLANEOUS PROVISIONS.

7.1 Venue. Venue shall lie only in the federal or state courts nearest to the North San Diego County Judicial District, State of California.

7.2 Modification. This Agreement may not be altered in whole or in part except by a modification, in writing, executed by all the parties to this Agreement.

7.3 Entire Agreement. This Agreement, together with the attached Exhibit "A", contains all representations and the entire understanding between the parties with respect to the subject matter of this Agreement. Any prior correspondence, memoranda, or agreements, whether or not such correspondence, memoranda, or agreements are in conflict with this Agreement, are intended to be replaced in total by this Agreement and its schedules. To the extent the provisions of this Agreement are inconsistent with the provisions of the Attached Exhibit "A" Consultant Proposal the provisions of this Agreement shall govern.

7.4 Assignment. Consultant shall not be entitled to assign all or any portion of its rights or obligations contained in this Agreement without obtaining the prior written consent of the District. Nothing in this Agreement shall obligate the District to give such consent. Any purported assignment without the District's consent shall be void.

7.5 Binding Effect. This Agreement shall inure to the benefit of and be binding upon the parties and their respective purchasers, successors, heirs, and assigns.

7.6 Unenforceable Provisions. The terms, conditions, and covenants of this Agreement shall be construed whenever possible as consistent with all applicable laws and regulations. To the extent that any provision of this Agreement, as so interpreted, is held to violate any applicable law or regulation, the remaining provisions shall nevertheless be carried into full force and effect and remain enforceable.

This Agreement is entered into in the County of San Diego, State of California.

"District":	"Consultant":
Tri-City Healthcare District	HealthSearch Partners
By: _____ Rocky Chavez, Board Chairman	By: _____ Neill Marshall, Board Chairman
Date:_____	Date:_____

EXHIBIT "A"

January 17, 2023

Rocky J. Chavez, Board Chairman
Tri-City Medical Center
Administration
4002 Vista Way
Oceanside, CA 92056

RE: Executive Recruitment Services

Dear Rocky:

I appreciate your interest in HealthSearch Partners managing a search for a new Chief Executive Officer for Tri-City Medical Center. We are delighted to submit this proposal and engagement letter, which describes our process and fee structure and would serve as our agreement for this project. The proposal price will be valid for a period of at least 120 days with an option for additional 30-day increments upon approval of the contractor and the Tri-City Board.

HealthSearch Partners is the sixth-largest healthcare executive search entity in the United States. Its team of executive search veterans brings 130-plus years of executive search experience to healthcare and non-profit organizations and executives who challenge the status quo and put their mission into action. HealthSearch consultants have worked with most of the country's largest and most prestigious non-profit healthcare systems. Our recent Chief Executive Officer projects have been for non-profit organizations with $5 million in net revenue and up to $5 billion in net revenue.

The significant steps and deliverables for a typical search are as follows:

- **Kick-off Meetings:** We will meet with you and other key stakeholders as directed by you to solicit detailed input on the critical characteristics desired in the new Chief Executive Officer and essential goals for the function in the short to mid-term. The product of this step is an Assessment Report that describes the situation, the organization's needs, the deliverables expected from the new Chief Executive Officer, and Position Specifications to identify the right candidates.

- **Sourcing/Screening/Interviewing:** We will contact potential prospects and referral sources across the region and the country based on the approved position profile. We will include, in our screening, referrals provided to us by Tri-City Medical Center, including personal referrals and prospective candidates that have already been identified. As prospects express interest, we will collect their resumes, conduct zoom video screens, and conduct preliminary, informal references to the extent possible. We will interview the most promising in person.

- **Presentation of Recommended Candidates:** A final group of candidates, typically six to eight, will be formally presented to the Search Committee in a face-to-face meeting. This confidential discussion will provide detailed information on each candidate's background, qualifications, and strengths/weaknesses. At this meeting, you will select

a group to invite for first-round interviews. Please note that due to ethical/confidentiality and other concerns, our practice is not to reveal candidates' identities until the presentation meeting.

- **Candidate/Client Interviews:** We will facilitate the candidates' initial and final interviews in Oceanside, California, and provide post-interview feedback from the candidates to you. We will assist you, as needed, in further evaluating the candidates as they move through the interview process.

- **Referencing:** We will conduct formal referencing for the final candidate(s) and provide a written summary of these references.

- **Negotiation/Closure:** We will serve as a facilitator/sounding board to both the final candidate and you in crafting and modifying an offer.

- **Guarantee:** If the successful candidate is terminated or leaves the organization voluntarily within two years of arrival, HealthSearch Partners will conduct a replacement search for no additional professional fee. Our guarantee assumes the search process outlined above is generally followed; we also assume the replacement search is for the same position and is launched within 60 days of the termination of the incumbent.

- **Non-solicitation:** As a values-driven firm, we subscribe to the Association of Executive Search Consultants' ethics statement. For 12 months following the closure of a successful search, we will not solicit Tri-City Medical Center employees for potential candidacy for other HealthSearch Partners clients. If employees from Tri-City Medical Center contact HealthSearch Partners during these 12 months, we will instruct them to seek and receive explicit approval from their direct supervisor before we will engage in further discussion regarding other HealthSearch Partners opportunities. In addition, the successful candidate selected during a search engagement will be considered off-limits to HealthSearch Partners for the entire period Tri-City Medical Center employs them.

- **Commitment to Diversity:** We are committed to developing diverse candidate slates and recognize this increasingly important factor in organizations. Historically, **approximately two-thirds of our successful candidates** have been women and/or minorities.

- **Expectations of Client:** Our clients play a critical and vital role in the search process, and there are several responsibilities Tri-City Medical Center will assume to help ensure a positive outcome. These include:

    - To provide HealthSearch Partners with the appropriate in-person access to essential Tri-City Medical Center leadership, stakeholders, and the final hiring decision-maker.
    - To provide timely feedback to HealthSearch Partners regarding client information needs, material changes to the organization or position, candidate information, and recommendations given by HealthSearch Partners.
    - To provide timely feedback to HealthSearch Partners regarding each onsite interview.
    - Tri-City Medical Center agrees that HealthSearch Partners has exclusive rights to represent Tri-City Medical Center on this assignment until it is completed or canceled. Tri-City Medical Center agrees to allow HealthSearch Partners to use the Tri-City Medical Center names and logos for public and private communication related to the search engagement.
    - If Tri-City Medical Center places the search "on hold" for more than 60 days, HealthSearch Partners reserves the right to renegotiate the terms of this agreement.

Please note that although our objective is to complete a search assignment within the first four months, we shall continue to work until the position is filled.

EXHIBIT "A"

Proposed Search Timeline*

WEEK OF	ACTIVITY
March 2-3	**Startup** meetings with critical stakeholders in Oceanside.
March 10	**Submission of Assessment Report and finalization of Position Specifications** for final approval by Tri-City Medical Center.
March 2 to April 21	**Sourcing and screening** candidates by HealthSearch Partners.
TBD (by April 28)	**Presentation of Candidates** by HealthSearch Partners- Meeting with Tri-City Medical Center to present the final slate of candidates and identify who to invite for first-round interviews.
TBD (by May 12)	**1st Round Interviews**: Identify several days for interviews of first-round candidates.
TBD (by May 26)	We recommend bringing onsite at least **2 Finalists** for an expanded round of in-person interviews. These interviews could range from 1 to 2 days and should involve key stakeholders from the startup process.
TBD (by June 2)	A **Final Candidate** identified and an offer developed and presented.
TBD (by June 2)	**The candidate accepts the offer**.
June/July	**Actual start date** depends on the finalist's personal and professional situation.

* These are our targeted dates. Actual dates will be adjusted as necessary.

EXHIBIT "A"

Fee Arragements

The professional fee for this assignment (Chief Executive Officer, Tri-City Medical Center) will be $149,000.

Fees are payable in six equal monthly installments invoiced at the initiation of the assignment and the beginning of each of the four subsequent months. The final payment is due upon completion. The first invoice is sent upon initiation of the project.

All out-of-pocket expenses (such as travel/meals for recruiter/candidate/client meetings) will be billed without markup. Out-of-pocket expenses are estimated to be $15,000. In addition, a one-time fixed amount of $3,000 shall be charged on the first invoice for the cost of messenger/courier, duplicating, information technology, online research, and other communications costs. If out-of-pocket expenses exceed the estimate, we will bill you the balance monthly after the fifth invoice. If the expense estimate exceeds out-of-pocket expenditures at the end of the search, we will reimburse you for the overpayment. Costs related to candidates' onsite interviews with clients are customarily reimbursed directly by the client.

Although we expect to complete a search assignment within the first four to six months, we shall continue to work until the position is filled. Tri-City Medical Center may cancel the project at any time. If cancellation occurs during the first month, the invoiced amount shall consist of the first retainer plus the first month's communication costs and any out-of-pocket expenses incurred. Assignments canceled during the second or third month shall be charged to retainers on a pro-rata basis, plus communication costs and expenses. If the project is canceled any time after the third month, we shall consider the retainer fee as having been earned. Our fee and project-related expenses shall be payable without regard to the ultimate resolution of the assignment. Kindly note that invoices are payable upon receipt.

If, as the result of this assignment, additional candidates introduced to Tri-City Medical Center by HealthSearch Partners are hired by Tri-City Medical Center within 12 months of the completion of the Chief Executive Officer search, Tri-City Medical Center will compensate HealthSearch Partners $60,000 for each such candidate hired by Tri-City Medical Center.

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 13th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns Standardized Procedure	2 year review	Forward to BOD for Approval
2. Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
3. Central Venous Access Devices, Adults Procedure	3 year review, practice change	Forward to BOD for Approval
4. Code Blue and Emergency Care Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
5. Computerized Axial Tomography (CT) Downtime Response Procedure	3 year review, practice change	Forward to BOD for Approval
6. Emergency Department Standardized Procedure	2 year review, practice change	Forward to BOD for Approval
7. Identification, Patient Policy	3 year review, practice change	Forward to BOD for Approval
8. Physician/ Allied Health Professionals (AHP) Inpatient Orders Policy	3 year review, practice change	Forward to BOD for Approval
9. Plan for Nursing Care	3 year review, practice change	Forward to BOD for Approval
10. Power Injection with Peripherally Inserted Central Catheter (PICC) Procedure	3 year review, practice change	Forward to BOD for Approval
11. Radial Artery Compression Band Procedure	3 year review, practice change	Forward to BOD for Approval
12. Rigid Laryngoscope Reprocessing Procedure	RETIRE	Forward to BOD for Approval
13. Universal Blood Saturation Screening for Critical Congenital Heart Disease (CCHD)	3 year review, practice change	Forward to BOD for Approval
14. Venipuncture for Specimen Collection Procedure	3 year review, practice change	Forward to BOD for Approval
Administrative 200		
1. Authorized Access Medications Policy 298	3 year review, practice change	Forward to BOD for Approval
Employee Health & Wellness		
1. Bloodborne Pathogen Exposure Protocol Grid	3 year review, practice change	Forward to BOD for Approval
2. General Guidelines	3 year review, practice change	Forward to BOD for Approval
3. Guidelines for Reporting Exposures	RETIRE	Forward to BOD for Approval
4. HIV Guideline Grid	3 year review, practice change	Forward to BOD for Approval
5. Occupational Exposure Blood/Body Fluid Secretions	3 year review, practice change	Forward to BOD for Approval
6. TB Surveillance	3 year review, practice change	Forward to BOD for Approval
7. Work Restrictions for Personnel with Infectious Disease	3 year review, practice change	Forward to BOD for Approval
Engineering		
1. Lockout Tagout Procedures	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 13th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
2. The Operation of the Hospital Electrical Distribution System	RETIRE	Forward to BOD for Approval
3. Use of Extension Cords	3 year review, practice change	Forward to BOD for Approval
4. Utility Management Plan 4003	1 year review	Forward to BOD for Approval
Environment of Care		
1. Emergency Management Plan	NEW	Forward to BOD for Approval
2. Environmental Health and Safety Committee Charter 1001	practice change	Forward to BOD for Approval
3. Waste Management	3 year review	Forward to BOD for Approval
Home Care		
1. Hazardous Infectious Materials Management	RETIRE	Forward to BOD for Approval
Infection Control		
1. Aerosol Transmissible Diseases and Tuberculosis Control Plan	3 year review	Forward to BOD for Approval
2. Bloodborne Pathogen Exposure Control Plan	3 year review	Forward to BOD for Approval
3. Cleaning, Disinfection and Sterilization Policy	3 year review	Forward to BOD for Approval
4. Infection Prevention Program Plan	3 year review, practice change	Forward to BOD for Approval
5. Standard and Transmission-Based Precautions	3 year review	Forward to BOD for Approval
Mammography Women's Center		
1. Communication of Results Women Center	3 year review	Forward to BOD for Approval
2. Completion of Diagnostic Report	3 year review	Forward to BOD for Approval
3. Diagnostic Mammography Policy	3 year review	Forward to BOD for Approval
4. Distribution of Mammography Reports Policy	3 year review	Forward to BOD for Approval
5. Mammography Image/Data Retention, Check-Out and Copying	3 year review	Forward to BOD for Approval
6. Mammography QA Plan DIT Policy	3 year review	Forward to BOD for Approval
7. Scheduling of Self Referring Mammography Patients Policy	3 year review	Forward to BOD for Approval
8. Screening Mammography Policy	3 year review	Forward to BOD for Approval
9. Staff & Personnel Listing Women's Center Policy	3 year review	Forward to BOD for Approval
Medical Staff		
1. Appropriate Use of Commercial Support and Exhibits 8710 - 603	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 13th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
2. Conflict of Interest for Medical Staff 8710-555	3 year review	Forward to BOD for Approval
3. Conflict of Interest Resolution 8710 - 605	3 year review	Forward to BOD for Approval
4. Conflict Resolution Medical Staff 8710-562	3 year review	Forward to BOD for Approval
5. Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds 8710-522	3 year review	Forward to BOD for Approval
6. Influenza Vaccination of Physicians and Allied Health Professionals (AHP) 8710-547	3 year review	Forward to BOD for Approval
7. Medical Staff Governance Documents Development and Review and Approval Mechanism 8710-500	3 year review	Forward to BOD for Approval
8. Name Tags for Health Practitioners 8710-521	3 year review	Forward to BOD for Approval
9. Physician Orders Family Members 8710-529	3 year review	Forward to BOD for Approval
10. Physician's Well-Being Committee Policy 8710-511	3 year review	Forward to BOD for Approval
11. Supervision of Residents in Emergency Medicine 8710-571	3 year review	Forward to BOD for Approval
Ultrasound & Vascular Imaging		
1. How to Report a Critical/ Stat Read	3 year review	Forward to BOD for Approval
Women & Newborn Services		
1. Partners in Care for WNS	3 year review, practice change	Forward to BOD for Approval
2. Standards of Care: Antepartum	3 year review, practice change	Forward to BOD for Approval
Wound Care		
1. Decontamination & Sterilization of Instruments	RETIRE	Forward to BOD for Approval
2. Infection Prevention and Control Activities	3 year review, practice change	Forward to BOD for Approval
Wound Hyperbaric Oxygen Therapy		
1. Cardiac Arrest	3 year review, practice change	Forward to BOD for Approval
2. Complications of HBOT	3 year review	Forward to BOD for Approval
3. Consent to Treatment	3 year review, practice change	Forward to BOD for Approval
4. Contraindications to HBOT	3 year review	Forward to BOD for Approval
5. Ear Exam	RETIRE	Forward to BOD for Approval
6. Ear Pressure Equalization	3 year review, practice change	Forward to BOD for Approval
7. Emergency Evacuation	3 year review	Forward to BOD for Approval
8. Emergency Shutdown	3 year review	Forward to BOD for Approval

Tri-City Medical Center

ADMINISTRATION CONSENT AGENDA
February 13th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
9. Fire Alarm	3 year review, practice change	Forward to BOD for Approval
10. Fire in Treatment Area	3 year review, practice change	Forward to BOD for Approval
11. Gas & Pressure Safety	3 year review	Forward to BOD for Approval
12. HBOT Treatment Guide	3 year review, practice change	Forward to BOD for Approval
13. HBOT Treatment Schedules	3 year review, practice change	Forward to BOD for Approval
14. Inspection of HBO chambers	3 year review, practice change	Forward to BOD for Approval
15. Management of Oxygen Toxicity Seizure	3 year review	Forward to BOD for Approval
16. Oxygen Supply Failure	3 year review, practice change	Forward to BOD for Approval
17. Patient Screening, Contraindications	3 year review, practice change	Forward to BOD for Approval
18. Patient-Family Orientation	3 year review	Forward to BOD for Approval
19. Physician Credentialing	3 year review, practice change	Forward to BOD for Approval
20. Pneumothorax	3 year review, practice change	Forward to BOD for Approval
21. Pre-Treatment Assessment	3 year review	Forward to BOD for Approval
22. Reporting Structure	3 year review	Forward to BOD for Approval
23. Safety Committee	3 year review	Forward to BOD for Approval
24. Transcutaneous O2 Monitoring	3 year review, practice change	Forward to BOD for Approval
25. Vacuum-Assisted Closure Device	3 year review, practice change	Forward to BOD for Approval

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: ADMINISTRATION OF PEDIATRIC HEPATITIS B VACCINE AND HEPATITIS B IMMUNOGLOBULIN (HBIG) TO NEWBORNS

I. **POLICY:**

A. Function: To provide guidelines for the Women and Newborn Services (WNS) Registered Nurse (RN) administering Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) to newborns.

B. Circumstances:
   1. Setting: WNS
   2. Supervision: None required.
   3. Requires that an RN complete administration Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) to newborns.

C. Consent:
   1. The RN shall obtain verbal parental consent prior to administration of the Pediatric Hepatitis B vaccine and/or Hepatitis B Immunoglobulin (HBIG) to the newborn.
      a. Prior to giving consent, the parent or patient's legal guardian shall receive written information about Hepatitis B according to Tri City Medical Center (TCMC) Patient Care Services Policy: Vaccination Administration. This will be documented in the Electronic Health Record (EHR) ~~in the education form~~.
      b. If the parent or legal guardian declines the Pediatric Hepatitis B vaccination and or HBIG injection, the RN shall contact the Pediatrician immediately for those infants of mothers with positive or unknown Hepatitis B results. Document refusal in the Medication Administration Record (MAR) and have parent sign the Refusal Hepatitis B Vaccine form. Refer to notification and documentation guidelines.

II. **PROCEDURE:**

A. When the mother is Hepatitis B Surface Antigen (HBsAg) (positive):
   1. The RN will administer Pediatric Hepatitis B vaccine and HBIG within 12 hours of birth, regardless of weight.

B. When the mother is Hepatitis B Surface Angtigen (HBsAg) (negative):
   1. The RN will administer Pediatric Hepatitis B vaccine, within 24 hours of birth for infants greater than or equal to 2000 grams, for infants going to the mother-baby unit.
   2. Infants going to the NICU should be given Pediatric Hepatitis B vaccine
      a. If full term or greater than or equal to 2000 grams
      b. If less than 2000 grams by one month of age if medically stable, or
      c. At discharge if before one month of age, and/or
      d. Transfer to the mother-baby unit prior to 24 hours of life.

C. When the mother's Hepatitis B Surface Angtigen (HBsAg) status is unknown:
   1. Give Pediatric Hepatitis B vaccine, soon after birth, but within 12 hours of birth, regardless of weight.
   2. Obtain STAT Hepatitis B screen.
      a. If maternal Hepatitis B Surface Antigen (HBsAg) status is determined to be HBsAg positive, give HBIG as soon as possible.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Department of Pediatrics	Pharmacy & Therapeutics Committee	Inter disciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
12/05, 8/07, 4/09, 06/11, 07/13, 03/18, 03/21	12/05, 8/07, 4/09, 06/11, 07/13, 4/15, 07/18, 11/21	03/11;7/13; 4/15, 07/18, 12/21	05/15, 11/18, 04/22	06/11, 9/13, 05/15, 03/19, 07/22	06/11, 09/13, 09/15, 04/19, 10/22	06/11, 10/13, 09/15, 07/19, 01/23	08/19, 02/23	10/15, n/a	06/11, 10/1, 10/15, 08/19

b. If the maternal status is still unknown by discharge and infant greater than or equal to 2000 grams, give HBIG prior to discharge or at 7 days of birth (whichever is first) if status remains unknown..
   i. NICU infants < 2000g: if the mother's HBsAg result is not available within 12 hrs of birth, give HBIG as soon as possible.
   ii. NICU infants ≥ 2000g: Administer HBIG within 7 days if the mother's HBsAg result is positive, or if maternal status remains unknown by discharge give prior to discharge.

D. The RN will administer Pediatric Hepatitis B vaccine and Hepatitis B Immunoglobulin (HBIG) in accordance with the Tri-City Medical Center Patient Care Services Policies:
   1. Medication Administration
   2. Vaccination Administration

E. Pediatric Hepatitis B vaccine dose is 5-10 mcg*/0.5 mL, administered intramuscularly. (*Note: Hep B mcg dosage varies depending on manufacturer)

F. Hepatitis B Immunoglobulin (HBIG) dose is 0.5 mL, administered intramuscularly -in the opposite thigh from the Hep B vaccination site.

G. Documentation
   1. The newborn's EHR
      a. Refer to TCMC Patient Care Services Vaccinations Administration Policy.
   2. Immunization Record
      a. Document newborns receipt of immunization on the Immunization Record.
      b. The Immunization Record shall be given to the newborn's parent(s) upon discharge of the newborn, and the parent(s) need to be notified to bring the record to the Pediatrician's office appointment.
      c. If the parent declines the immunization after receiving the Vaccine Information Sheet, document in the newborn's EHR. In the Medication Administration Record (MAR) this will be documented as "refusal".
         i. Have parent sign the form titled "Refusal of Hepatitis B Vaccine" and keep the original copy for the newborn chart.
         ii. Still give parent immunization record at discharge.
      d. Document tests, treatments, and physician notification in the EHR.
      e. When administering medications or implementing orders from a standardized procedure, the Registered Nurse shall enter the medication/order into the electronic health record as a standardized procedure.
         i. Not required if a screening process triggers the order.

I. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California unencumbered RN license working in Women and Newborn -Services/NICU.
B. Education: Registered Nurse
C. Initial Evaluation: Orientation
D. Ongoing Evaluation: Annually

II. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

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

III. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Administration of Pediatric Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to Newborns Standardized Procedure.

IV. FORM(S):

A. Refusal of Hepatitis B Vaccine form 6385-1023 – English – Sample
B. Refusal of Hepatitis B Vaccine form 6385-1025 – Spanish – Sample

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

A. Patient Care Services Policy: Vaccination Administration
B. Patient Care Services Policy: Medication Administration
~~C. Vaccine Information Sheet (VIS) Hepatitis B Vaccine: What You Need to Know – Sample (available via external link: https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf)~~

VI. **REFERENCE(S):**

A. Elimination of Perinatal Hepatitis B: Providing the First Vaccine Dose Within 24 Hours of Birth. *Pediatrics* (2017)~~;140~~; **140**.
B. Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, United States, 2018, www.cdc.gov/vaccines/schedules
C. Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices, February 6, 2018 *MMWR*.
D. Drutz, J.E., (2018) Hepatitis B virus immunization in infants, children, and adolescents

SAMPLE

I, _____, have been advised by my child's doctor/nurse that my child should receive the Hepatitis B Injection. I have been provided with and given the opportunity to read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the recommendation and my refusal with my child's doctor or nurse.

I understand the following:

- The purpose of and the need for the recommended vaccine
- The risks and benefits of the recommended vaccine
- If my child does not receive the vaccine according to the medically accepted schedule, the consequences may include the following:
  - Contracting the illness the vaccine is designed to prevent
  - Chronic disease or death as a result of the illness
- My child's doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine be given at this time according to recommendations.

I have decided at this time to decline the vaccine recommended for my child. I know that failure to follow the recommendations about vaccination may endanger the health or life of my child and others with whom my child might come into contact. I therefore agree to tell all health care professionals in all settings that my child did not receive the vaccination.

I acknowledge that I have read this document in its entirety and fully understand it, but still decline the vaccine for my child.

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

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

If patient is unable to sign, state reason: _____

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

INTERPRETATION / INTERPRETER'S STATEMENT

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

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

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

Affix Patient Label

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

6385-1023
(Rev 4/17)

REFUSAL OF HEPATITIS B VACCINE

Authorization
White - Medical Record Canary - Patient

Board Approved (Date)

SAMPLE

I, _____, have been advised by my child's doctor/nurse that my child should receive the Hepatitis B Injection. I have been provided with and given the opportunity to read the Vaccine Information Statement from the Centers for Disease Control and Prevention explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the recommendation and my refusal with my child's doctor or nurse.

I understand the following:

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- The risks and benefits of the recommended vaccine
- If my child does not receive the vaccine according to the medically accepted schedule, the consequences may include the following:
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    - Chronic disease or death as a result of the illness
- My child's doctor and the American Academy of Pediatrics, the American Academy of Family Physicians, and the Centers for Disease Control and Prevention all strongly recommend that the vaccine be given at this time according to recommendations.

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Name and relationship to patient

Affix Patient Label

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

6385-1023
(Rev. 4/17)

REFUSAL OF HEPATITIS B VACCINE

Authorization
White - Medical Record Canary - Patient

Board Approved (Date)

SAMPLE

A mi, _____, el doctor/la enfermera de mi niño(a) me han aconsejado que mi niño(a) debería recibir la inyección de Hepatitis B. Me han proporcionado y me han dado la oportunidad de leer la Declaración Informativa sobre la Vacuna de los Centros para el Control y Prevención de Enfermedades explicando la vacuna y las enfermedades que esta previene. He tenido la oportunidad de analizar la recomendación y mi rehúso (rechazo) con el doctor o la enfermera de mi niño(a).

Comprendo lo siguiente:

- El propósito y la necesidad de poner la vacuna recomendada
- Los riesgos y beneficios de la vacuna recomendada
- Si mi niño(a) no recibe la vacuna de acuerdo con el calendario médicamente aceptable, las consecuencias podrían incluir las siguientes:
  - Contraer la enfermedad que la vacuna está designada a prevenir
  - Enfermedad crónica o muerte como resultado de la enfermedad
- El médico de mi niño(a) y la Academia Americana de Pediatría, la Academia Americana de Médicos de Familia, y los Centros para el Control y la Prevención de Enfermedades enfáticamente recomiendan que la vacuna se ponga en este momento de acuerdo con las recomendaciones

Yo he decidido en estos momentos rechazar la vacuna recomendada para mi niño(a). Yo sé que no seguir las recomendaciones acerca de la vacunación podría arriesgar la salud o la vida de mi niño(a) y de otras personas con quien mi niño(a) pudiera entrar en contacto. Yo, por lo tanto, estoy de acuerdo en decirles a todos los profesionales que atienden la salud y en todas situaciones que mi niño(a) no recibió la vacunación.

Reconozco que he leído enteramente este documento y lo comprendo plenamente, pero aun así rechazo la vacuna para mi niño(a).

_____	_____	___/___/___	_____ AM/PM
Name	**Signature:**	**Date**	**Time**

Indicate relationship to patient: _____
Examples: Parent, Legal Guardian

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

INTERPRETATION (Complete if Interpretation provided)

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

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

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

Affix Patient Label

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

6385-1025
(Rev. 5/17)

REFUSAL OF HEPATITIS B VACCINE
(RECHAZO DE VACUNA HEPATITIS B)

Authorization
White - Medical Record Canary - Patient

Board Approved (Date)

SAMPLE

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Hepatitis B is a serious disease that affects the liver. It is caused by the hep
mild illness lasting
lifelong illness.

Hepatitis B virus inf

Acute hepatitis B v
that occurs within th
exposed to the hepat
- fever, fatigue, loss
- jaundice (yellow s
  bowel movements
- pain in muscles, j

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that occurs when the
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lead to
- liver damage (cirr
- liver cancer
- death

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Up to 1.4 million pe
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with the virus throug
- Birth (a baby who
  or after birth)
- Sharing items such
  infected person
- Contact with the b
  person
- Sex with an infect
- Sharing needles, s
  equipment
- Exposure to blood
  instruments

Each year about 2,0
hepatitis B-related li

Hepatitis B vaccine can prevent hepatitis B and its consequences, including liver cancer and cirrhosis.

2 [illegible]

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DELETE
SAMPLE

SAMPLE

3 Some people should not get this vaccine

Tell the person who is giving the vaccine

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- **If the person**
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5 What if there is a serious problem?

What should I look for?

- Look for anything that concerns you, such as signs

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Hepatitis B Vaccine

7/20/2016

42 U.S.C. § 300aa-26

Office Use Only

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine:
What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

2 Hepatitis B vaccine

Hepati
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The National Vaccine Injury Compensation

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Vaccine Information Statement (interim)

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8/15/2019 | 42 U.S.C. § 300aa-26

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CARDIAC REHAB CENTER (ON CAMPUS) EMERGENCY TREATMENT

I. **POLICY:**

A. Function: Safe and standardized management of unexpected cardiovascular events or exercise related changes in cardiovascular status including, but not limited to, acute angina or change in anginal pattern, stable angina, chest wall/incisional/musculoskeletal pain, cardiac dysrhythmias, hypotensive/syncopal episodes, and acute dyspnea.

B. Circumstances:

1. Setting: Cardiac Rehabilitation service area (on campus), Tri-City Medical Center
2. Supervision: RN; upon arrival of a physician, nursing staff shall follow physician orders instead of standardized procedure.
3. Patient contraindications – Patients with written orders to the contrary of the Standardized Procedure. Patients with Special Considerations:
   i. No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate".

C. Definitions:

1. Acute angina: Pain, pressure, heaviness, burning sensation, indigestion. May be felt in center of chest, arms, neck, jaw, and shoulders. Other symptoms may include weakness, shortness of breath, diaphoresis, nausea vomiting (1 or more symptoms may be present.)
2. Change in Anginal pattern: Change in frequency, duration, and pattern of angina.
3. Stable Angina: Angina symptoms are relieved with rest or nitroglycerin.
4. Chest wall/incisional/musculoskeletal pain: Atypical pain associated with movement, stretching, straining, coughing, and palpable tenderness.
5. Cardiac Dysrhythmias: Any rhythm other than sinus rhythm that requires immediate intervention due to life threatening potential or that result in the patient becoming symptomatic (compromised).
6. Hypotensive/syncopal episodes: Any decrease in blood pressure of 30 - 40 mmHg or more from pre-exercise levels or less than 80 mmHg systolic associated with symptoms.

D. Data Base:

1. Subjective: Patient complaints including, but not limited to, pain, pressure heaviness, burning sensation, indigestion felt in center of chest, arms, neck, jaw, shoulders. Other symptoms may include weakness, shortness of breath, nausea, dizziness, light-headedness, and confusion.
2. Objective: Cardiac rate and rhythm disturbances, decreased level of responsiveness, hypotension, labored respiration, oxygen saturation less than 92%, diaphoresis, vomiting.
3. Assessment: Unexpected cardiovascular events/exercise related changes in cardiovascular status.
4. Plan:
   i. Initiate standardized procedure as appropriate and notify cardiologist or primary physician (if no cardiologist) as soon as possible.

Patient Care Services Content Expert ~~Review~~	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Committee~~	Division of Cardiology	Pharmacy & Therapeutics Committee	Inter-disciplinary Practice Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
09/02, 03/10, 12/12, 06/16, 11/18, **09/21**	03/10, 02/13, 08/16, 06/19, **02/22**	12/10, 02/13, 09/16, 06/19, **03/22**	10/16, 08/19, **04/22**	01/11, 05/13, 11/16, 11/19, **07/22**	01/11, 09/13, 01/17, 01/20, **10/22**	02/11, 10/13, 02/17, 04/20, **01/23**	05/20, **02/23**	03/17, n/a	08/03, 01/05, 06/06, 08/08, 02/11, 10/13, 03/17, 05/20

ii. Call CODE BLUE by dialing 66 to respond to Cardiac Rehab Center as appropriate.
iii. Assist with transportation of patient to Emergency Department (ED) via wheelchair or gurney as appropriate. Provide protection of umbrella to protect patient from rain or inclement weather during transportation.

II. **PROCEDURE:**

A. Acute Angina or Change In Anginal Pattern:
1. Stop exercise
2. Assess patient's blood pressure, SpO_2, heart rate and rhythm, lung sounds, respirations, color and mentation. Assess chest pain (location, severity, character).
3. Administer oxygen to maintain SpO_2 greater than 95%.
4. Administer nitroglycerin (NTG) 0.4mg/actuation spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays for symptoms of angina unrelieved by rest.
   i. If chest pain is unrelieved after 3 NTG sprays, transport to ED for further evaluation.

B. Stable Angina:
1. Administer nitroglycerin (NTG) spray or tablets 0.4 mg sublingual at 5-minute intervals, not to exceed three sprays or tablets for symptoms of angina unrelieved by rest.
   i. If chest pain is unrelieved after 3 NTG sprays or tablets, transport to ED for further evaluation.
2. Assess and document patient's response to nitroglycerin and exercise.
3. Assess patient's blood pressure, heart rate and rhythm, respirations, color and mentation.
4. Stop activity if angina is unrelieved and proceed as for acute angina.

C. Chest Wall/Incisional/Musculoskeletal Pain:
1. Evaluate cause of pain.
2. Assess blood pressure, heart rate and rhythm, respirations, color, and mentation.
3. Discontinue modalities that aggravate symptoms, or decrease workloads.
4. Notify physician if symptoms persist.
5. Document assessment and treatment on patient's chart.
6. Re-evaluate at next exercise session.

D. Treatment for Dysrhythmias That May Result in Cardiopulmonary Arrest:
1. Assessment
   i. Establish baseline if time allows and patient is stable (Historical Data)
      a) Review baseline ECG
      b) Review medications
      c) Inquire regarding the use of stimulants (i.e. caffeine, smoking, cold remedies)
   ii. Evaluation of new arrhythmias
      a) Evaluate hemodynamic status, i.e., blood pressure, heart rate, skin color and temperature, lightheadedness, dizziness, shortness of breath.
2. Treatment
   i. Ventricular fibrillation and pulseless ventricular tachycardia, asystole, PEA
      a) Initiate CPR per American Heart Association guidelines (AHA) and Call Code Blue
      b) Place on a cardiac monitor
      c) For Ventricular fibrillation or pulseless ventricular tachycardia, Defibrilate per AHA guidelines.
      d) Resume CPR immediately after shock for 5 cycles or 2 minutes
      e) Establish IV access with NS
   ii. Symptomatic Cardiac Rhythm: Complete heart block, symptomatic bradyarrhythmia or tachyarrhythmia
      a) Administer oxygen to maintain SPO_2 greater than 95%

b) Place on a cardiac monitor
c) Alert **Patient Mobility Technician**~~Lift Team~~**(PMT)**/Rapid Response Team (RRT) to assist with immediate transport to ED

iii. New changes in cardiac rhythm: stable bradyarrhythmia or tachyarrhythmia, new onset atrial fibrillation, increase in premature ventricular contractions (PVC), or runs of stable ventricular tachycardia
a) Stop exercise
b) Assess patient's blood pressure, respiratory rate, SPO_2 percentage, skin color, temperature, mentation, and other symptoms
c) Administer oxygen to maintain SPO_2 greater than 95%
d) Contact physician for further orders
e) Transport to ED with assistance of **PMT**~~Lift Team~~ if necessary

E. Hypotensive Episodes:
1. Assist patient to supine position.
2. Assess blood pressure, heart rate, rhythm, respiration, oxygen saturation, skin color, temperature, mentation, and presence of other symptoms.
3. Administer oxygen to maintain SPO_2 saturation greater than 95%
4. Notify physician
5. If no improvement, transport to the ED

F. Acute Dyspnea:
1. Stop exercise.
2. Assess oxygen saturation by pulse oximetry
i. If oxygen saturation is less than 92%, place patient on oxygen and titrate to oxygen saturations greater than 95%.
3. Assess breath sounds
4. Assess patient for use of rescue drug inhalers and encourage patient to use inhaler if available.
5. Notify physician if symptoms do not improve and transport to the Emergency Department (ED) via wheelchair or gurney.

G. Left Ventricular Assist Device (LVAD):
1. Check to see if pump is still working:
i. Look to see if all lights are green
ii. Listen for quiet whirling sound with stethoscope or feel by placing hand over abdomen
2. Check that all connections to power source and fix if loose or disconnected.
3. Replace current batteries with a new, fully charged pair.
4. Contact LVAD coordinator **at the facility the procedure was performed.**
5. If patient unstable, call RRT to assist with immediate transport to ED
i. No compressions
ii. Keep all connections together if defibrillation is necessary,
a) DO NOT stop pump prior to delivering shock.

H. Documentation:
1. Document event, intervention, and response in the medical record and notify the physician.
2. Record subjective data
3. Record rhythm strip, blood pressure, heart rate, oxygen saturation
4. Send information to primary physician/cardiologist

III. REQUIREMENTS FOR CLINICIANS PROVIDING INTERVENTIONS:

A. Current unencumbered California RN license.
B. Education: Successful completion of ACLS course (with current course completion card).
C. Experience: Initial job requirements.
D. Initial Evaluation: During Orientation period.
E. Ongoing Evaluation: Annually with skills validation.

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

A. Method: This standardized procedure was developed through collaboration with Nursing, Medicine, and Administration.

B. Review: Every two (2) years.

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

A. All ACLS-certified Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform Cardiac Rehab Center (On Campus) Emergency Treatment Standardized Procedure.

Tri-City Medical Center	~~Distribution:~~ Patient Care Services
PROCEDURE:	**CENTRAL VENOUS ACCESS DEVICES, ADULTS**
Purpose:	To outline the nursing responsibility in: A. Insertion B. Assessment C. Maintenance D. Documentation E. Flushing F. Blood draws G. Dressing changes H. Accessing or de-accessing implantable venous access ports I. Removal of non-tunneled central lines (Peripherally Inserted Central Venous Catheter (PICCs), Short-Term Multi Lumen Catheters, Vas Catheters)
Supportive Data:	See Infection Control Manual Bloodborne Pathogen Exposure Control Plan (I.C.10).
Equipment:	Refer to Central Line Supply List for details.

A. **POLICY:**

1. Only Registered Nurses (RNs)/**physicians/Allied Health Professionals (AHP)** may access central lines.

~~1.~~

~~2.~~B. **INSERTION**:

a. Assemble supplies (See Central Line Supply List for procedure lists).
b. Assist physician/Allied Health Professionals (AHP) with selection of optimal catheter site.
c. Ensure ~~the physician/AHP has performed~~ chlorhexidine skin antisepsis **has been performed**.
d. Provide maximal barrier precautions for the inserting physician/AHP and assisting personnel (i.e. cap, mask, sterile gown, sterile gloves and full body sterile drape)
e. Ensure "time out" is performed per Patient Care Services: Universal Protocol Procedure.
f. Ensure the physician/AHP maintains sterility of the field throughout the procedure.
g. Verify a chest X-ray is ordered and completed after placement of a newly inserted central venous catheters that was not inserted using fluoroscopy.
h. Ensure Central Line Insertion **information is documented in the electronic health record (EHR)**~~Procedural Checklist (CLIP) is completed in Cerner~~.
i. Measure external length, if any, of catheter on insertion or upon admission if catheter placed at another facility.

~~i.~~

~~3.~~C. **ASSESSMENT**:

a. Verify chest x-ray results that central line placement is accurate before accessing central lines that were placed without using fluoroscopy.
b. Measure external length, if any, of catheter on insertion or upon admission if catheter placed at another facility.
c. Monitor central venous catheter sites appropriately every 2 hours and PRN.
d. Document each shift on the Lines and Devices section in IView.
e. Assess central venous catheters daily to determine continued need and are removed when no longer needed.
    i. Does not apply to long term catheters (i.e. groshong, tunneled catheter, medi-port, and vas cath).

Patient Care Services Content Expert ~~Department Review~~	**Clinical Policies & Procedures**	**Nursinge Leadership ~~Executive Council~~**	**Pharmacy & Therapeutics Committee**	**Infection Control Committee**	**Medical Executive Committee**	**Admini stration**	**Professional Affairs Committee**	**Board of Directors**
12/94, 12/09, 07/10, 03/13, 04/14, 05/17, **05/20, 01/21, 11/22**	07/10, 03/13, 04/14, 02/17, 06/17, **06/20, 10/21**	08/10, 03/13, 04/14, 02/17, 07/17, **07/20, 11/21**	04/14, 03/17, 09/17, **09/20, 11/21**	**01/22, 04/22, 11/22**	08/10, 05/13, 07/14, 04/17, 09/17, **01/23**	**02/23**	06/13, 08/14, 10/17, **n/a**	06/13, 08/14, 10/17

~~B.~~D. **MAINTENANCE:**

1. All patients with a central line will have a chlorhexidine **gluconate** (CHG) bath **daily**~~every 24 hours~~ (except in the Women and Newborn Services departments).
   a. Do not use CHG wipes on:
      i. Patients allergic to CHG
      ii. Breast feeding mothers
      iii. Pregnant Patients
      iv. Non-intact skin, head, face, or genitalia (clean these areas with soap and water)
   ~~b. CHG wipes should be used on buttocks and inner thigh after any episodes of fecal incontinence.~~
   ~~c. Patient must be moisturized after CHG bath completed and skin is dry.~~
2. All central line patients will have high touch areas cleaned with an **Environmental Protection Agency (EPA) registered hospital cleaning solution and disinfectant**~~Sani wipe~~ **daily**~~every 24 hours~~.
   a. High Touch areas include but are not limited to:
      i. Side rails of the patient's bed
      ii. Patient's call light/phone/TV remote
      iii. Patient's bedside table
      iv. Door knobs to room and bathroom
3. When possible, a patient specific vital signs machine is to remain at the patient's bedside for neutropenic patients during their entire length of stay.
4. Use all new intravenous (IV) tubing after new central line placement. Never disconnect IV tubing or attached devices from an old intravenous site and reconnect into the new central line.
5. Label IV tubing per Patient Care Services: Standards of Care, Adult.
6. Change tubing and any attached devices (e.g. extension tubingr) per Patient Care Services: Standards of Care, Adult.
~~7. Central line dressings will be changed every Saturday before midnight.~~
~~a.~~7. Assess catheter to determine if migration has occurred. If migration has occurred, notify MD.
   ~~i.~~a. Sutured central lines – ensure sutures are intact and the catheter has not become dislodged.
      ~~1)~~i. If sutures are no longer intact, measure external length and assess if migration has occurred.
   ~~ii.~~b. Suture-less central lines – measure external length of catheter.
      ~~1)~~i. Measure the external portion of the catheter from the insertion site to the hub of the access cap (neutral displacement connector) using a measurement tape.
      ~~2)~~ii. Compare measurement to length previously documented to determine if catheter migration has occurred.
8. Neutral displacement connectors (for example Microclave) are changed every Saturday with dressing change and every Wednesday (**recommended** Green caps on Saturday, Yellow caps on Wednesday **as available**).
9. Use an infusion pump for all infusions.
   a. Do not allow infusions to run dry.
10. Clamp tubing distally if air enters infusion tubing, aspirate fluid and air with a syringe from Y port. Never purge infusion line into patient.
11. Maintain and keep open rates at 20 mL per hour.
12. May connect continuous infusions IV tubing directly to lumen (hub to hub). Neutral displacement connectors (for example Microclave) are only required for intermittent access.
13. Port protector – Unused central line ports will have a Port protector placed on the end of the neutral displacement connector (Microclave).
   a. Apply the Port protector to the end of the neutral displacement connector (Microclave) by opening the packaging of the Port protector and twist into the end of the neutral displacement connector (Microclave).
   b. To access a central line that has a Port protector, remove the Port protector from the

neutral displacement connector (Microclave) and access central line port. No initial cleaning of the neutral displacement connector (Microclave) is needed after Port protector is removed.

c. Do not reuse the Port protector, a new one should be used each time it is removed, every 8 hours with routine IV flushing, when tubing is changed and PRN.

d. Port protector shall be placed only on the lowest IV port of the mainline (maintenance) infusion tubing.

i. Port protectors are not required on ports above the lowest port on a mainline.

e. If additional cleaning required between flushes or if a port protector was not used, cleanse port thoroughly using 3 alcohol wipes.

~~C.~~E. DOCUMENTATION / EDUCATION:

1. Document care provided in the electronic health record (EHR).
   a. ~~Document f~~Flushes in the Medication Administration Record (MAR).
   b. ~~Document p~~Patient teaching in the **EHR**~~Central Line Topics section – All Topics Adhoc Form~~.
   c. ~~Ensure the~~ CHG bath and High Touch Area **cleaning** ~~on the ADL section in Cerner~~.
   d. Initiate the **appropriate** ~~"Adult Lines Central"~~ **Interdisciplinary Plan of Care** (IPOC) ~~in Cerner~~.

~~D.~~F. FLUSHING:

1. Obtain a physician's/AHP's order prior to accessing any central venous catheter if the patient is admitted with a pre-existing line and a diagnosis of sepsis or suspicion of line sepsis.
2. Always flush and check patency (draw back for a positive blood return) with a 10 mL ~~size~~ syringe due to the greater amount of pressure per square inch exerted with smaller syringes.
   a. Once patency (blood return flash when you aspirate from the central line with a 10 mL syringe) has been established with a 10 mL normal saline flush, the use of a smaller syringe to administer medications is acceptable.
3. Flush with minimum of 10 mL normal saline:
   a. Before and after medication administration~~,~~
   b. After IV fluids or TPN discontinued
   c. For maintenance
   d. Before and after blood draws
   e. After blood backs up in the tubing
4. Flush unused ports with each use and as indicated in Catheter Specific Flushes Table.
5. Heparin flushes require a physician~~'s~~/AHP~~'s~~ order.
6. Flush ports with heparin for patients discharged with a central line, to ensure patency for home care or other facility use (see Catheter Specific Flushes Table).
7. Procedure:
   a. Identify type of catheter.
   b. Check for chlorhexidine gluconate, heparin, povidone-iodine, and alcohol allergies.
   c. Assemble supplies (see Central Line Supply List).
   d. Explain procedure to patient.
   e. Perform hand hygiene and don clean non-sterile gloves.
   f. Remove Port protector from the neutral displacement connector (Microclave) if used.
      i. If a Port protector is not present on injection port, cleanse neutral displacement connector thoroughly using 3 alcohol wipes or chlorhexidine swab.
   g. Connect a 10 mL luer lock syringe to the neutral displacement connector.
   h. Check for patency by pulling back to get a positive blood return.
      i. Catheters with Heparin: Remove 5-7 mL of blood from lumen and waste.
   i. Briskly flush catheter with10 mL of normal saline.
   j. Always wipe the neutral displacement connector with an alcohol wipe immediately before and after each syringe insertion to remove bacteria and prevent blood from accumulating.

k. Heparinize catheter lumen(s) if applicable (see Catheter Specific Flushes Table).
l. Repeat flush procedure for each catheter lumen.
m. If catheter does not aspirate easily with a brisk free flowing blood return when checking patency or if catheter does not flush easily and some resistance is met when flushing, refer to the Patient Care Services: Catheter Clearance with Alteplase (Cathflo Activase) Procedure.

~~E.~~G. **BLOOD SPECIMEN COLLECTION FROM VENOUS ACCESS DEVICES:**

1. Peripheral blood is preferable for coagulation studies. ~~A physician's/AHP's order is required if a line will be used to obtain blood for coagulation studies when the line has heparin infusing or if heparin was used as a routine flush.~~
2. Maintain a closed system by drawing blood directly from the neutral displacement connector when possible; except when drawing blood cultures.
   a. If the neutral displacement connector is removed for a blood draw, sterile technique (with sterile gloves, mask and sterile field) must be used per Patient Care Services: Sterile Technique Policy.
3. On Acute Care Services (ACS), **Progressive Care Unit** and Telemetry, a phlebotomist shall place plastic bags labeled with the patient's identifiers in the "Pending Labs" box on each unit prior to the morning blood draws.
4. Nursing shall review their orders for morning draws and complete the blood draws.
~~5. Label specimen per Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure.~~
~~6.~~5. A phlebotomist must be present for blood cultures and blood bank draws in all clinical areas **except Surgical Services**. Label specimen per Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure.
   ~~a. Ensure correct process and labeling for blood cultures.~~
   ~~b. Ensure labeling of correct blood products.~~
~~7.~~6. Procedure:
   a. Remove patient identified plastic bag with specimen collection supplies from the Pending Lab box on Acute Care Services and Telemetry.
      i. Do not take plastic specimen bag into isolation rooms.
   b. Verify patient by ensuring two patient identifiers match the specimen collection labels
   c. Perform hand hygiene.
   d. Assemble supplies (see Central Line Supply List).
   e. Explain procedure to patient.
   f. Position patient, supine is the preferred position.
   g. Turn off any continuous infusions and disconnect as needed.
   h. Ensure all clamps are open (if not going hub to hub for collection).
   i. Perform hand hygiene and don clean non-sterile gloves.
   j. Remove Port protector from the neutral displacement connector (Microclave), if used.
      i. If a Port protector is not present or cap has been on port for longer than 7 days on injection port, use alcohol pad to vigorously cleanse the neutral displacement connector or injection port and the area where valve connects to end of catheter. Repeat three times using a new alcohol pad each time. Allow injection port to dry~~,~~; do not fan or blow on port to speed drying.
   k. Check patency.
   l. Flush with 10 mL normal saline after patency has been established.
   m. Wait 2 minutes.
   n. Draw off and discard 5 mL of blood. If drawing specimens for blood cultures, coagulation studies are to be obtained, or the line has TPN infusing, draw off and discard 10 mL of blood.
      i. Prior to drawing blood cultures, disconnect tubing or neutral displacement connector, attach 10 mL syringe to hub, and collect the blood to be discarded.
      ii. To draw blood culture, follow aseptic technique, use a new 10 mL syringe, and collect blood directly at the hub. Flush with 10 mL of Normal Saline and clamp

tubing before disconnecting syringe. Reconnect tubing or replace with a new neutral displacement connector being careful not to contaminate the end of the hub.

o. Clean the neutral displacement connector with an alcohol wipe immediately before and after each access to remove bacteria and prevent blood from accumulating.
   i. Allow to dry, do not fan or blow on site to speed drying.

p. For Direct Transfer Method:
   i. Insert safety vacutainer blood collection device into the neutral displacement connector using a slight clockwise turning motion.
   ii. Insert blood specimen collection tube and activate vacuum by fully engaging the blood tube.
      1) Insert blood specimen collection tube in the appropriate numbered draw order (i.e., 1, 2, etc.).
   iii. Remove and insert new vacuum tubes as needed.

q. For Indirect Transfer Method:
   i. Attach new 10 mL luer lock syringe(s) to collect blood as needed.
      1) A safety transfer device must be used to fill the vacuum tube from a syringe.

r. Remove device or syringe and wipe away blood residual.

s. Flush as indicated in Catheter Specific Flushes Table and reconnect to infusions.

t. Re-clamp lines as appropriate.

u. Remove gloves and perform hand hygiene.

v. Don clean gloves.

~~w. Document your Cerner logon, date and time of lab draw on the specimen label(s)~~

~~x.~~**w.** Label specimen per Patient Care Services: Specimen Labeling Policy.
   ~~i. On ACS and telemetry, ensure the color written on the patient label(s) matches the color of the specimen collection tube(s).~~

~~y.~~**x.** Place labeled specimen collection tube(s) in the ~~patient's~~ specimen collection bag ~~on ACS and Telemetry units~~.

~~z.~~**y.** Place specimen collection bag in the "Lab Pick Up" box **or send directly to lab**.

~~F.~~H. DRESSING CHANGES:

1. All central lines shall have a Biopatch disk at the insertion site and be covered with a transparent dressing.
2. All central line dressings shall be changed every Saturday before midnight.
   a. Central lines used for dialysis will be changed with dialysis treatment or as needed.
3. Gauze dressing (including transparent dressings with gauze underneath) will only be used for bleeding or leaking at insertion site (edematous patient).
   a. For newly inserted PICCs with a gauze dressing, the original dressing must be changed one day after insertion then every two (2) days after.
4. -Non-coring safety needles devices for implanted ports will be changed every Saturday before midnight with dressing change.
5. All dressings shall be changed as needed if they become loose, soiled, or moist.
6. Patients admitted with a pre-existing central line, will have the dressing changed within 24 hours after admission unless dressing is not dry and intact, then the dressing will be changed as soon as possible.
7. Procedure:
   a. Obtain central line dressing change kit and sterile gloves from supply Pyxis.
   b. Explain procedure to patient.
   c. Use Standard Precautions during dressing change (refer to Infection Control: Standard and Transmission Based Precautions Policy IC.5).
   d. Perform hand hygiene, apply surgical hat and mask to self and apply mask to patient. Complete hand hygiene once again, apply clean non-sterile gloves remove the dressing and discard.

e. Inspect and palpate the site for:
   i. Signs of infection (i.e. redness, or purulent drainage).
   ii. Ensure the securement device and/or sutures are intact.
   iii. Ensure the catheter is not kinked, leaking, or otherwise compromised.
f. Remove non-sterile gloves and perform hand hygiene.
g. Open sterile supplies and don sterile gloves.
h. Apply Chloraprep using a gentle back-and-forth motion for 30 seconds to cleanse exit site and allow site to air-dry for at least 30 seconds. ~~(~~Use Betadine if patient is allergic to Chlorhexadine~~)~~.
i. Cleanse catheter tubing from exit site to end of catheter tubing.
j. Allow antiseptic on skin and tubing to air dry (do not blow on or fan site) before redressing.
k. Position tubing in a loop away from the insertion site.
l. Transparent Dressing with Biopatch:
   i. Place Biopatch disk around catheter (not on top) with blue side up and white foam side next to skin at exit site.
   ii. To ensure easy removal, place Biopatch disk with the catheter resting on or near the radial slit. The edges of the slit must touch the skin to ensure efficacy.
   iii. Center transparent dressing over exit site and the Biopatch disk.
   iv. Write date of dressing change and your initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.
m. Special Consideration: Implanted Venous Access Devices/Vita Ports/Medi-Ports:
   i. Place folded 2x2 gauze under non-coring safety needle device only if the base of the device is not flush with skin after insertion.
   ii. Gauze should be placed under the non-coring safety needle device in such a way as to allow visibility of insertion point.
   iii. Secure the tubing from the non-coring safety needle device with sterile steri-strips if needed.
   iv. Pinch to remove the small plastic guide piece from the top of non-coring safety needle device before applying transparent dressing.
   v. Center transparent dressing to cover the safety non-coring needle device and site.
   vi. Write date of dressing change and initials legibly with a permanent black marker directly on the transparent dressing, allowing time for the ink to dry.

~~G.~~I. **ACCESSING OR DE-ACCESSING IMPLANTED VENOUS PORTS:**

1. Accessing procedure:
   a. Obtain physician's/AHP's order to use implanted device.
   b. Assemble supplies (see Central Line Supply List) and use non-coring safety needle device.
   c. Explain procedure to patient.
   d. Check for Chloraprep, Heparin, Betadine, and alcohol allergies.
   e. Use standard precautions while accessing implanted venous ports (refer to Infection Control: Standard and Transmission Based Precautions Policy IC.5)
   f. Wear a mask and surgical hat during procedure.
   g. Assemble equipment on sterile field.
   h. Perform hand hygiene and don sterile gloves and using aseptic technique waste 5mL normal saline from 10mL pre-filled syringe then prime the non-coring safety needle and extension tubing (with neutral displacement connector attached). Leave the syringe attached.
   i. Using Chloraprep, cleanse area over implanted port thoroughly with a gentle back-and-forth motion for 30 seconds. Allow to air-dry for 30 seconds. Do not fan or blow on site to speed drying. Use Betadine if patient is allergic to Chloraprep or alcohol.
      i. Locate port septum by palpation and triangulate port between the thumb and first

two fingers of non-dominant hand.

ii. Aim for the center of the port and insert the needle, perpendicular to port septum. Advance needle through skin and septum until it reaches the bottom of the reservoir.

j. Do not begin injection or infusion until proper needle placement is confirmed by aspirating blood. Confirm placement by:
   i. Aspirating 5 mL of blood using the 10 mL syringe attached to the extension tubing.
   ii. Waste 5 mL aspirant.
   iii. Flush with 10 mL normal saline.
   iv. Apply dressing ~~per "Dressing Change" (section G) procedure~~.
      1) Date and initial dressing.

k. After procedure, flush with 10 mL normal saline and follow with catheter specific flush (see Catheter Specific Flushes Table) or connect to IV infusion as ordered.
   i. If implanted port must be accessed multiple times for PRN or intermittent medication regime, obtain a physician's/AHP's order for KVO solution.
   ii. If KVO order is unobtainable and port must be accessed multiple times perform the following:
      1) Withdraw 5 mL from accessed implanted port and discard (removes heparin).
      2) Flush port with 10 mL of normal saline after heparin has been removed.
      3) Administer medication or IV via port.
         a) When port is no longer needed, flush with 10 mL of normal saline and heparinize port per flush table (Catheter Specific Flushes Table).

l. Access needle for implanted ports shall be changed every 7 days.

2. De-accessing procedure:

a. If port is heparinized, no flush is needed ~~and skip to e. of this section~~.

b. If port is not heparinized

~~b.~~**i.** Check for blood return prior to flushing port with a 10 mL pre-filled normal saline syringe.

~~c.~~**ii.** Flush port with 10 mL normal saline.

~~d.~~**iii.** Always flush port with specific flush prior to de-accessing (see Catheter Specific Flushes Table).

~~e.~~**c.** Perform hand hygiene, apply mask and don clean non-sterile gloves to remove transparent dressing. Lift from the edge and stretch film laterally for easier removal. Remove securement device if applicable.

~~f.~~**d.** Inspect the site for signs of infection (redness, pain, swelling and/or purulent drainage).

~~g.~~**e.** Cleanse exit site using Chloraprep, the preferred antiseptic, or Betadine if patient is allergic to Chloraprep or alcohol. Let dry for 30 seconds.

~~h.~~**f.** To remove the non-coring safety needle device, place fingers on the base to stabilize. With other hand, place finger on the tip of the safety arm. Lift the safety arm straight back as needle is safely removed. A click will be heard indicating the tip of the needle is fully encased.
   i. If removing a non-coring needle device that does not have a safety feature to prevent a needle stick, use two tongue depressors to stabilize in between the patient's skin and underneath the non-coring needle device to prevent a rebound of the needle when removing.

~~i.~~**g.** If access had a central line dressing and was not an in and out access, cleanse site using alcohol wipe or chlorhexidine before applying band-aid. Allow to dry for 30 seconds.

~~j.~~**h.** Apply small band-aid.

~~k.~~**i.** Discard needle in a sharps container.

~~H.~~J. **REMOVAL OF NON-TUNNELED CENTRAL LINES (PICCs, Multi-Lumen, Vas Cath):**

1. Procedure:
   - **a.** Verify physician/AHP order to discontinue line.
   - **b.** **Verify correct patient using two patient identifiers.**
   - **c.** **Ensure a peripheral line is present and patent.**
   - ~~a.~~**d.** **Transfer or discontinue any IV solutions infusing through the central line**
   - ~~b.~~**e.** ~~Assemble~~ **Gather** supplies (see Central Line Supply List).
   - **f.** Explain procedure to patient, **and reason for removal**
     - **i.** **Explain the importance of patient participation during the catheter removal**
       - **1)** **The patient will be asked to hold their breath and bear down slightly as the catheter is removed.**
     - **ii.** **Instruct patient to report any signs or symptoms during or after removal:**
       - **1)** **Shortness of breath**
       - **2)** **Bleeding at the site of removal**
       - **3)** **Discomfort at the site of removal** ~~.~~
   - **g.** **Assess vital signs, coagulation values, and the catheter site**
     - **i.** **Notify physician/AHP for any abnormal coagulation results, or any signs/symptoms of site infection (warmth, tenderness, drainage).**
       - ~~c.~~**1)** **If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's/AHP's order**
   - ~~d.~~**h.** Place absorbent pad under catheter site.
   - ~~e.~~**i.** Have patient lay flat **and, if not contraindicated, place bed in slight Trendelenberg's position to minimize risk of air being drawn in causing a venous air embolism.** ~~or have head of bed no more than 30 degrees if possible.~~
   - **j.** **Have patient turn his or her head away from the catheter site (for internal jugular and subclavian sites only).**
   - **k.** **Ensure that all central line lumens are capped and/or clamped**
   - ~~f.~~**l.** Use standard precautions for removal of non-tunneled central lines (refer to Infection Control: Standard and Transmission Based Precautions Policy IC.5).
   - ~~g. Open the suture removal kit.~~
   - **m.** Perform hand hygiene, apply mask and don clean non-sterile gloves to remove the dressing and discard.
   - ~~h.~~**n.** **Remove the non-sterile gloves, perform hand hygiene, and apply a pair of sterile gloves.**
   - ~~i. Check site for signs of infection.~~
     - ~~i. If there are signs of infection, send the catheter tip to the laboratory for culture and sensitivity testing, per physician's/AHP's order.~~
   - ~~j.~~**o.** Remove securement device if applicable.
   - ~~k.~~**p.** Cleanse exit site with Chloraprep with a back and forth motion for 30 seconds. Use Betadine if patient is allergic to Chloraprep or alcohol.
   - ~~l.~~**q.** Carefully remove sutures by grasping one-at-a-time with forceps held by the non-dominant hand. Use the dominant hand to clip suture at a spot close the skin. Take care so as not to cut catheter or patient's skin. **Gently pull the sutures through the skin.**
   - **r.** Instruct patient to **take a deep breath in and hold it, and to** perform Valsalva maneuver during removal **unless contraindicated.** ~~If patient is unable to hold his/her breath and bear down, place the bed as flat as possible.~~
     - **i.** **If the patient is unable to follow directions, remove the catheter during the patient's exhalation phase.**
     - ~~m.~~**ii.** **If patient is receiving mechanical ventilation, catheter will be removed during the inspiratory phase, or when a breath is delivered via a bag-valve device.**
     - iii. For PICC linesss, ~~h~~have patient keep her/his arm straight.
     - ~~i.~~**iv.** **For catheters in the femoral vein, have the patient extend the leg and ensure the groin area is adequately exposed.**

s. ~~With 4x4 pad in non-dominant hand, grasp catheter with dominant hand and gently pull the catheter to remove. As catheter is coming out, place 4x4 over insertion site.~~

t. **With a 4x4 pad in the non-dominant hand, withdraw the catheter with the dominant hand.**
   - i. **Pull catheter parallel to the skin using a steady continuous motion.**
   - ii. **As catheter is coming out, place the 4x4 pad over the insertion site.**
   - iii. **The distal end of the catheter should be removed quickly to prevent the proximal and medial openings (in a multi-lumen catheter) from permitting entry of air into the venous system.**
   - ~~n.~~iv. **If resistance is met, do not continue to remove the catheter, and notify the physician/AHP.**

u. Once removed, **instruct the patient to exhale, and** apply pressure with **two fingers using the** ~~sterile~~ 4x4 gauze to the insertion site ~~for 5-10 minutes or until~~ bleeding has ceased.
   - ~~o.~~i. **Hemostasis may take up to 10 minutes.**
   - ii. If patient is taking anticoagulation medication, you may need to hold pressure for 10-20 minutes.
   - ~~i.~~iii. Call MD if there is excessive bleeding or site continues to bleed after 20 minutes of applying pressure to the site.

v. **Lay the catheter on the absorbent pad, and check to be sure that the entire catheter has been removed.**
   - i. **If damage or fragmentation of the catheter is suspected, notify the physician/AHP immediately. Do not discard the catheter.**

w. **If the physician/AHP orders the catheter tip to be cultured, have another provider assist with cutting the catheter tip with sterile scissors and placing it in a sterile specimen container before placing the catheter on the absorbent pad.**
   - 1) **Routine culturing of catheter tips is not recommended.**

x. **Once bleeding has stopped, a**~~A~~**pply an occlusive dressing consisting of sterile Xeroform petroleum-based gauze, and cover with a** ~~new sterile folded 4x4, secure with~~ large transparent dressing.~~,~~

y. ~~and i~~Instruct patient to leave dressing on for 24 hours. Place date and initials with a permanent black marker on dressing.

z. **Instruct patient to:**
   - i. **Remain in supine position, if tolerated, for 30 minutes after catheter removal;**
   - ~~p.~~ii. **Report shortness of breath, hematoma, or bleeding.**

aa. ~~Instruct patient to report shortness of breath, hematoma, or bleeding.~~

~~q.~~**bb. Remove and discard used supplies in appropriate receptacles.**

~~I.~~K. **ACCESSING THE DOUBLE LUMEN SUBCLAVIAN/INTERNAL JUGULAR VASCATH/PERMCATH:**

1. These catheters contain large doses of heparin. Heparin must be aspirated before use.
2. Accessing procedure:
   - a. Obtain a physician's/AHP's order to access only the venous port (blue port).
   - b. Explain procedure to patient.
   - c. Assemble supplies (see Central Line Supply List).
   - d. Use standard precautions while accessing the double lumen subclavian/internal jugular vascath/permcath (refer to Infection Control: Standard and Transmission Based Precautions Policy IC.5).
   - e. Expose the vas cath/permacath in a way to prevent the patient from contaminating the ports with linens or gown.
   - f. Place a sterile chux or drape under the access area to protect clothing and linen.
   - g. Perform hand hygiene, apply mask and don sterile gloves.
   - h. Ensure venous line is clamped before accessing.
   - i. Saturate venous port thoroughly with Betadine and let stand for 5 minutes.

j. Remove access cap and place sterile displacement connector (Microclave) on the end of port.
k. Attach 10 mL syringe using aseptic technique.
l. Unclamp and aspirate 5 mL (7 mL if drawing a PT or PTT).
m. Clamp line and discard syringe.
n. Attach 10 mL syringe containing 10 mL of normal saline.
o. Unclamp venous port and instill 10 mL of normal saline.
p. Clamp venous port and remove syringe.
   i. Venous line may now be accessed for IV fluids/IV medication administration.
      1) If a blood draw is needed, refer to Patient Care Services: Collection of a Blood Specimen by Skin Puncture Procedure.

3. De-accessing:
   a. Flush venous port with 10 mL of normal saline after medication administration, after discontinuing IV fluids or after completion of blood draw.
   b. Heparinize Port (see Catheter Specific Flushes Table for dosage) and label with a "Caution – High Dose Heparin" sticker.

~~J.~~L. RELATED DOCUMENT(S):

1. Central Line Catheter Specific Flushes ~~–Sample~~
2. Central Line Supply List ~~–Sample~~
3. Infection Control: Standard and Transmission Based Precautions Policy IC.5
4. Patient Care Services: Specimen Labeling, Nurse Collectibles Procedure
5. Patient Care Services: Sterile Technique Policy
6. Patient Care Services: Catheter Clearance with Alteplase (Cathflo Activase) Procedure
7. Patient Care Services: Collection of a Blood Specimen by Skin Puncture Procedure
8. Patient Care Services: Standards of Care, Adult
9. Patient Care Services: Universal Protocol Procedure

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

~~1. Bard, Hickman, Leornard, Broviac, Intro-Eze, & Surecuff (2007). Hemodialysis/apheresis long term central venous catheters. *Bard Access Systems, Inc.*~~
~~2.~~1. Infusion Nurses Society (**2021**~~2016~~). Infusion nursing standards of practice. *Infusion Nursing Society (INS).*
~~3.~~2. Infusion Nurses Society (**2021**~~2016~~). Policies and procedures for infusion therapy. *Infusion Nursing Society (INS).* 5th edition.
~~4.~~3. San Diego Dialysis Center. (2014). FMC hemodialysis procedure manual.
4. **Elsevier Performance Manager Clinical Skills. (2020, 06 22). *Central Venous Cather: Blood Sampling.* Retrieved from Elsevier Performance Manager Clinical Skills: https://point-of-care.elsevierperformancemanager.com/skills/73/quick-sheet?skillId=CC_061**
5. **Elsevier Performance Manager Clinical Skills. (2020, 06 22). *Central Venous Catheter: Maintanance and Dressing Change.* Retrieved 06 22, 2020, from Elsevier Performance Manager Clinical Skills: https://point-of-care.elsevierperformancemanager.com/skills/77/quick-sheet?skillId=CC_065**
~~5.~~6. **Wiegand, D. L. ((2017). Procedure manual for high acuity, progressive, and critical care. 7th ed. Elsevier, St. Louis, MO.**

RETIRE Sample – Move & Link as Related Document

Central Line Supply List ~~–Sample~~

Central Line Supply Lists	
	1. Central Line insertion kit 2. Caps for assistant and physician/AHP 3. Full face shield for assistant 4. Mask with face shield for physician/AHP 5. Sterile gloves for assistant and physician/AHP 6. Sterile gown for physician/AHP 7. Full body sterile drape 8. Alcohol gel hand hygiene solution
Flushes	1. Non-sterile gloves. Mask if flushing a vas cath/permacath. 2. Alcohol wipes 3. Sterile field (may use 4x4 sterile gauze) 4. Sterile flush solution (see Catheter Specific Flushes - Attachment B) 5. 10mL Sterile normal saline filled syringe 6. 1 neutral displacement connector for each lumen.
Blood Specimen Collection	1. Non-sterile gloves (sterile gloves and sterile field for blood cultures) 2. Mask and goggles or full-face shield 3. Alcohol wipes (3) or chlorhexidine swab 4. One 10 mL luer lock syringe for blood waste 5. Luer lock syringe(s) for blood specimen collection as provided by phlebotomist or safety vacutainer blood collection device 6. Patient lab identification labels 7. Vacuum blood specimen tubes as provided by phlebotomist 8. Plastic bag with patient labels for ACS and Telemetry morning blood draws 9. 10mL luer lock syringe with 10mL sterile normal saline 10. Sterile flush solution as appropriate (see Catheter Specific Flushes - Attachment B) 11. Neutral displacement connector
Dressing Changes	1. entral line dressing change kit 2. Sterile gloves 3. Neutral Displacement Connector (color specific for that day)
Accessing or De-accessing Implantable Venous Ports	1. Central Line Dressing Kit a. Non-sterile gloves b. Mask c. Cap d. 2 x 2 gauze e. Chloraprep (use Betadine if patient has allergy) f. Transparent Dressing g. Biopatch (Mediport kit does not have Biopatch) 2. Neutral Displacement Connector 3. Sterile gloves 4. 10mL syringe filled with sterile normal saline 5. Steri Strips (optional) 6. Use only non-coring safety needle device to access implanted port, 7. Extension tubing per patient needs for length and gauge. 8. Neutral displacement connector attached to extension tubing 9. Tape 10. Additional supplies if De-Accessing a. Flush solution as appropriate (See Central Line Catheter Specific Flushes) b. Bandaid c. Tongue Depressors x2 if access needle is not a safety needle
Removal Of Non-Tunneled Central Lines (PICCs, Multi-Lumen, Vas Cath)	~~1.~~a. Non-sterile gloves/ Mask and goggles or full-face shield ~~2.~~b. Suture Removal Kit ~~3.~~c. Barrier-proof absorbent pad ~~4.~~2. Regular plastic bag for packaging and dressing disposal ~~5.~~a. 2x2 gauze, two 4x4 gauze ~~6.~~b. Large transparent dressing

	c. Chloraprep **Swab 3-pack** or Betadine if patient is allergic to Chloraprep or alcohol i. **Obtain and use Betadine instead if patient is allergic to Chloraprep** d. **Xeroform Petroleum-based 2x2 dressing** **3. Sterile Gloves** **4. Sterile specimen container if a culture of the catheter tip will be obtained.** **~~7.~~5. Sterile scissors if a culture of the catheter tip will be obtained.**

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Central Line Catheter Specific Flushes ~~– Sample~~

CENTRAL LINE CATHETER SPECIFIC FLUSHES			
TYPE	FLUSH SOLUTION	FREQUENCY	COMMENTS
Central Lines	Normal saline10mL	Q 8 hrs	1. Use proximal port as 1st choice for drawing blood, routine IV administration, and medication. 2. Use Medial port for TPN and may use for medications only if TPN not being given and not anticipated. 3. Distal port as alternative site for blood draw, administration of viscous fluids (i.e. blood products, colloids, albumin), CVP monitoring, and continuous fluid administration.
PICC/Midline	Normal saline 10mL	Q 8 hrs	
Patients going home with Central line or PICC	Heparin 20 units per lumen • 2mL of Heparin (10units /mL)	Q 12 hrs	Home Care: Q 24 hrs
Groshong	Normal saline 10mL	Once a week	
Implanted Port (VAD)			
Groshong	Normal saline 10mL	Once a month	
Vita-Port	Heparin 300 units • 300 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician/AHP order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Medi-Port	Heparin 500 units • 500 units Heparin in pre-filled syringe (100 units/ml) • If Heparin pre-filled syringes are unavailable, pharmacy will provide patient-specific syringes.	Once a month	1. Get a physician/AHP order for KVO solution if port must be accessed multiple times. 2. Withdraw 5mL from port to remove heparin if port must be accessed multiple times before flushing with 10mL of normal saline.
Vas Cath	Heparin Concentration 1000 units/mL • Check number on venous port • Instill that exact number in mL of heparin using the 1000 units/mL concentration (i.e. 1.6=1.6mL, 1.7=1.7mL, 1.8=1.8mL).	Once a week If not being accessed for dialysis	1. Only the Venous (blue port) port may be accessed and a Physician's/AHP's order is required before use. 2. Venous port must be clamped before syringes are connected or withdrawn. 3. Accessing – MUST ASPIRATE HEPARIN BEFORE USE. Using a 10mL syringe, remove 5mL of blood from the venous port and discard (7mL if drawing PT and/or PTT). Then port can be accessed. 4. De-accessing – Each Vas Cath/Permacath have a number located on the venous port that is the number of mL of heparin to be instilled when heparinizing the port (i.e. 1.6,1.7, 1.8)

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: CODE BLUE AND EMERGENCY CARE

I. **POLICY:**

A. Function: Management of Code Blue and emergency care in the adult (14 years or older) patient including cardiopulmonary arrest (CPA), cardiac dysrhythmias, acute respiratory compromise (ARC), and hypotension associated with volume deficit.

1. Special considerations shall be observed in the management of cardiac arrest, bradycardia, asystole, and pulseless electrical activity (PEA) in the post-sternotomy patient following cardiac surgery.

B. Circumstances:

1. Setting: Tri-City Medical Center
2. Supervision: None required. However, upon arrival of a physician or Code Blue Registered Nurse (RN), nursing staff will follow orders of the Code Blue RN and ultimately orders from physician.
3. Patient contraindications – Patients with written orders contrary to ~~of~~ the Standardized Procedure. Patients with Special Considerations:
   a. No Code – A no-code is synonymous with "no resuscitation" or "do not resuscitate" and allow a natural death

C. Definitions:

1. Cardiopulmonary Arrest (CPA)- any pulseless cardiac arrests requiring chest compressions and or defibrillation, or cardiac events with pulse requiring chest compression for poor perfusion
2. Cardiac Dysrhythmias – Any sustained tachy or brady dysrhythmias requiring immediate intervention due to life threatening potential or that may result in the patient becoming symptomatic.
3. Acute respiratory compromise (ARC) – Any decrease in respiratory rate, depth, and/or decrease in oxygenation requiring immediate intervention due to life threatening potential or that may result in a patient becoming symptomatic.
4. Hypotension associated with volume deficit – Any decrease in blood pressure of 30 - 40 mmHg or more from pre-operative/pre-procedural levels or less than 80 mmHg systolic associated with signs of absolute or relative fluid loss.
5. Emergent Resternotomy – A re-opening of a surgically-closed sternum to resuscitate a patient experiencing a life-threatening arrest following cardiac surgery to reverse cardiac tamponade and/or to provide internal cardiac massage.

D. Data Base:

1. Subjective – Patient complains of dizziness, lightheadedness, chest pains, shortness of breath, or confusion.
2. Objective – Decreased level of consciousness or unresponsive, respirations labored or absent and/or pulse absent, rhythm disturbances (if patient is monitored), low or absent blood pressure.
3. Diagnosis – Life threatening emergency.
4. Plan:
   a. Initiate Standardized Procedure as appropriate and notify attending physician
      i. Notify cardiothoracic surgeon if patient is a post-sternotomy cardiac surgery patient.

Revision Dates	Clinical Policies & Procedures	Nursing Leadership Executive Council	Pharmacy and Therapeutics	Critical Care Committee	Inter-disciplinary Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
03/00, 01/05, 12/05, 05/08, 06/11, 07/13, 09/14	03/11, 07/13, 09/14, 02/17, 05/17, 05/20	03/11,10/14, 02/17, 05/17, 06/20, 05/22	06/11, 09/14, 05/17, 07/20, 07/22	02/15, 08/17, 06/21, 08/22	06/11, 04/15, 01/18, 07/21, 10/22	06/11, 05/15, 04/18, 10/21, 01/23	02/23	08/15, 05/18	06/11, 08/15, 05/18

ii. Notify anesthesiologist **for patients in Perianesthesia Care Unit (PACU) and Obstetrical PACU or Operating Room**~~via the Operating Room~~ at extension 5400

b. Initiate standardized procedure/advanced life support as appropriate and call Code Blue by dialing 66 on the telephone request a "Code Blue" announcement and provide patient location.

5. Assessment -- Patient will be reassessed after each intervention.
6. Record Keeping -- Events are to be recorded in the electronic health record (EHR) (in the emergency event record) and the Cardiopulmonary Arrest Record. White copy to remain on chart.

II. **PROCEDURE:**

A. CARDIAC DYSRHYTHMIAS
1. Continuous cardiac monitoring.
2. Administer oxygen to maintain SpO_2 greater than or equal to 95%
3. Establish IV access with normal saline (NS) solution.
4. Notify attending physician/anesthesiologist in PACU prior to initiation of treatment if situation permits. Otherwise, contact appropriate physician after therapy is started.

B. ASYSTOLE OR PULSELESS ELECTRICAL ACTIVITY (PEA)
1. Initiate CPR at a rate of 100-120/minute ratio 30:2 and call Code Blue.
   a. Special Considerations for Post-Sternotomy patients experiencing asystole: Before initiating CPR, if epicardial pacing wires are present, first connect pacing wires to external pacemaker and initiate emergency pacing (Mode at 80 beats per minute at the maximum atrial and/or ventricular output voltages).
      i. In the absence of epicardial pacing wires, initiate external pacing.
      ii. If there is a delay in obtaining pacing equipment beyond one minute, begin CPR.
      ~~b.~~**iii.** If attempts to pace fail to restore cardiac output, begin CPR.
      ~~c.~~**iv.** Prepare for emergent resternotomy within five minutes of onset of event.
   ~~d.~~**b.** Special Considerations for Post-Sternotomy patients experiencing PEA: If a pacemaker is attached and functioning, briefly turn off the pacemaker to exclude underlying ventricular fibrillation (VF).
2. Establish IV access with NS.
3. Confirm asystole in more than one lead.
4. Administer Epinephrine (0.1 mg/mL) 1 mg IV, repeat every 3-5 minutes.
   a. Use Epinephrine cautiously in the post-sternotomy patient by administering in increments of 0.5 mg IV.
5. Obtain ABGs.

C. VENTRICULAR FIBRILLATION AND PULSELESS VENTRICULAR TACHYCARDIA
1. Initiate CPR at a rate of 100-120/minute ratio 30:2 and call Code Blue.
   a. Special Considerations for Post-Sternotomy patients: Before initiating CPR, attempt to administer up to three consecutive defibrillation shocks with 200 joules each.
   b. External cardiac massage may be delayed up to one minute while providing defibrillation attempts.
   c. After three failed attempts to defibrillate, begin CPR.
   d. Prepare for emergent resternotomy within five minutes of event.
   e. Administer Amiodarone 300 mg IVP via a central line.
   f. Continue CPR with single defibrillation with 200 joules every two minutes until resternotomy.
2. Defibrillate with 200 joules. Resume CPR immediately after shock for 5 cycles or 2 minutes.
3. Establish IV access with NS.
4. Administer all medications during CPR or before or after defibrillation.

5. Epinephrine: (0.1 mg/mL)1 mg IV, repeat every 3 - 5 minutes.
   a. Use Epinephrine cautiously in the post-sternotomy patient by administering in increments of 0.5 mg IV.
6. Pause CPR briefly (less than 10 seconds) to check rhythm after 5 cycles or 2 minutes of CPR.
7. Defibrillate with 200 joules and resume CPR for 5 cycles (2 minutes)
8. Consider antiarrhythmic:
   a. Amiodarone 300 mg IVP once.
   b. In 3 – 5 minutes, consider,
      i. Additional 150 mg of Amiodarone IV push
      ii. Lidocaine 1.5 mg/kg IV push first dose, then 0.5 mg/kg, repeat in 5 minutes up to a total of 3 doses or total dose of 3 mg/kg.
9. Defibrillate with 200 joules and resume CPR for 5 cycles or 2 minutes
10. Consider Magnesium sulfate 2 grams (4 mL of a 50% solution diluted in 10 mL D5W or normal saline) IVP or intraosseous (IO) for torsades de pointes. Identify and treat cause.
11. After return of spontaneous circulation (ROSC), begin continuous infusion of medication effective in dysrhythmia suppression as recommended below:
    a. Amiodarone 1 mg/min x 6 hours, then 0.5 mg/min maintenance drip
    b. Lidocaine drip (2 gm in 500 mL D5W) at 1mg/min

D. BRADYCARDIA:

SYMPTOMATIC: Serious signs and symptoms such as chest pain, shortness of breath, decreased level of consciousness, or hypotension are present and believed to be related to a slow heart rate.

1. Administer oxygen to maintain SpO_2 greater than or equal to **~~94~~95%**
2. Establish IV access with NS.
3. Special Considerations for Post-Sternotomy patients experiencing severe bradycardia: If epicardial pacing wires are present, connect pacing wires to external pacemaker and initiate emergency pacing (DOO mode at 80 beats per minute at the maximum atrial and/or ventricular output voltages).
   a. In the absence of epicardial pacing wires, initiate external pacing.
4. Atropine **1.0~~0.5~~** mg IV push, repeat every 3 - 5 minutes up to a total of 3 mg.
   a. Atropine is not recommended for the post-sternotomy patient.
5. Initiate transcutaneous pacing (TCP) at rate of 80 and mA of 80.
   a. Ensure 1:1 capture is obtained
   b. Set safety margin 10 mA above initial capture
6. Consider dopamine 5 mcg/kg/min. The ~~Code Blue~~ RN may titrate in increments of 2 mcg/kg/min every 5 minutes to maintain heart rate greater than 60bpm up to 20 mcg/kg/min as Blood Pressure tolerates. Or start Epinephrine 2 mcg/min. The ~~Code Blue~~ RN may titrate in increments of 2 mcg/min every 5 minutes to maintain heart rate greater than 60bpm up to 20 mcg/min as BP tolerates.

E. TACHYCARDIA – UNSTABLE PULSE PRESENT:

UNSTABLE: Heart rate is greater than 150 bpm and serious signs and symptoms such as chest pain, shortness of breath, decreased level of consciousness, altered mental status, hypotension, or acute heart failure are present and believed to be related to rapid rate. Prepare to perform immediate synchronized cardioversion.

1. Institute oxygen therapy to maintain SpO_2 greater than or equal to 95%.
2. Establish IV access with NS.
3. Notify Respiratory Care Practitioner (RCP)
4. Consider sedation if the patient is conscious, ~~but~~ do not delay cardioversion.
5. Ensure the defibrillator pads and monitor leads, **as applicable,** are attached to the patient and the defibrillator is in synchronization mode
6. Synchronized cardioversion with the following initial dose. Select synchronization mode with each increase in joules.
   a. Narrow Regular QRS Complex: Cardiovert with 50 – 100 joules.

b. Narrow Irregular QRS Complex: Cardiovert with 120 – 200 joules.
c. Wide Regular QRS Complex: Cardiovert with 100 – 200 joules.
d. Wide Irregular QRS Complex. Do not use synchronized function. Defibrillate with 200 joules.

7. Call Code Blue, if appropriate.

F. TACHYCARDIA STABLE (Regular QRS Complex Pulse Present):
1. Narrow Regular QRS Complex:
a. Attempt Vagal maneuvers (bear down, cough)
b. Adenosine 6 mg rapid IV push, **followed by 20cc rapid saline flush,** repeat in 1 - 2 minutes with 12 mg **rapid** IV push **if need, followed by 20cc rapid saline flush** ~~if needed~~.
2. Undifferentiated Regular Monomorphic Wide QRS Complex
a. Adenosine 6 mg rapid IV push, **followed by 20cc rapid saline flush,** repeat in 1 – 2 minutes with **Adenosine** 12 mg **rapid** IV push **if needed, followed by 20cc rapid saline flush** ~~if needed~~
b. Amiodarone 150 mg IVPB over 10 minutes. **(S**seek expert consultation for maintenance infusion.**)**

G. TACHYCARDIA (Stable Irregular QRS Complex Pulse Present)
1. Identify rhythm as atrial fibrillation or atrial flutter or multifocal atrial tachycardia
a. Narrow Irregular QRS Complex **seek expert consultation to control rate with diltiazem or beta blockers.**
~~i. Seek expert consultation to control rate with diltiazem or beta blockers~~
b. Wide Irregular QRS Complex, **Amiodarone 150mg IVPB over 10 minutes and seek expert consulation to control rate.**
~~i. Amiodarone 150 mg IVPB over 10 minutes~~
~~ii. Seek expert consultation to control rate~~

H. CHEST PAIN (Related to coronary artery occlusion or spasm.)
1. Assess pain quantity, quality, location, radiation, time of onset and precipitating factors.
~~1.~~**2.** **Obtain STAT 12-lead ECG and review for ischemic changes.**
~~2.~~**3.** Apply oxygen at 4 L/min via nasal cannula.
a. Supplemental oxygen is not needed for patients without evidence of respiratory distress if the SpO_2 is greater than or equal to 95%.
~~3.~~**4.** Administer Nitroglycerin 0.4 mg sublingual every 5 minutes PRN for chest pain up to 3 doses. Hold if SBP is less than 90 mmHg.
a. If Nitroglycerin is ineffective in relieving chest pain and patient has no contraindications, administer Morphine 1 mg IV push times 1.
i. Use with caution in unstable angina/non-STEMI.
~~4.~~**5.** ~~Obtain STAT 12-lead ECG and review for ischemic changes~~.

I. ACUTE RESPIRATORY COMPROMISE(With pulse)
1. Open patient's airway and administer one breath approximately every 6 seconds via bag **valve** mask.
2. Administer oxygen to maintain SpO_2 greater than or equal to 95%.
3. Call Code Blue if appropriate.
4. Establish IV.
5. Administer Naloxone (Narcan) 0.4 mg IV if patient has a patient controlled analgesia (PCA) or receiving narcotics.
6. Obtain STAT ABGs and chest x-ray as indicated.
7. Assist with intubation as appropriate.

J. HYPOTENSION ASSOCIATED WITH VOLUME DEFICIT
1. Administer oxygen to maintain SpO_2 greater than or equal to 95%.
2. Establish large bore IV access with normal saline solution.
3. Infuse 250 mL normal saline or lactated ringers; repeat every 10 minutes up to a total of 1000 mL.

4. After fluid bolus, consider vasopressors to maintain systolic blood pressure greater than 90 mmHg
   a. Dopamine 5 mcg/kg/min. The ~~Code Blue~~ RN may titrate in increments of 2 mcg/kg/min every 5 minutes for SBP> 90mmHg or MAP >65mmHg up to 20 mcg/kg/min
   b. Norepinephrine 2 mcg/min. The ~~Code Blue~~ RN may titrate in increments of 2 mcg/min every 5 minutes for SBP >90mmHg or MAP > 65mmHg up to 30 mcg/min.

III. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration.
B. Review: Every two (2) years.
C. Standardized Procedure follows American Heart Association (2015) Advanced Cardiac Life Support Guidelines.

IV. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All ACLS-certified Registered Nurses from the following clinical areas:
   1. Intensive Care Unit
   2. Telemetry
   3. Post Anesthesia Care Unit
   4. Endoscopy, Cardiac Cath Lab and Interventional Radiology who have successfully completed requirements as outlined below are authorized to direct and perform the Code Blue and Emergency Care (Cardiopulmonary Arrest) Standardized Procedure.
   5. Emergency Department

V. REQUIREMENTS FOR RNs INITIATING INTERVENTIONS:

A. Current **unencumbered** California RN license.
B. Education: Successful completion of Basic ECG course, ACLS course (with a current course completion card).
C. Experience: Initial job requirement.
D. Initial Evaluation: During ~~initial Critical Care Skills Lab or in~~ Department Orientation.
E. Ongoing Evaluation: Annually ~~during Skills Validations with standardized procedure test~~.

VI. REFERENCE(S):

A. American Heart Association (AHA): Advanced Cardiovascular Life Support (ACLS)
B. Dunning et al. (2017) The society of thoracic surgeons expert consensus for the resuscitation of patients who arrest after cardia surgery. *The Annals of Thoracic Surgery 103*(3), 1005-1020.
C. Ley, S. J. (2015) Standards for resuscitation after cardiac surgery. *Critical Care Nurse, 35*(2), 30-38.

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**COMPUTERIZED AXIAL TOMOGRAPHY (CT) DOWNTIME RESPONSE**
Purpose:	To outline process during CT downtime.

A. **POLICY:**

1. Tri-City Medical Center (TCMC) has two (2) operational CT scanners. In the event that one (1) scanner is down the patients will be prioritized for examination based on patient acuity.
2. Downtime response is not required for routine maintenance of one (1) scanner at a time.
3. For scheduled downtime of one (1) machine lasting one week or greater, a mobile CT scanner will be secured prior to the downtime.
4. If both scanners are anticipated to be down greater than (>) two (2) hours, an attempt to locate a mobile CT scanner will be immediately initiated.

B. **PROCEDURE IF BOTH CT SCANNERS DOWN:**

1. Unanticipated Downtime:
   a. Radiology calls:
      i. The Emergency Department (ED) ~~Assistant Nurse Manager (ANM)~~**Nurse Leader (NL)**/designee at extension 3509 to provide an estimate of the duration of CT Scanner downtime.
         1) The ED ~~ANM~~**NL**/designee notifies ED physicians of CT downtime as appropriate.
      ii. The Administrative ~~Coordinator~~**Supervisor (AS)**
         1) Notifies Hospitalists and Administration as appropriate.
   b. The ED ~~ANM~~**NL**/designee and ED physicians evaluate the need for diversion of head injuries, potential stroke patients, and traumas.
   c. The Mobile Intensive Care Nurse (MICN) enters this information into the Image Trend Resource Bridge to notify agencies of diversion status.
   d. Radiology leadership will notify the Radiology Medical Director or Radiologist On-Call.
   e. Radiology notifies:
      i. ED ~~ANM~~**NL**/designee when CT is functioning.
         1) ED ~~ANM~~ **NL**/designee notifies MICN and appropriate agencies, and AS when the CT is available.
      ii. Administrative ~~Coordinator~~**Supervisor**
         1) Hospitalists and Administration as appropriate.
2. Scheduled Downtime:
   a. Radiology leadership shall notify the ED ~~Manager~~**Leadership** not less than 10 days prior to scheduled Preventive Maintenance (PM) date.
   b. The ED ~~Manager~~**Leadership** or designee shall notify ED physicians, MICN nurse, and staff of scheduled downtime.
   c. Radiology notifies ED ~~ANM~~**NL**/designee when CT is functioning.
      i. ED ~~ANM~~**NL**/designee notifies MICN, and appropriate agencies and AS when the CT is available.

Patient Care Services ~~Department Review~~	Clinical Policies & Procedures Committee	Nursing Leadership ~~Executive Council~~	Department of Emergency Medicine	Pharmacy & Therapeutics Committee	Medical Executive Committee	Professional Affairs Committee	Administration	Board of Directors
9/05; 12/08, 03/18, **09/22**	08/11, 04/18, **10/22**	08/11, 04/18, **11/22**	05/18, **12/22**	n/a	10/11, 05/18, **01/23**	11/11, 06/18	**02/23**	11/11, 06/18

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

STANDARDIZED PROCEDURE: EMERGENCY DEPARTMENT

I. **POLICY:**

A. Function: To define appropriate utilization of specific orders and order sets, otherwise referred to as standardized procedures.

B. Circumstances:

1. Setting: Tri-City Medical Center, Emergency Department (ED)
2. Supervision: An Emergency Department Physician will be available for consultation. Registered Nurses will immediately contact the physician for any patient who is critical in nature or unstable. Physician contact will not be delayed in order to initiate or complete Standardized Procedures.
3. Patient contraindications: None

C. Documentation:

1. The Registered Nurse (RN) will document all interventions performed into the electronic health record (EHR).
2. The RN will enter all orders performed per the standardized procedure in the EHR.

II. **PROCEDURE:**

A. Abdominal Pain between the ages of 10 – 29 :

1. In patients who present to the ED with abdominal pain, the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Jic Blue
      iv. Serum HCG in females
      v. Lipase
   b. Nurse Orders:
      i. Routine urinalysis with reflex culture
   c. Medications:
      i. For patients who are >=16 years old, the RN may order Ondansetron (Zofran) 8 mg oral disintegrating tablet (ODT) times one (1), prn for nausea
      ii. For patients who are 10-15 years old, the RN may order Ondansetron (Zofran) 4 mg oral disintegrating tablet (ODT) x one (1) prn nausea

B. Abdominal Pain, ages 30 and older :

1. In patients who are >= 30 years old who present to the ED with abdominal pain, the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Jic Blue
      iv. Serum HCG in females aged 30 to 55
      v. Lipase
   b. Nurse Orders:
      i. Routine urinalysis with reflex culture

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Department of Emergency Medicine	Pharmacy & Therapeutics Committee	Inter-disciplinary Committee	Medical Executive Committee	Admini-stration	Professional Affairs Committee	Board of Directors
06/04, 03/06, 08/08, 07/09, 06/11, 06/14, 12/18, 07/21	01/11, 11/13, 10/14, 01/15, 12/16, 12/18, 02/22	01/11, 11/13, 10/14, 02/15, 03/17, 12/18, 03/22	06/11, 12/14, 05/17, 02/19, 04/22	06/11, 11/13, 01/15, 07/17, 03/19, 7/22	06/11, 02/14, 06/15, 10/17, 04/19, 10/22	06/11, 02/14, 06/15, 03/18, 07/19, 01/23	08/19, 02/23	06/15, 04/18, n/a	06/11, 02/14, 07/15, 04/18, 08/19

c. Medications:
   i. Ondansetron (Zofran) 8 mg ODT times one (1), PRN for nausea
d. Additional orders if patient presents with upper abdominal pain (above umbilicus or abdominal pain of unknown location) to rule out cardiac conditions:
   i. Cardiology:
      1) EKG STAT
         a) Print old EKG if available
         b) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to ED physician to rule out ST-elevation Myocardial Infarction (STEMI)
   ii. Labs:
      1) Creatine Kinase (CPK)
      2) CK, Mb Fraction (CKMB) if CK elevated
      3) Cardiac Troponin (Troponin I)

C. Asthma with Wheezing:
1. In patients who present to ED with wheezing and a stated history of asthma, the RN shall order the following:
   a. Nursing Orders:
      i. Pulse oximetry monitoring
   b. Medications:
      i. In patients who are greater than or equal to 12 years of age.
         1) Albuterol 5 mg nebulized times one (1) with Ipratropium 0.5 mg nebulized times one (1) per Respiratory Therapy
      ii. In patients who are aged 2-11 years
         1) Albuterol 2.5 mg nebulized x 1 with Ipatropium 0.5 mg nebulized x 1 per Respiratory Therapy

D. Chest Discomfort in Patients age 30 and over:
1. In patients who present to the ED with chest pain, pressure, squeezing, shortness of breath, pain or discomfort in other parts of the body including one or both arms or shoulders, upper back, neck, jaw, abdomen, or female, elderly or diabetic patients with atypical symptom suspicious for acute coronary syndrome (ACS) such as diaphoresis, nausea, dizziness, altered level of consciousness the Registered Nurse (RN) shall order the following:
   a. Cardiology:
      i. EKG STAT
         1) Print old EKG if available
         2) STAT ED EKG's will be completed with the goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
   b. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Creatine Kinase (CPK)
      iv. CK, Mb Fraction (CKMB) if CK elevated
      v. Cardiac Troponin (Troponin I)
   c. Nurse Orders:
      i. Bring patient to first available bed
      ii. Initiate at least one peripheral intravenous (IV) saline lock
      iii. Initiate cardiac monitor
      iv. Initiate oxygen 2 liters per minute (LPM) per nasal cannula (NC) to maintain oxygen saturation by pulse oximetry (SPO2) greater than 92%
   ~~d. Medications:~~

~~i. Aspirin 325 mg one (1) tablet by mouth (PO) chewed times one (1) if not already administered~~

~~e.~~d. Radiology:
i. X-Ray Chest 2 View
1) If patient is female and under 55, shield pelvis

E. Dysuria:
1. In patients who present to the ED with dysuria, hematuria, urgency, or frequency, the RN shall order:
a. Nurse Orders:
i. Routine urinalysis with reflex culture
ii. Urine HCG for females age 10-55

F. Extremity Trauma:
1. Notify physician STAT for open fractures, dislocations, or neurological or vascular compromise.
2. Consult physician for x-ray orders for back, skull, facial bones, chest, pelvis, hips, and ribs.
3. In patients who present to ED with injuries that are suspicious for fracture, the RN shall order the following:
a. Medications:
i. Acetaminophen
1) For ages 3 months-11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
a) Maximum 325 mg/dose
b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
2) For 12 years and older, acetaminophen 650mg PO or PR times one
a) Maximum 650 mg/dose
b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
b. Radiology:
i. Acromioclavicular Joints
ii. Ankle complete 4 views left
iii. Ankle complete 4 views right
iv. Heel left OS Calcis
v. Heel right OS Calcis
vi. Clavicle left
vii. Clavicle right
viii. Elbow left
ix. Elbow right
x. Femur left
xi. Femur right
xii. Finger left
xiii. Finger right
xiv. Foot 4 views left
xv. Foot 4 views right
xvi. Forearm left
xvii. Forearm right
xviii. Hand 4 views left
xix. Hand 4 views right
xx. Hip Left, with AP Pelvis
xxi. Hip Right with AP Pelvis
xxii. Humerus left
xxiii. Humerus right

xxiv. Knee left
xxv. Knee right
xxvi. Shoulder left
xxvii. Shoulder right
xxviii. Tibia/Fibula left
xxix. Tibia/Fibula right
xxx. Wrist 4 views left
xxxi. Wrist 4 views right
xxxii. X-ray extremity wound site if suspect foreign body

G. Fever in children who are under 90 days old:
1. In patients who are under 90 days of age and who present to ED with rectal temperature of 38°C (100.4°F) or greater, assign an emergency severity index (ESI) level 2 and arrange for immediate placement in the treatment area. The RN shall order the following:
a. Labs:
i. CBCD
ii. Metabolic Panel, Basic
iii. C-Reactive Protein (CRP)
iv. Blood Culture (only one required for less than 3 months of age)
b. Nurse Orders:
i. Routine urinalysis, catheter specimen
ii. Urine culture
iii. Pulse oximetry monitoring
iv. Initiate intravenous (IV) saline lock
c. Medications:
i. Acetaminophen 15 mg/kg PR times one (1)
1) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
d. Radiology:
i. X-Ray: Chest 2 View PA and LAT

H. Fever in children from 91 days old to 18 years of age:
1. In patients who present to the ED with fever, the RN shall order:
a. Medications:
i. Acetaminophen
1) For ages 91 days - 11 years, acetaminophen 15mg/kg PO or PR times one (1), round to nearest 5mg
a) Maximum 325 mg/dose
b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
2) For patients who are greater than or equal to 12 years of age, acetaminophen 15mg/kg PO or PR times one (1)
a) Maximum 650 mg/dose
b) Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours.
ii. Ibuprofen
1) For ages 6 months to 11 years, ibuprofen 10mg/kg PO times one (1), round to nearest 5mg
a) Maximum 400 mg/dose
b) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.
2) For 12 years and older, ibuprofen 400mg PO times one (1)
a) Hold if the patient has received ibuprofen or ibuprofen containing products in the past 6 hours.

I. Generalized Weakness, Syncope, Dizziness or Altered Mental Status

1. In patients who present to ED with generalized weakness, syncope, or dizziness, or altered mental status the RN shall order the following:
   a. Cardiology:
      i. STAT EKG
         1) Print old EKG if available
         2) STAT ED EKG's will be completed with a goal of 10 minutes of being ordered and delivered directly to an ED physician to rule out STEMI.
   b. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Creatine Kinase (CPK)
      iv. CK, Mb Fraction (CKMB) if CK elevated
      v. Cardiac Troponin (Troponin I)
      vi. TSH
   c. Nurse Orders:
      i. Routine urinalysis, clean catch
      ii. Urine culture, clean catch
      iii. Serum HCG if female and 10 – 55 years of age
   d. Radiology:
      i. Chest X-ray 2 View PA and LAT
         1) If patient female and under 50 years of age, shield pelvis

J. Gastro Intestinal (GI) Bleed

1. In patients greater than or equal to 16 years old who present to the ED with the complaint of blood in the stool, vomiting of blood or coffee ground emesis, the RN shall order the following:
   a. Labs:
      i. Type and Screen
      ii. Check capillary blood glucose
      iii. CBCD
      iv. Metabolic Panel, Comprehensive
      v. INR
   b. Insert 18g IV
   c. If SBP <=90, or HR > 120, the RN shall
      i. insert 16g IV x 2
      ii. Administer 500 mL 0.9 NaCl IV fluid bolus times one (1), infuse wide open

K. Psychiatric Evaluation

1. In patient who present to the ED with suicidal ideation, hallucinations, delusions, or who are an immediate safety risk to self or others
2. The RN shall order the following:
   a. Labs:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Ethanol, Serum (Blood Alcohol Level)
      iv. Urine toxicology screen
      v. Cannabinoid level
      vi. TSH level
      vii. Serum HCG if female age 10 to 55
   b. Nurse Orders:
      i. Urinalysis, routine with reflex culture
   c. For the patient with suicidal ideation the RN shall implement suicide observation and precautions per the Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide.

L. Sepsis

In patients who are >= 18 years old with signs/symptoms of SEPSIS including: Temperature greater than (>=) 38.3 or less than (<) 36 (or history of recent fever/ infection) PLUS heart rate above 90 and/or respiratory rate above 20 and or Systolic Blood Pressure Below 90mmHg

1. The RN shall order the following:
   a. Laboratory:
      i. CBCD
      ii. Metabolic Panel, Comprehensive
      iii. Blood Cultures times 2
      iv. Lactate with repeat lactate per sepsis protocol
      v. JIC Blood Bank
      vi. Urinalysis with reflex to culture
      vii. Serum HCG if female and 10 to 55 years of age
      viii. Amylase
      ix. Lipase
      x. Magnesium
      xi. Phosphate
      xii. INR
      xiii. Troponin
      xiv. PTT
   b. Radiology: Chest Xray: posteroanterior and lateral
   c. Cardiology: Stat EKG
   d. Nursing:
      i. Start 18 gauge IV (preferred)
      ii. Fluid Bolus 500 mL Normal Saline wide open
      iii. Cardiac Monitor
      iv. Pulse oximeter
      v. O2 2 l/min by nasal cannula (titrate to keep O2 saturation above 92%)
      vi. Notify Physician to consider activating "Code Sepsis"

M. Vaginal Bleeding, Possible Pregnancy:

1. In patients who present to the ED with vaginal bleeding, and states she is pregnant or could be pregnant, the RN shall order the following:
   a. Labs:
      i. CBCD
      ii. ABORh Type
      iii. Beta HCG, Quantitative
      iv. Routine urinalysis with reflux culture
   b. Nurse Orders:
      i. If heart rate is greater than 120 BPM or the systolic blood pressure is less than 90 mmHg:
         1) Immediately notify physician of patient's condition
         2) Initiate two 16 gauge (if possible) peripheral IV's
         3) Set up for pelvic exam and notify physician
         4) Medications:
            a) Administer 500 ml 0.9 NaCl IV fluid bolus times one, infuse over 30 minutes
   c. Radiology:
      i. RN may order pelvic ultrasound after consultation with MD or PA

N. Vomiting, Diarrhea, Dehydration:

1. In patients who present to the ED with vomiting, diarrhea and or dehydration the RN shall order the following:
   a. Laboratory:
      i. CBCD

ii. Metabolic Panel, Comprehensive
iii. Urinalysis with reflex to culture
iv. Serum HCG if female and 10 to 55 years of age

b. Nurse orders:
i. Initiate peripheral IV for severe vomiting

c. Medications:
i. Adults (16 years of age and older):
1) Ondansetron 4 mg ODT times one (1)
2) Ondansetron 4 mg IVP times one (1) for severe vomiting.
ii. Pediatrics (0 to 15 years of age):
1) Ondansetron 2 mg ODT times one (1) in patients less than 15 kg
2) Ondansetron 4 mg ODT times one (1) in patients greater than 15 kg

O. General Pain Management

1. In patients who are greater than or equal to 12 years of age, who present to the ED with complaints of mild PAIN (1-3) from any cause, the RN may order the following
a. Acetaminophen 15 mg/kg po x one (1)
i. Maximum 650 mg/dose
ii. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours
b. For moderate or severe pain, consult physician

2. In patients who are 6-11 years of age, who present to the ED with complaints of mild PAIN (1-3) from any cause, the RN may order the following:
a. Acetaminophen 15 mg/kg po x one (1)
i. Maximum dose 325 mg
ii. Hold if the patient has received Acetaminophen or Acetaminophen containing products in the past 4 hours
b. For moderate or severe pain, consult physician

III. REQUIREMENTS FOR CLINICIANS INITIATING STANDARDIZED PROCEDURE:

A. Current California unencumbered RN license
B. Excellent customer service communication
C. Education: Successful completion of Standardized Procedure training
D. Initial Evaluation: Demonstrated competency
E. Ongoing Evaluation: Annually

IV. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE:

A. Method: This Standardized Procedure was developed through collaboration with Nursing, Medicine, and Administration. New standardized procedures or additions to existing standardized procedures will be approved by the Department of Emergency Medicine, Pharmacy and Therapeutics (if medications are involved) and the TCMC Board of Directors.
B. Review: Every two (2) years

V. CLINICIANS AUTHORIZED TO PERFORM THIS STANDARDIZED PROCEDURE:

A. All Registered Nurses who have successfully completed requirements as outlined above are authorized to direct and perform the Emergency Department Standardized Procedure.

VI. RELATED DOCUMENT(S):

A. Patient Care Services Policy: Assessing and Managing Patient at Risk for Suicide

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 08/01 **SUBJECT:** Identification, Patient

REVISION DATE: 03/03, 02/05, 06/06, 06/09, 02/12, 12/14 06/18

Department Approval:	~~02/18~~10/22
Clinical Policies & Procedures Committee Approval:	~~04/18~~11/22
Nursing Leadership Approval~~Executive Council~~:	~~04/18~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~05/18~~01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	~~06/18~~ n/a
Board of Directors Approval:	06/18

A. POLICY:

1. It is the policy of Tri-City Medical Center to reliably identify the individual as the person for whom the service or treatment is intended and co-match the service or treatment to that individual. Exception: Patients unable to provide identifying information, who experience conditions requiring emergency care will receive treatment prior to identification if such care and treatment is necessary to stabilize the patient's condition (example: unidentified patient arriving comatose to the emergency department, i.e. John/Jane/Baby Doe).
2. All patients must wear a correct and legible patient identification (ID) band at all times.
3. The patient's primary nurse is responsible for the accuracy of the patient's ID band.
4. Two patient identifiers are used when administering medication, blood or blood components, when collecting blood samples and other specimens for clinical testing and when providing treatments or procedures and diagnostic testing (excluding consultation and teaching) to ensure the correct patient is involved.
   a. The first identifier is the patient name (If the name is too long an exact match up to 13 characters is required).
   b. The second identifier is:
      i. Patient date of birth - Outpatient Areas
      ii. Patient Medical Record Number - Inpatients
      iii. Patient Account/Financial Number (FIN) - Emergency Department
5. All containers used for blood and other specimens will be labeled in the presence of the patient.
6. ~~Additionally, s~~Staff shall verbally assess the patient to assure proper identification, asking the patient's name (if appropriate for age, condition and ability to understand) and matching the verbal confirmation to the written information on the identification band.
7. ~~If a patient is to have blood products administered, a Transfusion Service ID band must be applied by either laboratory staff or nursing personnel and can only be removed by laboratory staff.~~
   ~~a. Contact Lab to remove and replace the armband~~
   ~~b. Surgical Services RNs may remove the transfusion service ID band if necessary for site access. The band must be immediately reapplied to the available site.~~
8. ~~7.~~ Any staff person removing an ID band for any reason is responsible for replacing the ID band and ensuring accuracy and legibility.
9. ~~8.~~ If the patient is not alert, a family member or representative may verify accuracy of the information.

~~10.~~**9.** Name alert signs for similar patient names shall be posted on the chart and at the nurse's station.

~~11.~~**10.** ~~-~~All newborns must be banded before being separated from their mother (see Patient Care Services Procedure: Identification of Newborns).

~~12.~~**11.** No procedure shall be conducted when patient identification cannot be verified because the imprinted band is illegible or missing. Defective or missing ID bands shall be replaced immediately with new, accurate, legible ID bands.

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

1. Patient Care Services Procedure: Identification of Newborns

Tri-City Healthcare District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 12/01

SUBJECT: Physician/Allied Health Professionals (AHP) Inpatient Orders

REVISION DATE: 10/02, 05/03, 06/03, 06/05, 06/06, 04/09, 06/11, 07/12, 01/13, 04/14, 01/18

~~POLICY NUMBER: IV.M~~

Patient Care Services Content Expert ~~Department~~ Approval: ~~10/17~~09/22
Clinical Policies & Procedures Committee Approval: ~~10/17~~10/22
Nursing Leadership~~Executive Council~~ Approval: ~~10/17~~11/22
Medical Staff Department or Division n/a
Pharmacy & Therapeutics Committee Approval: ~~11/17~~11/22
Medical Executive Committee Approval: ~~11/17~~01/23
Administration Approval: 02/23
Professional Affairs Committee Approval: ~~01/18~~ n/a
Board of Directors Approval: 01/18

A. **PURPOSE:**

1. To define the parameters for the receipt, validation, and follow through of Medical Staff orders to increase patient safety and reduce physician/Allied Health Professional (AHP) order errors.

B. **DEFINITION(S):**

1. Chart Check: Chart checks ensure transcribed orders from the previous shift are current, accurate, appropriate for the nursing unit, and have been entered into Cerner.
2. Electronically Transmitted Order: an order that has been written by the prescriber and electronically transmitted to authorized hospital personnel.
3. Medical Staff orders: therapeutic interventions that are written, verbal, electronically transmitted, or dictated by telephone by a member of the Medical Staff or an AHP.
4. Range Dosing: orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status.
5. Standardized Procedure Order: an order written in the medication record as a result of implementation of a standardized procedure.
6. Telephone Order (T.O.): order communicated by telephone when the prescriber is not physically present (face-to-face) with the authorized personnel.
   a. On the paper chart as T.O.
   b. Texting orders via electronic portable devices are prohibited.
7. Verbal Order (V.O.): order communicated by oral, spoken, or face-to-face communication between prescriber and authorized hospital personnel within their scope of practice.
   a. On the paper chart is noted as V.O.
8. Read Back Process: All telephone/verbal orders shall be read back to the prescriber in their entirety from the primary source.
9. Titrating Orders: orders in which the dose is either increased or decreased in response to the patient's clinical status. See Patient Care Services: Titrating Medications, Adult Patients Policy.
10. Taper Orders: orders in which the dose is decreased by a specified amount with each dosing interval.
11. Hold Orders: order for discontinuation of the medication (refer to Patient Care Services: Automatic Stop Orders Policy).

C. **POLICY:**

1. Authorized personnel may accept orders from:
   a. Members of the Tri-City **Healthcare**~~Hospital~~ District (TCHD) Medical Staff and AHPs for inpatient/outpatient treatment and diagnosis:
      i. A Physician's Assistant who has been appropriately credentialed through the Medical Staff may transmit orders from the physician/AHP given verbally, via telephone, or in writing. Orders must be co-signed by the Physician's Assistant and supervising physician or attending physician/AHP within 48 hours for medication orders and fourteen (14) days post discharge for all other orders.
   b. The following categories of practitioners who are not TCHD Medical Staff members or AHPs for outpatient diagnostic tests and services:
      i. Doctors of Medicine (M.D.)
      ii. Doctors of Osteopathic Medicine (D.O.)
      iii. Doctors of Podiatric Medicine (D.P.M.)
      iv. Doctors of Dentistry (D.D.S.)/ Doctor of Dental Medicine (D.M.D.)
      v. Nurse Practitioner (NP)
      vi. Physician Assistant (PA)
      vii. Chiropractor (D.C.)
      viii. Licensed Acupuncturist (L.AC.)
      ~~viii.~~**ix. Certified Registered Nurse Anesthesiologist (CRNA)**
   c. It is the responsibility of the unit/department accepting the order to verify the physician/AHP is authorized to order (i.e., maintains the appropriate license).
   d. Registered Nurses (RN) may accept verbal orders from the Lifesharing RN on brain dead potential organ donors whose care has transferred to Lifesharing, under the direction of their Medical Director.
   e. RNs or other designated personnel may accept and implement a medication order which is transmitted by a designee of the Medical Staff member to the RN after determining that the order is being transmitted and not initiated by the Medical Staff member's designee, that the order is appropriate for the patient's condition and is in his or her best interest, and the order is in compliance with applicable statutes, regulations, and hospital policies.
2. All orders shall be recorded (written) legibly or entered electronically into the patient's record in a timely manner.
   a. Order(s) shall include name of physician/AHP giving order, date and time, name of person receiving order if other than physician/AHP.
   b. A licensed practitioner, within their scope of practice, may receive orders.
   c. Orders that do not contain the required elements shall be considered incomplete and shall not be implemented until clarified. If the prescriber cannot be reached and the intervention is urgently needed, the appropriate on-call physician/AHP shall be contacted to clarify the order.
   d. If the refusal order icon appears, the order shall be clarified with attending physician/AHP.
   e. "Blanket orders" for medication, treatments, procedures, and laboratory tests (i.e. "continue previous medications," "resume all pre-op medication, labs or treatments," "resume all physical therapy (PT) therapy," or "discharge on current medications") will not be accepted.
   f. Telephone orders shall be entered directly into the Electronic Health Record (EHR). When it is not possible to enter a telephone order, document the order immediately on the Physician's Order sheet and ensure it is signed, dated, and timed by the individual who received the order.
      i. The complete order(s) shall be clearly read back to the physician/provider directly from the primary source.
         1) Orders entered directly into the EHR shall be entered using the correct Communication Type.

2) If orders written on the Physician's Order sheet, the Read Back box shall be check-marked (✓) to document orders were read back.

ii. Orders must be signed within 48 hours for medication orders and fourteen (14) days post discharge for all other orders.
1) Medical Staff members covering for another may sign his/her order.

iii. Telephone orders for antineoplastic agents are not permitted.
1) Exceptions: See Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation Policy.

iv. Emergency telephone orders/verbal orders will not be accepted for withdrawing life support (i.e., mechanical ventilation).

v. Verbal orders are to be used only to meet the care needs of the patient when it is impossible or impractical for the ordering physician/AHP to write/enter the order without delaying treatment. Every effort is to be made by the ordering physician/AHP to enter orders into Cerner or in writing when they are on the unit.
1) Verbal orders given during patient procedures are to be recorded and signed by the ordering physician/AHP immediately following the procedure.

g. Medication orders:

i. Only medications needed to treat the patient's condition are ordered.
1) Diagnosis, condition, or indication for use must be documented for each medication ordered.

ii. An acceptable medication order contains the following information:
1) Drug name (brand or generic)
2) Dose
3) Strength and concentration
4) Frequency
5) Route of administration
6) Duration (see Patient Care Services: Automatic Stop Orders Policy)
7) Indication if PRN

iii. Physician/AHP PRN medication orders shall specify an indication or symptom unless only one indication exists for the medication.
1) If an order is written without an indication, the use of the "PRN Medication Default Reasons" will auto populate for select medications on the medication administration record (MAR).
2) Multiple orders for the same PRN reason will not be accepted unless one of the following criteria are met:
a) Order clarifies the sequence of administration. Example: Percocet 5/325 1 tab PO Q4H PRN severe pain (7-10) Morphine 2 mg IV Q4H PRN severe pain not relieved by Percocet
b) Order specifies different, non-overlapping ranges for the symptoms. Example: Percocet 5/325 1 tab PO Q4H PRN moderate pain (scale)
i) Morphine 4 mg IV Q4H PRN severe pain (scale)
3) Any order with the same PRN reason as a previous order will supersede the previous order. The pharmacist will automatically discontinue the previous order.
4) If the indication entered does not reflect the patient's condition or if there are any questions concerning the appropriate indication the physician/AHP shall be contacted for clarification.

iv. Range Orders: orders may only contain one set of ranges (dose or frequency). If orders are received with more than one set of ranges, then the healthcare provider must contact the physician/AHP to change the order unless a policy or protocol is in place for interpretation of range orders (i.e. sliding scale insulin

order, Post Anesthesia Nursing Unit opiate orders). See Patient Care Services: Medication Administration for Administration of Medications Policy.

v. Range orders for a dosage that is more the double than smallest dose, shall not be accepted by pharmacy and shall be clarified with the physician/AHP by pharmacy
   1) Example: Morphine 2-8 mg IV every 4 hours PRN will be clarified by pharmacy.
   2) Acceptable orders include: Morphine 2-4 mg IV every 4 hours PRN or Morphine 4-8 mg IV every 4 hours PRN after speaking with the physician/AHP.

vi. Pediatric Orders:
   1) Physician/AHP orders for pediatric populations shall contain weight based dosing (i.e. mg/kg), calculated dose, and the patients current weight except for the following defined medication classes:
      a) Medications not determined by the patient's weight (i.e., iron sulfate).
      b) Vaccines:
         i) Ensure the weight-based dose does not exceed the recommended adult dose.

vii. A pharmacist shall check all medication orders for appropriateness before access is granted through the Pyxis to licensed staff, unless a physician/AHP is administering the medication or overseeing the administration of the medication (i.e. "Non-Profile" Pyxis areas).
   1) See Patient Care Services: Medication Administration Policy if a nurse needs to obtain medications not yet reviewed by a pharmacist.

viii. Orders that do not contain the required elements or entered incorrectly shall be considered incomplete and shall not be implemented until clarified. If the prescriber cannot be reached and the intervention is urgently needed, the appropriate on-call physician/AHP shall be contacted to clarify the order.

ix. Titration medication orders must include the rate of infusion and instructions for titration with goal parameters, unless part of an approved protocol. See Patient Care Services: Titrating Medications, Adult Patients Policy.

x. Taper orders must include a detailed taper/wean schedule, including specific dose reductions per specified dosing intervals, unless they are part of an approved protocol specified by the prescribing physician/AHP.

xi. Any medications put on "hold" by the physician/AHP shall automatically be discontinued by the nurse and Pharmacy and must be reordered by the physician/AHP if and when the medication is resumed.

xii. Medication orders will be renewed in a timely manner and in accordance to Patient Care Services: Automatic Stop Order Policy.

xiii. Preprinted orders will be accepted if they have been approved by the Pharmacy and Therapeutics Committee.

3. Transfer Process:
   a. When a patient is transferred from one level of care to another the physician/AHP updates the orders and completes medication reconciliation per medical staff policy. The nurse will review the orders and contact the physician/AHP for any clarification of orders.
   b. When a patient undergoes one of the following minor procedures and returns to the same level of care the physician/AHP is not required to rewrite orders:
      i. Heart catheterization
      ii. Interventional procedures including PICC line placement
      iii. Endoscopy including bronchoscopy
      iv. Inpatient dialysis
      v. Pain management

vi. Insertion of feeding tube, radiologic, GI or surgical
vii. Tracheostomy

c. When a patient undergoes a surgical procedure, all previous orders shall be discontinued and post-operative orders implemented.

d. Discharge Medication Orders: See Pharmacy Policy: Discharge Prescriptions.

4. Reviewing Orders on Inpatient Units:

a. All orders entered electronically or written on the Physician Order sheet must be reviewed for correctness and clarity and acknowledged in a timely manner before being implemented.

i. Notify the physician/AHP if needed for clarification of any orders.

ii. Orders entered electronically:

1) Complete Nurse Review

iii. Orders written on Physician Order Sheet **shall be entered into the EHR:**

1) For approved Pre-Printed Orders:

a) **Transmit**~~Scan~~ the Physician's Order sheet to the pharmacy.

b) A RN will compare medication orders from the physician/AHP's order(s) with the information entered electronically by the pharmacist and complete Nurse Review.

c) A RN will compare non-medication orders with the information entered electronically.

d) A RN will note (sign) the orders by writing name, title, date, and time in the Nurse's Signature Box on the Physician's Order sheet.

b. Complete an occurrence report/quality review report for medications entered incorrectly. For such orders with one or all of the following: wrong dose, route, time, frequency, or spelled incorrectly by:

i. Physician order entry error, the pharmacist/nurse will clarify with the ordering physician.

ii. Pharmacist order entry error, nursing will not review/note (sign) the orders until the corrections are made by pharmacy on Nurse Review.

5. Chart Checks:

a. Chart checks shall be implemented every shift.

b. Chart checks shall include:

i. Orders entered electronically:

1) Review orders and ensure Nurse Review has been completed.

2) Orders should be completed or discontinued as applicable.

3) Orders should be reviewed for duplicate orders which should be corrected to reflect most current order.

ii. Orders written on Physician Order sheet:

1) Review for written orders. Ensure medications have been **ordered electronically/transmitted**~~scanned~~ to Pharmacy and all orders have been correctly entered electronically and noted (signed).

c. Process for chart checks:

i. Review Physician Order sheets for new orders within the last twelve (12) hours or since last chart check.

ii. Review electronic orders for new orders within the last twelve (12) hours or since the last chart check.

~~iii. Validate completed chart checks by documenting on twelve (12) hour chart check power form ensuring both paper and electronic orders have been reviewed.~~

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

1. Patient Care Services: Automatic Stop Orders Policy
2. Patient Care Services: Chemotherapy Prescribing, Processing, and Preparation Policy
3. Patient Care Services: Medication Administration Policy

4. Patient Care Services: Titrating Medications, Adult Patients Policy
5. Pharmacy Policy: Discharge Prescriptions Policy

Tri-City Medical Center
Oceanside, California

Plan for Nursing Care

I. **PURPOSE**

A. The hospital-wide plan for the provision of services is designed to assure:
   1. Patient Care Services (PCS) are appropriately integrated throughout the organization;
   2. Adequate resources are available to assess, plan, deliver, manage, and evaluate patient care;
   3. The design of patient care services provided throughout the organization is appropriate to the scope and level of care required by the patients served;
   4. Uniform performance of patient care is provided throughout the organization.

B. The hospital-wide plan for the provision of services is reviewed at least annually or as deemed necessary due to changing patient populations or other internal or external factors such as:
   1. Patient care requirements **per scope of service**~~;~~
   2. The Hospital's recruitment, retention, and staff development capabilities~~;~~
   3. Information from performance improvement, risk management, utilization management, safety reviews and other evaluation activities~~;~~
   4. Evaluation of innovations and improvements in patient care~~;~~
   5. Affiliations, managed care contracts and reimbursement changes~~;~~
   6. Feedback from patients, families, hospital staff, and physicians regarding patient care concerns or issues~~;~~
   7. The Hospital's Strategic and Facilities Plan and annual budget~~;~~
   8. Regulatory or accreditation changes~~;~~
   9. Collective Bargaining Agreement (CBA) revisions~~.~~

C. This review is to be performed by the Executive Team, the Medical Executive Committee, and the Board of Directors.

II. **DEFINITION OF NURSING**

A. Nursing is the protection, promotion and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response and advocacy in the care of individuals, families, communities and populations. ~~American Nurses Association, Scope of Practice, 2015 3rd Ed.~~

III. **NURSING VISION AND DISTRICT VALUES**

A. To become known for nursing care that is the magnetic force which attracts the community to Tri-City Healthcare District (TCHD).

B. The needs of our patients come first.

IV. **GUIDING PRINCIPLES**

A. We never lose sight of our patients' and families' needs and expectations **including the need for education**.

B. We strive to make the most efficient use of our resources.

C. We are alert for opportunities to improve.

D. We encourage patients and families to participate in their care and decisions affecting their care.

E. We focus on team relationships and healthy interpersonal skills.

F. We enter into partnerships with patients, families, and other health care professionals eagerly.

Department Review	Clinical Policies and Procedures	Nursing Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
07/16, 06/17, 09/22	09/16, 07/17, 11/22	09/16, 07/17, 01/23	n/a	n/a	10/16, 08/17, 01/23	02/23	10/17, n/a	10/17

G. We base our decisions for care on the nursing practice act, nursing standards and nursing evidence-based research.
H. We acknowledge that maintaining the highest standards of patient care is a never-ending process which involves the patient, family, all health care providers, and the community at large.
I. We view learning as a lifelong process which is essential to our development.
J. We embrace change to promote and advance the delivery of care to our patients.
K. We utilize informatic solutions and technology to support all areas of nursing~~, including but not limited to, the direct provision of care, establishing effective administrative systems, managing and delivering educational experiences, enhancing lifelong learning and supporting nursing research.~~

V. PHILOSOPHY OF NURSING/CORE BELIEFS

A. Nurses at TCHD believe that Professional Nursing is both an art and a science; a dynamic practice based upon the nursing process and a combination of knowledge, skills and the provision of care that incorporates professional values, compassion, and commitment to excellence. We believe:
1. Caring - is the essence of nursing ~~. A caring approach includes: knowledge, adaptable approaches~~ **and is** based on the care-recipient's unique needs~~, patience, honesty, trust, humility, hope and courage~~.
2. Diversity - is a core element for caring and leadership~~. It requires that the individual affirm his or her own unique self while learning to respect~~ and address the needs of others who may have different values.
3. Accountability - is the hallmark of professional practice. ~~It requires responsibility to set personal standards for accomplishing expected goals, objectives and outcomes; for relationships and working together (collegiality); for supporting colleagues/peers;~~ and for adherence to organizational policy and procedure.
4. Integrity - is the foundation for clinical practice, leadership, and learning **based on**~~. It encompasses a commitment to people (staff, colleagues, families, community, and~~ adherence to the professional nursing code of ethics and professional nursing standards of practice.
5. Advocacy - is an inherent element of nursing ethics and nursing practice to~~. As an advocate, the nurse is responsible for~~ safeguard~~ing~~, promote~~ing~~, and support~~ing~~ the patient's values and decisions.
6. Scholarship – is a life-long practice where the nurse acquires ongoing knowledge for expert practice in professional nursing.~~, transcultural nursing care and leadership. Experienced nurses serve as mentors to others in assisting them to achieve a higher level of evidence based practice~~.

VI. SCOPE OF PATIENT CARE

A. Patient care at TCHD encompasses health promotion, disease prevention and treatment activities in the community, home, acute care, inpatient and outpatient arena. ~~This care is provided collaboratively by health care providers with specialized knowledge, judgment and skill.~~ Patient care is planned, coordinated, provided, delegated and supervised by professional health care providers.~~ who recognize physical, psychological, and spiritual needs of patients.~~
~~1. All PCS departments have a plan that describes their scope of service.~~

VII. PRACTICE STANDARDS

A. ~~American Nurses Association Code of Ethics for Nurses 2015 2nd Ed.~~ Ethics is an integral part of the foundation of nursing practice. The Code of Ethics for Nurses provides a framework for nurses at TCHD to use in ethical analysis and decision-making~~. The nine provisions of the Code of Ethics describe the most fundamental values and commitments of the nurse, boundaries of duty and loyalty and duties beyond individual patient encounters. These interpretive statements are not negotiable in any setting:~~
~~1. Respect for Others~~

~~2. Commitment to the Patient~~
~~3. Advocacy for the Patient~~
~~4. Accountability and Responsibility for Practice~~
~~5. Duty to Self and Duty to Others~~
~~6. Contribution to Healthcare Environments~~
~~7. Advancement of the Nursing profession~~
~~8. Promotion of Community and World Health~~
~~9. Promotion of the Nursing Profession~~

B. American Nurses Association Scope & Standards for Nursing Practice – This scope statement and standards of nursing practice guide, define and direct professional nursing practice in all settings and outlines the expectations of the professional role within which all registered nurses must practice.

C. California Nurse Practice Act – The Nurse Practice Act outlines the laws and regulations that define the scope of nursing practice in the state of California. TCHD nurses are responsible to be informed of these laws.

VIII. PATIENT CARE MODEL: SYNERGY™

A. TCHD Nurses use the Synergy Model for patient care to match the needs of our patients to the competencies of the nurse to ensure optimal outcomes.

B. The Synergy model delineates three levels of outcomes: those derived from the patient, those derived from the nurse, and those derived from the healthcare system.

C. Nurse Competencies:
1. Clinical judgment, including decision making, critical thinking and basic nursing skills~~.~~
2. Caring practices~~, responding to the unique needs of patients and families.~~
3. Advocacy **and moral agency**~~to help identify and resolve concerns as they arise.~~
4. Collaboration ~~with the entire team of caregivers.~~
5. **Response**~~Sensitivity and response~~ to diversity ~~to incorporate differences into patient care.~~
6. Facilitation of learning ~~to ensure patients and families know how to continue care.~~
7. Clinical inquiry~~, including questioning and evaluation of practices to provide the best possible care.~~
8. Systems thinking ~~to take a holistic approach to every care giving situation.~~

D. Patient Characteristics:
1. Participation in decision making about treatment options~~.~~
2. **Participation**~~Involvement~~ in care~~.~~
3. ~~Level of s~~**Stability, ability to maintain steady-state equilibrium** ~~(critical, fair, and stable).~~
4. Complexity ~~of the illness or injury.~~
5. Resiliency of the patient~~.~~
6. Vulnerability or susceptibility to stressors of all types~~.~~
7. ~~Availability of r~~**Resources availability**~~, including support systems upon discharge.~~
8. Predictability of the illness or injury~~.~~

IX. PROFESSIONAL STAFF NURSE CORE PERFORMANCE EXPECTATIONS

A. Assessment:
1. The Registered Nurse (RN) collects comprehensive data pertinent to the patient's health or the situation.

B. Diagnosis:
1. The RN analyzes the assessment data to determine the diagnosis of issues.

C. Outcome Identification:
1. The RN identifies expected outcomes for a plan individualized to the patient or the situation.

D. Planning:

1. The RN develops a plan that prescribes strategies and alternatives to attain expected outcomes.

E. Implementation:
   1. The RN implements the plan
   2. Coordination of Care:
      a. The RN coordinates care
   3. Health Teaching & Health Promotion:
      a. The RN employs strategies to promote health and a safe environment
   4. Consultation:
      a. The advanced practice registered nurse and the nursing role specialist provide consultation to influence the identified plan, enhance the abilities of others, and effect change.

F. Evaluation:
   1. The RN determines the patient's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

X. PROFESSIONAL RESPONSIBILITIES OF THE REGISTERED NURSE

A. Takes initiative for own learning gaps, seeks experiences and formal and independent learning activities ~~to maintain and develop clinical and professional skills and knowledge~~.

~~B. Is aware of own positive and negative biases and limitations.~~

~~C. Has self-confidence in own expertise.~~

~~D.~~B. Involves patient/family in the plan of care; informs team members of patient needs, goals, preferences and expected outcomes.

~~E.~~C. Actively participates in report, rounds, staffing, shared decision-making activities develops plan of care; discusses it with patient, family and care team and revises it as necessary.

~~F. Accesses current nursing journals on research, best practices, technology and innovations.~~

~~G. Actively participates in unit retention strategies.~~

~~H.~~D. Embraces opportunities to preceptor, mentor colleagues, and students, sharing learning to further the practice of nursing.

~~I.~~E. Embraces change as a mechanism to promote patient care and the nursing profession.

XI. STAFFING PLANS

A. Staffing plans and scheduling for patient care service departments are developed based on the mandated RN to patient ratio and intensity of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately (competently and confidently) provide the type of care needed.

B. Each department has a ~~formalized~~ staffing grid which is reviewed at ~~annually~~ **as needed** based on the following**, including but not limited to**: Hours Per Patient Day/Hours Unit Of Service, utilization review, employee turnover, performance assessment and improvement activities, changes in customer needs/expectations, "Best Practice" information from other sources, new services planned, patient volume and population changes, and risk management. Staffing grids are decentralized ~~in the Staffing Office~~ and are kept in unit/departmental documents.

~~C. The Hospital and CNA bargaining unit will meet annually to validate the acuity assignment process.~~

XII. DELIVERY OF NURSING CARE

A. Areas where nursing care is delivered under the Division of Nursing (including but not limited to):
   1. Acute Care Services (1 North, Inpatient Acute Rehabilitation ~~([~~ARU~~])~~, 2 Pavilion, 4 Pavilion):
      a. Acute Care Services develop, implement, and evaluate a plan of nursing care for adult (14 years and older) acute care patients who are acutely ill or injured and are in varying stages of recuperation from diagnostic, therapeutic, or surgical intervention.

i. 1 North: Orthopedic diagnoses are emphasized.
ii. Inpatient Acute Rehabilitation (ARU): The ARU provides restorative and maintenance programs for the adult patient (ages 14 years and older) suffering from cerebral vascular disease and other diseases or conditions requiring neurological or functional rehabilitation services. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family/significant others, the nurse, social worker, admissions liaison and utilization review coordinator, physical therapist, occupational therapist, speech therapist, therapeutic recreational specialist, discharge coordinator and the Medical Director of the Acute Rehabilitation Unit.
iii. 2 Pavilion: Oncological diagnoses are emphasized; along with general medical surgical diagnosis.
iv. 4 Pavilion: Medical monitoring unit available for rate monitoring only. Neurology patients, specifically with stroke and seizure diagnosis; dialysis.

~~2. Behavioral Health Services/Crisis Stabilization Unit:~~
~~a. The Behavioral Health Unit/Crisis Stabilization Unit develops, implements, and evaluates a plan of psychiatric nursing care to adults 18 years and older who are significantly impaired as a result of psychiatric disorders. This plan incorporates active interdisciplinary treatment teams consisting of psychiatric nurses and physicians, social services personnel, psychologists, mental health workers, and recreational therapists. The plan of care utilizes a variety of pharmacologic, behavioral, and psychotherapeutic interventions (groups and individual therapy) to restore optimal patient~~

~~3.~~2. Emergency Services:
a. The Emergency Department provides comprehensive services and develops, implements, and evaluates a nursing plan of care for all patients presenting to the department, and provides medical direction to paramedics via the Base Station radio. The plan of care incorporates mutual interdisciplinary interactions while maintaining patient's advocacy and includes the patient, family, significant others and the nurse in response to the psychological and physical needs.

~~4.~~3. Home Health:
a. The Home Health Department develops, implements, evaluates and executes a comprehensive care plan for patients 18 years and older who meet the criteria. ~~Home Health provides services for Medicare, Medi-Cal and contracted insurance companies. Home Health is Medicare certified and follows the guidelines of homebound status for Medicare.~~ The plan of care is multidisciplinary which **is** ~~includes RN, Licensed Vocational Nurse (LVN), Certified Home Health Aid (CHHA), Registered Diatition (RD), Physical and Occupational Therapy, Social Services, patient, family and caregivers as~~ an integral part of achieving restorative status. The Home Health team promotes patient advocacy interacting with physicians and community resources for positive physical, emotional and spiritual outcomes.

~~5.~~4. Infusion Center- Outpatient Hospital:
a. The purpose of this area is to meet the needs of patients who require **chemotherapy,** blood transfusions, antibiotic therapy, arthritic infusions, and IV infusions for dehydration. ~~Offsite Outpatient infusion is for Chemotherapy.~~

~~6.~~5. Intensive Care Unit:
a. The Intensive Care Unit develops, implements, and evaluates a plan of nursing care for patients 14 years of age and older ~~or weighing at least 35 kilograms~~ with actual or potential life threatening medical or surgical conditions.

~~7.~~6. Neonatal Intensive Care Unit (NICU):

a. The purpose of this unit is to develop, implement, and evaluate a plan of care for infants born prematurely and/or infants who are critically ill. Patient needs are met through individualized and specialized care coordinated through the interdisciplinary team approach. This plan emphasizes supportive, developmental and therapeutic care unique to the needs of each infant and includes the family and/or designated family/infant support members.

~~8.~~7. Progressive Care Unit/Specialty Clinic:
   a. This is a 41 bed secured unit that provides various services to patients age 18 and above demonstrating aberrant behavior requiring 24 hour supervision concurrently with their medical condition. Justice involved individuals may be placed on this unit. This level is appropriate to use when the patient is hemodynamically stable along with any of the following. InterQual criteria will be utilized to meet the level of care required for the available bed.
      i. Continuous Cardiac Monitoring (See Telemetry: Admission and Discharge Criteria Policy)
      ii. Chemotherapy Administration (See Patient Care Services: Chemotherapy Administration Procedure)
      iii. Acute rehabilitation
      iv. Ante-partum care
      v. Post-partum care
      vi. Medical-Surgical

~~9.~~8. Perioperative/Perianesthesia Services:
   a. Post-Anesthesia Care Unit (PACU):
      i. Provides nursing care to patients in the post-operative/post anesthetic phase of the Perioperative period. Nursing care plans are developed, implemented and evaluated on individual patient needs. Nursing care is provided to deliver a safe, effective and appropriate level of care to patients 14 years of age and older.
   b. Pre-Operative Hold:
      i. The purpose of this unit is to assess, implement and evaluate a plan of pre-admission education to pre-operative patients 14 years of age and older, and significant others. Each patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care. The plan emphasizes supportive, therapeutic, and preventive care inclusive of the unique physical and emotional needs of the patient.
   c. Surgery:
      i. The purpose of Surgery/Operating Room is to provide surgical care to patients fourteen (14) years of age and older throughout the intraoperative phase of patient care. The endoscopy suite is also included within the surgery department. Nursing care plans are developed, implemented, and evaluated for each individual patient who enters the operating room. Most surgical specialties are provided, including cardiac. There are no trauma or transplant services provided.
   d. Outpatient Post-Anesthesia Care Unit:
      i. The purpose of this area is to provide nursing care to patients requiring recovery from outpatient interventional procedures or stage two recovery (when needed). Nursing care is provided to deliver a safe, effective and appropriate level of patient care.
   e. Preoperative Education (Outpatient Service Center):
      i. The purpose of this area is to provide preoperative education to and assessment of patients prior to the day of the surgical procedure. Patients may either have face to face visits, or a telephone call for assessment and education.

~~10.~~9. Telemetry (2 East, 2 West, 4 East, 4 West and 3 Pavilion):
   a. The purpose of Telemetry is to develop, implement, and evaluate the Plan of Nursing Care for all clients. Telemetry accepts patients 14 years of age and older who require cardiac monitoring, ~~arterial line monitoring,~~ chronic mechanical ventilation, ~~mechanical ventilator weaning,~~ or patients requiring intensity of service which cannot be provided in the acute care setting.

~~11.~~10. Women and Newborn Services:
   a. The Women and Newborn Services department develops, implements, and evaluates a plan of care for the mother and family experiencing the birth of a child or pregnant women experiencing medical/surgical/obstetrical complications. This plan incorporates mutual interdisciplinary interactions while maintaining patient advocacy. This plan of care includes the patient, family, significant others and the nurse in response to psychological and physical needs.

~~12.~~11. Wound Care (Inpatient and Outpatient):
   a. The Wound Care Team provides advanced therapy and treatment for patients with non-healing wounds or who are at risk for limb loss. A plan is developed after thorough assessment of factors that may impede healing including vascular insufficiency, infection, biomechanical forces, and physical and psychological needs. Interventions such as prevention/protection, debridement, grafts, or hyperbaric oxygen are implemented and reassessment/updating of the plan occurs at least weekly and as needed. Wound volume is tracked to assure anticipated healing trajectories are met. The patient, family and significant others, as well as a multidisciplinary Wound Team, are involved in the plan of care.

B. Areas where Nursing Care is delivered, not under the Division of Nursing:
   1. Nursing care departments not specifically reporting to the chief nurse executive are overseen by the chief nurse executive via a dotted line relationship, ongoing meetings, regular communication opportunities, review and oversight of nursing practice issues, and approval of policies and procedures.
   2. Cardiac Catheterization Lab:
      a. The purpose of the Cardiac Catheterization Laboratory is to diagnose the exact nature, extent and severity of a patient's heart disease to determine the correct therapeutic approach. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.
   3. Cardiac Rehabilitation:
      a. The purpose of the Cardiac Rehabilitation department is to evaluate, monitor, and educate patients on the importance of risk factor modification and lifestyle changes necessary to improve quality of life and overall cardiovascular health and to avoid any further complications or events pertaining to heart health. Patient treatment plans are developed by a multidisciplinary staff based on individual patient needs, medical history, and goals. The main foci are the ECG monitored exercise training session, medication understanding and compliance, diabetes management, and weight management.
   4. Cardiovascular Health Institute:
      a. The Cardiovascular Health Institute focus is disease prevention, education, and treatment through a multidisciplinary approach of Cardiology, Interventional Radiology, Cardiac and Vascular Surgery and through cardiovascular screenings. Patient's needs are met through a Nursing Clinical Care Coordinator who coordinates and manages patient-focused care, communicates openly with the patient's physicians, and simplifies and streamlines the experience.
   5. Neurovascular Institute:
      a. The Neuroscience Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of neurological and neurosurgical health. The objective is to provide high quality, seamless care

for all patients who receive care from the most basic screening to most complex neurosurgical procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.

6. Orthopaedic Institute:
   a. The Orthopaedic and Spine Institute is a co-management collaborative between Tri-City Healthcare District and physicians who practice within all domains of orthopedic and spine services. The objective is to provide high quality, seamless care for all patients who receive care from the most basic musculoskeletal screening to most complex joint and spinal procedures. The multi-disciplinary approach is aimed at achieving the highest quality patient outcome of care that is delivered in the most efficient manner.
7. Interventional Radiology:
   a. Interventional Radiology is a sub-specialty of Diagnostic Radiology that has evolved over the past 25 years to become an integral part of comprehensive nursing care, providing alternatives to surgery for a broad range of health problems. Patient's needs are met through individualized and specialized nursing care coordinated through the interdisciplinary team approach for care.

XIII. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

~~A. A collaborative multidisciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between departments providing patient care, patient services and support services within the hospital, and as appropriate with community agencies to ensure efficient, effective and continuous patient care.~~

~~B. To facilitate effective interdepartmental relationships, problem-solving and shared decision making is encouraged at the point of service within the organization. Staff is encouraged to address one another's issues and concerns and seek mutually acceptable solutions. Supervisors and managers have the authority to solve problems and seek solutions within their span of control. Positive interdepartmental communications are strongly expected as part of our service standards.~~

~~C.~~A. When problems/issues identified involve two or more areas providing patient care, patient services or support services, supervisors or managers may elect to establish an interdepartmental work group of the personnel from the areas involved for the purpose of identifying mutually acceptable solutions. Other options would include nursing professional practice or operations. Leaders have several options for solutions to interdepartmental issues. Some of these options include: establishing interdepartmental work groups/committees (ad hoc or permanent); referring to the **Quality Assurance** Performance Improvement Committee for consideration in forming a Rapid Improvement Event; and addressing issues in staff meetings.

XIV. REPORTING RELATIONSHIPS

A. The clinical practice departments are organized and grouped according to services offered and are under the management of a Director/**Nurse Leader**~~Manager~~. Each Director/**Nurse Leader**~~Manager~~ is accountable to the Chief Nurse Executive (CNE) for patient care and services provided in their areas.
   1. Staff meetings shall be conducted by the Director/**Nurse Leader**~~Clinical Manager or~~ designee with a mechanism established for all staff members' participation.
   2. The ~~Manager/~~**Nurse Leader**~~ANM~~ shall meet with their assigned Director/CNE at least monthly.
   3. Directors/**Nurse Leaders**~~Managers~~ shall ensure staff communication meetings are held at least monthly.
   4. Directors/**Nurse Leaders**~~/Managers~~ may attend the Medical Staff Division Meetings when appropriate.

B. The Chief Nurse Executive (CNE):

1. Assures that the clinical departments are organized consistently with the variety and complexity of patient care service and the scope of clinical activities.
2. Is responsible and accountable for the daily operations of the PCS units and is a member of the Senior Leadership Team and participates in Board meetings as a C-Suite member.~~.~~
3. Reports the status of the plan for Nursing Services to the ~~Clinical~~ Quality Committee, and to Board of Directors.
4. Attends Medical Executive as the representative for the Department of Nursing.

~~C. Patient Care Services Councils communicate with medical staff committees in the following way:~~

~~1. Quality reports to the Medical Quality/Peer Review Committee and QAPI.~~
~~2. CNE sits on the Medical Executive Committee (MEC) as a non -voting member.~~
~~3. Medical Executive Committee reports to the Board of Directors (BOD)~~

XV. QUALITY

A. Each Nursing area has developed a plan for patient care with metrics for quality and performance improvement. These are measured ~~at least monthly~~ and reported to the through QAPI and the Board annually. ~~Areas of monitoring include but are not limited to:~~

~~1. Comprehensive unit-based safety program (CUSP) Projects~~
~~2. Catheter-associated urinary tract infection (CAUTI)~~
~~3. Central line-associated bloodstream infection (CLABSI)~~
~~4. Falls~~
~~5. Hand washing~~
~~6. Hospital acquired condition (HAC)~~
~~7. Medication Administration~~
~~8. Skin Care~~

~~B. Task forces, teams, committees and councils with staff participation as appropriate, shall be utilized to address issues identified through the Performance Improvement process.~~

XVI. BUDGET

A. The plan for the provision of patient services includes the hospital's budget process and considers the following:
   1. Patient requirements and their implications for staffing;
   2. The hospital's ability to attract and develop staff;
   3. Relevant information from performance improvement, risk management, utilization review, and other evaluation activities pertaining to unit, area, or departmental staffing;
   4. Feedback and specific concerns raised by patients, staff, and physicians.

~~B. In preparation for each fiscal year, the Department Director and/or Manager develop an operating and capital budget for each respective cost center and it is then submitted to the executive team and Board of Directors for final approval. Actual performance compared to the budget is reviewed regularly during the course of the fiscal year and is distributed to the department Director and/or Manager. A formal annual review of the effectiveness of the budgetary plan is made following the close of each fiscal year. Requests for capital equipment expenditures are initiated within each department/unit and are forwarded to the vice presidents, Chief Executive Officer, Chief Operating Office, Chief Nurse Executive, Chief Financial Officer, Chief Human Resources Officer, Chief Compliance Officer; for certain capital items, referral to the Board of Directors for final approval is required.~~

XVII. NURSING LEADERSHIP

A. To maintain a working environment that encourages professional growth through practice, education and research, peer review, resulting in quality nursing care and satisfaction.
B. The Role of Nursing Leadership in Facilitating Excellent Nursing Care
   ~~1. We recognize the excellence delivered by our staff. As nurse leaders, we believe our critical role is making this excellence possible.~~

~~2.~~**1.** We believe nurses who provide direct patient care provide invaluable direction, information and insight into the delivery of patient care and nursing practice.~~, therefore; every attempt to ensure their attendance at Shared Decision Making Council meetings is made.~~

~~3.~~**2.** Nursing is a profound partnership between nurses and patients. Nurses help patients to achieve their potential for health and to cope with their illness/injury. The professional nurse combines superb technical skill with an expert knowledge base. The professional nurse then needs an outstanding knack for communication-ease to achieve the best patient outcomes.

~~XVIII. NURSING SHARED DECISION MAKING STRUCTURE~~

~~A. The Shared Decision Making (SDM) structure shall be clearly defined through which the nursing staff will coordinate and integrate the delivery of nursing care. The SDM structure will recognize participation from all nursing staff members and will give evidence of shared decision making within the formal structure of the nursing staff.~~

~~B. The Purpose of SDM:~~

~~1. To provide a structure that supports the point of care and sustains ownership and accountability at the point of service. This structure builds a culture for people to be together, to tell the story. It creates: shared meaning and purpose in work, healthy relationships and meaningful conversations. All staff is encouraged to begin to participate at the level that they are most comfortable with, and then to "spread their wings" as they become more familiar with the concept of SDM, feeling empowered to contribute to decisions and trust that the community of nursing embraces their contributions, it will flourish. Decisions are made through consensus. Proposed decisions are brought to the various nursing committees for discussion, revisions, approval or disapproval. Final decisions are based on research, evidence, regulations and/or best practices.~~

~~XIX. SHARED DECISION MAKING COMMITTEES~~

~~A. Patient Care Services (PCS) is managed through application of Interdisciplinary Shared Leadership.~~

~~1. The councils of the PCS areas operate under Shared Leadership.~~

~~a. A staff and management representative of the unit based committees may participate in the councils~~

~~b. Staff members/Assistant Nurse Managers (ANM) shall participate in committees/councils as assigned and shall be provided time for attendance when on duty. (See Professional Nursing Governance Bylaws for detail).~~

~~XX.~~**XVIII. RELATED DOCUMENT(S):**

A. Patient Care Services: Chemotherapy Administration Procedure
B. Telemetry: Admission and Discharge Criteria Policy

~~XXI.~~**XIX. REFERENCE(S):**

A. American Nurses Association. (2015) *Code of Ethics for Nurses with Interpretive Statements.* Washington, D.C.: American Nurses Publishing.
B. American Nurses Association. (**2021**~~2015~~) *Nursing: Scope and Standards of Practice*~~.~~**, 4th edition.**
C. California Nurse Practice Act (**2021**~~2016~~)
D. O'Grady, T. P. (1999) *Leading the Revolution in Health Care.* 164.
~~D.~~**E. 2022. *AACN Synergy Model for Patient Care*, https://www.aacn.org/nursing-excellence/aacn-standards/synergy-model**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**POWER INJECTION PROCEDURE FOR PERIPHERALLY INSERTED CENTRAL CATHETER (PICC)**
Purpose:	To outline the Registered Nurse's (RN) responsibility when attaching and disconnecting a Power Injectable Peripherally Inserted Central Catheter with the Contrast Power Injector. Maintain compliance with state and manufacturers guidelines.
Supportive Data:	The Power Injectable computerized tomography (CT) peripherally inserted central catheter (PICC) is indicated for short or long term peripheral access to the central venous system for intravenous therapy and power injection of contrast media. For blood sampling, infusion, or therapy use a ~~5~~ **6** French or larger catheter. The maximum recommended infusion rate is 4 milliliter/sec for power injection of contrast media. **Maximum flow rate is denoted on catheter hub or power port.** The maximum pressure of power injectors used with the Power Injectable CT PICC may not exceed 250 psi.
Equipment:	Power Injectable CT PICC, Power Injector, Computerized ~~Axial~~ Tomography Scanner/magnetic resonance imaging (MRI) Scanner. 1. Non-sterile gloves. 2. **3 - 70% alcohol antiseptic pads.** ~~alcohol swabs.~~ 3. Sterile field (may use 4x4 sterile gauze). 4. **One empty** 10mL**or larger leur lock syringe.** ~~4.~~**5. Two syringes filled with at least 10mL sterile normal saline.** ~~or more Sterile Normal Saline filled syringe.~~ ~~5. 1 Anti-reflux valve for each lumen.~~

A. **POLICY:**

1. Use only lumens marked Power Injectable for power injection of contrast media.
   a. Warning: Use of lumens not marked Power Injectable for power injection of contrast media may cause failure of the catheter.
2. Confirm injection flow rate does not exceed capacity of ~~5~~ **6** French ~~double lumen~~ peripherally inserted central catheter (PICC) line with technologist.
   a. Warning: Exceeding the maximum flow rate of 4 mL/sec may result in catheter failure and/or catheter tip displacement. **Maximum flow rate is denoted on catheter hub or power port.**

B. **PROCEDURE PERFORMED BY A REGISTERED NURSE:**

1. **Suspend all fluids infusing into the PICC.**
2. **Check the ~~5~~ rights of medication administration per Patient Care Services Policy: Medication Administration.** ~~: right patient, right contrast, right dose, right route and right time.~~
3. ~~1.~~ Perform hand hygiene.
4. ~~2.~~ Don **new**~~clean~~ non-sterile gloves.
   ~~Clamp both PICC ports and suspend all Intravenous (IV) meds and Total Parenteral Nutrition (TPN)~~
5. ~~3.~~ **Clamp the catheter/ports. Always clamp the catheter before removing caps. Never leave an unclamped catheter unattended.**
6. ~~4.~~ Select port to be used and ensure patency.
   a. Warning: Failure to ensure patency of the catheter prior to power injection studies may result in catheter failure.

Patient Care Services Content ~~Expert~~~~Department Review~~	Clinical Policies & Procedures	Nursing Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
11/06, 06/08, 11/09, 01/18, **09/22**	11/09, 03/15, 02/18, **10/22**	12/09, 03/15, 03/18, **11/22**	**n/a**	05/15, 03/18, **11/22**	06/15, 03/18, **01/23**	**02/23**	02/10, 07/15, 04/18, **n/a**	02/10, 07/15, 04/18

~~a.~~**b. Prior to cap removal, disinfect the cap and hub of power port and discard antiseptic pad.**

c. ~~Cleanse catheter tip thoroughly with three (3) alcohol swabs~~**Remove cap from the power port and using a new antiseptic pad, disinfect the hub by scrubbing the sides (threads) with 70% alcohol for 30 seconds, making sure to remove any residue** and allow to air dry **for 30 seconds.**~~.~~

d. Attach **an empty** 10 mL or larger syringe **to power port, unclamp and aspirate until blood return. Clamp port, remove and discard blood filled syringe.**

~~b.~~**e. Attach 10 ml prefilled sterile normal saline syringe, unclamp port, inject flush, clamp port, remove and discard syringe.** ~~filled with sterile normal saline.~~

~~c. Unclamp and aspirate for adequate blood return and flush the catheter with the full 10 mL or more of sterile normal saline.~~

~~5. Detach syringe.~~

~~6.~~7. Attach the IV tubing from the power injector syringe directly to the PICC. ~~with the anti-reflux valve attached.~~

~~7.~~8. Keep PICC to be used for power injection unclamped while keeping secondary catheter lumen not connected to power injection system clamped.

~~8.~~9. Notify technologist that the system is connected.

~~9.~~10. Monitor PICC and injection site while the injection is under way, **if possible**. Immediately notify technologist if of any abnormal infiltration, leaking or catheter failure.

~~10.~~11. Exit the room upon request of the technologist to avoid any exposure to radiation. Technologist will give a 10 second warning announcement.

~~11.~~12. After imaging is complete, disconnect the power injection tubing.

~~12.~~13. Flush the Power PICC with 10 mL of sterile normal saline, using a 10 mL or larger syringe.

~~13.~~14. Resume previous IV fluids or clamp unused port.

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

1. Infection Control Policy IC8 Hand Hygiene
2. Patient Care Services Central Venous Access Procedure

D. **REFERENCE(S):**

1. Angiodynamics, Inc. Morpheus CT PICC Insertion Kit, **Revised 2/1/2022.** ~~http://www.angiodynamics.com/products/morpheus-smart-picc2014.~~ **USVABR590-Medcomp-All-ages-PICCBrochure-FINAL.pdf (angiodynamics.com)**
2. Bard Access Systems Power PICC. Polyurethane Radiology Catheters with Microintroducer Set, Instructions for Use. **February, 2016,** ~~http://powerpicc.com/clinician-info.php 2014~~ **USVABR590-Medcomp-All-ages-PICCBrochure-FINAL.pdf (angiodynamics.com)**

~~1.~~3. **Centers for Diseass Control and Prevention. (nd). Central venous catheter hub cleaning prior to accessing. Central Venous Catheter Hub Cleaning Prior to Accessing (cdc.gov)**

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**RADIAL ARTERY COMPRESSION BAND**
Purpose:	To ensure continuity of care and patient safety when using a radial compression band to maintain or regain hemostasis post cardiac catheterization or post radial artery procedure.
Supportive Data:	Vasc Band Hemostat Package insert – Instructions for Use, Vascular Solutions, Inc Vascular Solutions Vasc Band Hemostat Tips for Optimal Performance Vascular Solutions Vasc Band Hemostat Clinical Deployment Steps TR Band Instructions for Use
Equipment:	Radial Artery Compression Device Syringe – syringe supplied by compression device manufacturer with Pulse Oximeter with Probe 2 x 2 Gauze Dressing Small Transparent Dressing (i.e., tegaderm) Wrist Positioning Splint Personal Protective Equipment (i.e., gloves, gown, mask, face shield, eye protection)

A. **DEFINITION(S):**

1. Radial Compression Device: A radial artery compression device is used to control surface bleeding from radial arterial access sites after radial artery catheter removal.
2. Band Balloon: a clear plastic inflatable balloon used to apply pressure to the radial artery.
3. Arterial Occlusion: – A blockage of blood flow through an artery
4. Non-Occlusive Pressure Applied to an Artery: – manual pressure or pressure applied with the use of a mechanical device that does not block (prevent) the flow of blood through an artery.
5. Occlusive Pressure Applied to an Artery: – manual pressure or pressure applied with the use of a mechanical device that blocks the flow of blood through an artery

B. **POLICY:**

1. The radial artery sheath may be removed by the procedural staff or Interventional Cardiologist prior to applying the radial arterial compression band.
2. The Registered Nurse (RN) on the receiving unit is responsible for monitoring, weaning, and removing the radial arterial compression band post procedure.
3. A radial band may not be used to apply occlusive pressure to the radial artery at any time.
4. Do not place a blood pressure (BP) cuff or obtain blood pressure measurements on the affected arm.

C. **PROCEDURE:**

1. Application of the Radial Arterial Compression Band
   a. Using sterile technique, open the pouch and transfer the band and syringe onto the sterile field.
      i. Identify the type of syringe (locking or non-locking)
   b. At the end of the catheterization procedure, withdraw the introducer sheath 2-3 centimeter (cm) from the puncture site.
   c. Align the center of the band balloon 2-5 millimeter (mm) proximal to the puncture site and wrap the band around the patient's extremity.
      i. Inflation line can point in either direction e.g. toward patient's hand or toward patient's head.

Patient Care Services Content Expert	Clinical Policies & Procedures	Nursing Leadership	Division of Cardiology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
01/17, 03/19, 09/22	02/17, 03/19, 10/22	02/17, 03/19, 11/22	04/17, 05/19	n/a	06/17, 05/19, 01/23	06/19, 02/23	07/17, n/a	07/17, 06/19

d. Secure the device to the patient's extremity using the hook and loop fastener. For optimal fit, secure the band around the extremity, allowing no room for slack, but do not overtighten.
e. Draw 18 milliliter (mL) of air into the syringe and connect the syringe to the inflation valve on the band
f. Slowly inject air into the band balloon while simultaneously removing the sheath from the vessel. Once the sheath is completely removed, continue to inject air into the balloon until hemostasis is achieved. Note: the nominal air injection volume for the band is 15 mL and the maximum air injection volume is 18 mL
g. Slowly withdraw air from the band balloon until there is oozing from the puncture site. Once oozing is observed, re-inject 2 mL of air into the band until complete hemostasis is achieved.

2. Post-Application of the Radial Band:
   a. Initial Assessment on Arrival to Nursing Care Areas
      i. Upon arrival to the nursing care area assess the following every 5 minutes times (x) 3: (Timing begins with the first assessment performed with the procedure RN).
         1) Blood pressure (BP)
         2) Heart Rate (HR)
         3) Cardiac rhythm
         4) Oxygen Saturation (SpO_2)
         5) Assess temperature once on arrival and then as ordered
         6) Radial pulse by palpation proximally and distally to the band
         7) Neurovascular checks (perfusion by means of pulse oximetry, color, sensation and temperature of the affected arm).
         8) Presence of bleeding
      ii. Implement continuous pulse oximetry monitoring
         1) Place the pulse oximeter probe on the index finger or thumb on affected wrist
         2) Check pulse oximetry waveform
            a) If pulse oximetry waveform is not visible (e.g., lost), decrease pressure slowly by removing 1 mL of air from the band until a waveform is visible
            b) If pulse oximetry waveform is lost and bleeding is present see Management of Bleeding
      iii. Document vital sign results and assessment findings in the Electronic Health Record (EHR)
   b. Vital Signs Assessment and Monitoring:
      i. Assess the following every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the band is removed and then per the Standards of Care or unit policy. Document results in the EHR.
         1) Vital signs (BP, HR, cardiac rhythm, respiratory rate, SpO2). Assess temperature as ordered
   c. Procedure Site Assessment:
      i. Assess the procedure site every 15 minutes x 4 then, every 30 minutes after completing the initial assessment until the band is removed, then per the Standards of Care or unit policy.
      ii. Procedure site assessment, includes but is not limited to, the following:
         1) Assess the procedure site for the presence of bleeding e.g., new or an increase presence of blood, blood oozing around balloon and/or the presence of a hematoma
         2) Assess perfusion of procedure hand (by means of color, sensation and temperature of the arm with the band)
         3) Palpate the radial pulse

iii. Document the assessment findings in the EHR

3. Neurovascular Assessments:
   a. Perform a neurovascular assessment with vital signs and site assessments
   b. The band should be left on the patient's extremity for at least 120 minutes (2 hours) following catheterization unless directed otherwise by physician's order or patient's condition.
4. Device Removal:
   a. Maintain the band on for the recommended device removal time, withdraw 2 mL of air from the band and observe the puncture site for bleeding
      i. If using a locking syringe, place syringe in the locked position prior to attaching to the inflation valve.
   b. If bleeding is present, re-inject 1-2 mL of air to restore hemostasis. Wait 30 minutes and repeat Device Removal process
   c. If no bleeding is present, continue to remove 2 mL of air every 15 minutes x 3 or until pressure is fully released (e.g. the band balloon is depressed).
   d. When the pressure is fully released and hemostasis is confirmed, carefully remove the band from the puncture site. Do not disrupt the clot.
   e. Apply a 2 x 2 gauze dressing and secure the dressing with a transparent dressing. Do not apply a non-adhering wrap over the dressing.
   f. Remove wrist positioning splint 15 to 60 minutes after dressing applied.
   g. Discard radial band, syringe and wrist positioning splint
5. Management of Bleeding:
   a. Ensure device is in the proper position
   b. Slowly inject enough air in the band balloon to restore hemostasis. Do not inject more than 15 mL of air.
   c. Palpate for the presence of a radial pulse. A palpable radial pulse must be present at all times.
   d. Do not over-inflate the compression device to occlude radial pulse.
   e. Notify the physician immediately if unable to regain hemostasis.
   f. Uncontrolled bleeding:
      i. Remove radial arterial compression device, elevate arm while applying manual pressure to the radial artery proximal to the puncture site to stop the bleeding.
      ii. Notify Physician immediately.
6. Removing the Dressing:
   a. Remove dressing within 24 hours of application or prior to discharge for inpatients. Do not disrupt the clot.
   b. Apply a Band-Aid to puncture site or leave open to air if ordered
7. Reportable Conditions:
   a. Notify the procedure physician immediately if any of the following occur:
      i. New onset of distal pain, numbness, tingling, duskiness, bleeding, unable to palpate the radial pulse or circulation to the hand appears compromised
8. Documentation:
   a. Document the following in the EHR
      i. All assessments
      ii. Vital signs with pulse oximetry results
      iii. Neurovascular assessments
      iv. Dressing applications and changes
      v. Physician Notification
      vi. Education provided – use Depart Custom Education: Cardiac leaflet Radial Artery Cardiac Catheterization/Angioplasty Discharge Instructions

Tri-City Medical Center	Distribution: Patient Care Services
PROCEDURE:	RIGID LARYNGOSCOPE REPROCESSING
Purpose:	Establish a standard practice for reprocessin laryngoscope handles and blades after use d
Equipment:	1. Plastic Ziplock bag 2. Personal Protective Equipment (PPE)

RETIRE – follow Patient Care Services Procedure: Point of Use Pre-Cleaning of Reusable Instruments

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

1. ~~Semi-Critical Medical Instruments: Instruments that contact mucous membranes or non-intact skin, but are not intended to penetrate sterile tissue. Items directly attached to instruments that contact mucous membranes, such as the handles of rigid laryngoscopes, should be considered semi-critical instruments.~~
2. ~~Intubation Trays: Specially prepared trays with all necessary emergency equipment needed for intubation prepared by the Sterile Processing Department (SPD).~~
3. ~~Laryngoscope: Any of several types of tubes, equipped with electrical lighting, used in examining or operating upon the interior of the larynx through the mouth.~~
4. ~~Laryngoscope handles: Handheld battery-powered, fiber-optic light source for use in intubation.~~
5. ~~Laryngoscope blades: Assorted size laryngoscope blades that attach to the Laryngoscope handles for use during intubation.~~

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

1. ~~Contaminated reusable rigid laryngoscope handles and blades shall be processed as soon as possible after use.~~
   a. ~~Prolonged delay between use of the laryngoscope and reprocessing may result in the drying and hardening of debris on the laryngoscope's surfaces.~~
   b. ~~Designated personnel are responsible to return and exchange trays in SPD.~~
2. ~~The handle and blade shall be transported in an enclosed zip lock bag or plastic container to the dedicated decontamination area for reprocessing.~~
3. ~~The designated transporter delivers the tray to the processing area for decontamination.~~
4. ~~The tray is checked for contamination and is cleaned using hospital approved disinfectant.~~
5. ~~Sterile items on the tray are inspected for package integrity. Items suspected of possible contamination shall be disposed.~~
6. ~~Remove batteries and bulb from the laryngoscope handle.~~
7. ~~Clean the blade and handle using an enzymatic cleaner.~~
   a. ~~Blades and handles must undergo a minimum of high-level disinfection. The reprocessing of the device must take into consideration the manufacturer's recommendation, the type of material (if it is able to withstand the reprocessing method), and the infection risk to the patient.~~
8. ~~Place reusable laryngoscope handles and blades in a basket~~
9. ~~Place basket in the washer/disinfector and run at the pre-set cycle for instruments~~
10. ~~For steam sterilization, place the reusable laryngoscope handles and blades in individual peel packs and run the cycle following the manufacturer's recommendations.~~
11. ~~The bulb and batteries are reinstalled into the laryngoscope handle and tested before placing into a peel pack and placed in the tray.~~
    a. ~~This process is performed using clean technique to avoid recontamination of equipment.~~
12. ~~Single use disposable handles and blades will be disposed of at point of use following the manufacturer's recommendations.~~

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

1. ~~Infection Control Policy: Hand Hygiene – IC.8~~

Department Review	Clinical Policies & Procedures	Nurse Executive Council	Pharmacy & Therapeutics Committee	Infection Control Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
12/07, 10/10; 01/15, 06/22	10/10; 02/15, 11/16, 06/22	11/10, 01/17, 07/22	n/a	03/17, 11/22	11/10, 05/17, 08/17, 01/23	02/23	01/11, 09/17, n/a	01/11, 09/17

2. Infection Control Policy: Standard and Transmission Based Precautions – IC.5

D. **REFERENCES:**

1. Association for the Advancement of Medical Instrumentation. ST79
2. Department of Health Services Recommendations for Reprocessing of Semi-Critical Instruments Such as Rigid Laryngoscopes. April, 30th 2007. AFL 07-09

Tri-City Medical Center	Patient Care Services
PROCEDURE:	UNIVERSAL BLOOD SATURATION SCREENING FOR CRITICAL CONGENITAL HEART DISEASE (CCHD)
Purpose:	To provide guidelines for universal blood saturation screening for newborns who are discharged from Tri-City Medical Center
Supportive Data:	Pulse oximetry is a simple, non-invasive way to rule out CCHD in the newborn. In a joint statement the American Academy of Pediatrics (AAP) and American Heart Association (AHA) state: "Routine pulse oximetry performed on asymptomatic newborns after 24 hours of life, but before hospital discharge may detect CCHD. Routine pulse oximetry performed after 24 hours in hospitals with on-site pediatric cardiovascular services incurs very low cost and risk of harm."
Equipment:	Pulse Oximeter

A. **PROCEDURE:**

1. **Prior to starting the test provide written and verbal education on Critical Congenital Heart Disease (CCHD) screening to the parent(s).**
2. **Infants will be screened after 24 hours of age or as close to discharge as possible for newborns who will be discharged early.**
3. **Screenings should be completed when the infant is awake, quiet and calm.**
   a. **If the infant is under phototherapy lights, he/she needs to be removed for the duration of the screening.**
4. **Pre-ductal and post-ductal saturations will be taken on the right hand and on either foot. They can be conducted separately or simultaneously.**
5. **To confirm an accurate reading, the pulse oximeter will be observed for a PI value (confidence index) that is equal to or above 1, or for color-coded equipment, green lights should be observed.**
6. **Reusable pulse oximetry probes are to be placed in the designated container in the soiled utility room.**
7. **If a parent refuses a CCHD screening, have the parent read and sign the refusal form for Newborn Oxygen Saturation Screening for CCHD, document the refusal in the eElectronic hHealth rRecord (EHR) and notify the provider.**
8. **In NICU, the test will be performed at 24-48 hours of life unless an Echocardiogram is performed, the infant has received oxygen within the last 12 hours or at the discretion of the neonatologist.**

B. **RESULT INTERPRETATION:**

1. **Pass: Pulse oximetry saturations are equal to, or greater than, 95% in both extremities with less than or equal to 3% difference between the reading from the right hand and from either foot.**
2. **Fail: Notify the provider for the following:**
   a. **Any pulse oximetry saturation level less than 90% in any extremity**
   b. **Three consecutive pulse oximetry saturation levels:**
      i. **Of 90%-94% in any extremity**
      ii. **Or a greater than a 3% difference between the two readings**
3. **Rescreen Criteria: If the oxygen saturations are 90%-94% in both the hand and foot or there is a greater than 3% difference perform a second screening in one hour.**
   a. **Upon second screening: If the newborn meets pass criteria, no additional evaluation will be required unless signs or symptoms of CCHD are present. If the**

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Council~~	Department of Pediatrics	Pharmacy & Therapeutics Committee	Interdis ciplinary Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
06/12, 07/13, 06/18, **06/22**	07/12, 07/13, 4/15, 09/18, **07/22**	08/12, 7/13, 4/15, 11/18, **08/22**	05/15, 02/19, **11/22**	05/15, 03/19, **n/a**	09/12, 09/13, 09/15, 04/19, **n/a**	09/15, 07/19, **01/23**	08/19, **02/23**	09/12,10/13, 10/15, **n/a**	09/12, 10/13, 10/15, 08/19

oxygen saturation levels do not meet the pass criteria a second time, repeat the screen a third time in one hour.

b. Upon third screening: If the newborn meets the pass criteria, no additional evaluation will be required unless signs or symptoms of CCHD are present. If the oxygen saturation levels do not meet the pass criteria a third time, contact the provider.

C. DOCUMENT:

1. Verbal and written education given and verbal understanding of the parent(s)
2. Results of screening
   a. Pulse oximetry reading of both the pre-ductal and post-ductal levels
   b. Location of pre-ductal and post-ductal
   c. CCHD result: pass, fail or repeat
   d. If parent or guardian refused the screening
   ~~A.~~e. Reason screening not completed, if indicated

~~1. Give parent/significant other parent education sheet at the time of the test or when parent/significant other available.~~
   ~~a. If the test is refused have parent read and sign Refusal form for Newborn Oxygen Saturation Screening for CCHD, document the refusal in the electronic health record (EHR) and notify provider.~~
~~2. Gather supplies and or equipment needed to perform the test.~~
   ~~a. If not using a disposable pulse oximeter, use a clean pulse ox probe for each infant screened.~~
~~3. Conduct the screening:~~
   ~~a. In a quiet area. If possible, have the parent available to quiet and soothe the infant.~~
   ~~b. While the infant is quiet, awake, and calm.~~
      ~~i. Do not attempt to perform pulse oximetry on an infant while he or she is sleeping, crying or cold as oxygen saturations may be affected.~~
   ~~c. If baby discharged at less than 24 hours – perform the test as close to discharge as possible~~
~~4. Perform pulse oximetry on the right hand and one foot after 24 hours of age; measurements should be taken in parallel or one after the other.~~
   ~~a. Premature infants should have the screening performed when medically appropriate.~~
      ~~i. In NICU the test will be performed at 24-48 hours of life unless an Echocardiogram is performed or baby on oxygen within the last 12 hours at the discretion of the neonatologist~~
~~5. Ensure all readings are accurate by using the pulse oximetry equipment confidence indicators.~~
   ~~a. Pass criteria~~
      ~~i. If the oxygen saturation is greater than or equal to 95% in either extremity, with a less than or equal to 3% difference between the two, the infant will "pass" the screening test and no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.~~
   ~~b. Fail criteria~~
      ~~i. If the pulse oximetry reading is less than 90% in either the hand or the foot, immediately notify the infant's physician or in NICU the Neonatologist.~~
   ~~c. Rescreen criteria~~
      ~~i. If oxygen saturations are 90-94% in both the hand and foot or there is a greater or equal to 3% difference perform a second screening in one hour~~
      ~~ii. Upon second screening:~~
         ~~1) If meets pass criteria, no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.~~
         ~~2) If meets the fail criteria, immediately notify the infant's physician or in NICU the Neonatologist~~

~~3) If oxygen saturations are 90-94% in both the hand and foot or there is a greater or equal to 3% difference a second time, repeat the screen a third time in one hour.~~

~~iii. Upon third screening:~~

~~1) If meets pass criteria, no additional evaluation will be required unless signs or symptoms of Congenital Heart Disease (CHD) are present.~~

~~2) If meets the fail criteria, immediately notify the infant's physician or in NICU the Neonatologist.~~

~~3) If oxygen saturations are 90-94% in both the hand and foot or there is a greater or equal to 3% difference a third time, the infant meets the fail criteria and immediately notify the infant's physician or in NICU the Neonatologist~~

~~6. Document:~~

~~a. Education given and verbalized to parent(s) or guardian(s)~~

~~b. Results of screening~~

~~i. Pulse oximetry reading (preductal and postductal)~~

~~ii. If parent or guardian refused the screening~~

~~iii. If infant passed, failed~~

~~iv. If had an Echocardiogram was performed~~

~~v. Transferred to NICU~~

~~vi. Failure information given to the parents "Parent Fail Letter"~~

~~c. Provider notifications in the newborn's electronic medical record.~~

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

1. Parental Refusal of Screening for Critical Congenital Heart Disease 7400-1069 – English – Sample
2. Parental Refusal of Screening for Critical Congenital Heart Disease 7400-1071 – Spanish – Sample

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

1. Newborn CCHD Pulse Oximetry Screening Algorithm

F. **REFERENCE(S):**

3. Advances in Neonatal Care, (2012), A Nurse-Driven Algorithm to Screen Congenital Heart Defects in Asymptomatic Newborns.
4. American Academy of ~~Pediatrics,(~~**Pediatrics,** (2012), Endorsement of Health and Human Services Recommendation for Pulse Oximetry Screening for Critical Congenital Heart ~~Disease~~ **,Disease,** Pediatrics, 129, 190-192.
5. American Academy of Pediatrics, (2013), Oxygen Saturation Nomogram in Newborns Screened for Critical Congenital Heart Disease; 131, e 1803-1810.
6. American Academy of Pediatrics, (2013), Strategies for Implementing Screening for Critical Congenital Heart Disease, Pediatrics, 128, e1259-e1267.

~~7. Advisory Committee on Heritable Disorders in Newborns and Children. (2010, October 15). Letter to the Secretary of the U.S. Department of Health and Human Services. Retrieved April 25, 2011, from www.hrsa.gov/heritabledisorderscommittee/correspondence/October15th2010letter.htm.~~

~~8.~~7. Congenital Heart Disease Screening **Program** Toolkit, A **T**toolkit for Implementing Screening, **4th** ~~2~~2nd edition, Children's National **Health System**~~Medical~~, **2013.** ~~Center, 2011.~~

~~9.~~8. Hoffman J. I. E. (2011). It's time for routine neonatal screening by pulse oximetry. *Neonatology. 99,* 1-9.

~~10.~~9. Kemper AR, Mahle WT, Martin GR, Cooley WC, Kumar P, Morrow WR, Kelm K, Pearson GD, Glidewell J, Grosse SD, Lloyd-Puryear M, Howell RR. Strategies for Implementing Screening for Critical Congenital Heart Disease. *Pediatrics.* 2011; ~~128:~~**e128:** e1-e8

~~11.~~**10.** Center for Disease Control and Prevention: Morbidity and Mortality Weekly Report June 19, 2015, Vol. 64 No.23, State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects-United States, 2011-2014.

SAMPLE

Parental Refusal of Newborn Screening for Critical Congenital Heart Disease

By signing this form, I understand that I am choosing NOT to have my child receive newborn screening for Critical Congenital Heart Disease (heart defects). The method of testing for CCHD is with pulse oximetry. Pulse oximetry is a simple and painless test that measures how much oxygen is in the blood. The screening does not detect all heart defects, but combined with physical examination, pulse oximetry can be an important indicator of heart problems in newborns.

REFUSAL OF SCREENING:

- ○ I, as an individual and as parent or guardian of the child named below, choose not to have my child receive a non-invasive, point of care screening for Critical Congenital Heart Disease (heart defects).

I, as an individual and as the parent or guardian of the infant named below, understand that:

Choosing not to have my newborn screened for heritable and congenital disorders may result in delayed treatment if she or he has a disease that can be detected by newborn screening.

Initial here: _____

Delayed treatment for diseases detected by newborn screening may result in my child suffering from permanent damage, which may include profound neurological or developmental delay, growth failure, organ failure, and/or death.

Initial here: _____

I, as an individual and as parent and guardian of the child named below, further understand that diseases detectable by newborn screening may cause permanent health problems prior to the onset of symptoms, which may not appear until several days, weeks, or months after birth.

Initial here: _____

Release of Hospital from Liability: I, as an individual and as parent and guardian of the child named below, hereby release Tri-City Medical Center and its employees and agents for any injury or ill effects which may result from my refusal of CCHD screening for my child.

Initial here: _____

_____

Parent or guardian signature Date / Time

_____

Parent or guardian printed name Date / Time

_____

Relationship to child

_____

Affix Patient Label

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

7400-1069
(Rev 7/13)

PARENTAL REFUSAL

White - Chart Yellow - Patient

SAMPLE

Rehúso de los Padres - Examen de Enfermedad Cardíaca Congénita Crítica para Recién Nacidos

Comprendo que, al firmar este formulario, estoy eligiendo REHUSAR a que mi criatura reciba un examen para detectar en los recién nacidos defectos del corazón, o lo que se llama Enfermedad Cardíaca Congénita Crítica (CCHD por sus siglas en inglés). El método que se utiliza para el examen de CCHD es la oximetría de pulso. La oximetría de pulso es un examen sencillo sin dolor que mide cuánto oxígeno hay en la sangre. El examen no detecta todos los defectos cardíacos (del corazón) pero en combinación con el examen físico, la oximetría de pulso puede ser un indicador importante de problemas del corazón en los recién nacidos.

REHÚSO AL EXAMEN:

Yo, como individuo y como padre/madre o guardián de la criatura nombrada abajo, elijo que mi criatura no reciba un examen no invasivo de diagnóstico inmediato para detectar la Enfermedad Cardíaca Congénita Critica (defectos del corazón).

Yo, como individuo y como padre/madre o guardián del infante nombrado abajo, comprendo que:

Elegir que no examinen a mi recién nacido para detectar trastornos hereditarios y congénitos, podría resultar en que se retrase el tratamiento si él o ella tuviera una enfermedad que puede ser detectada por el examen para los recién nacidos.

Iniciales aquí: _____

Retrasar el tratamiento para enfermedades detectables por medio del examen para los recién nacidos podría resultar en que mi criatura sufriera daño permanente, que podría incluir retrasos severos neurológicos o del desarrollo, falla en el crecimiento, insuficiencia o fallas en los órganos y/o la muerte.

Iniciales aquí: _____

Yo, como individuo y como padre/madre o guardián de la criatura nombrada abajo, entiendo además que las enfermedades que son detectables por medio del examen para los recién nacidos pueden ocasionar problemas de salud permanentes antes de que aparezcan los síntomas, los cuales pudieran aparecer hasta varios días, semanas, o meses después del nacimiento.

Iniciales aquí: _____

Liberación de Responsabilidad del Hospital: Yo, como individuo y como padre/madre y guardián de la criatura nombrada abajo, por la presente libero a Tri-City Medical Center y a sus empleados y agentes de cualquier lesión o efectos nocivos que pudieran resultar de mi rechazo del (rehúso al) examen de CCHD para mi criatura.

Iniciales aquí: _____

Firma del Padre/Madre o guardián — Fecha / Hora

Imprima el nombre del Padre/Madre o guardián — Fecha / Hora

Relación con la criatura

Affix Patient Label

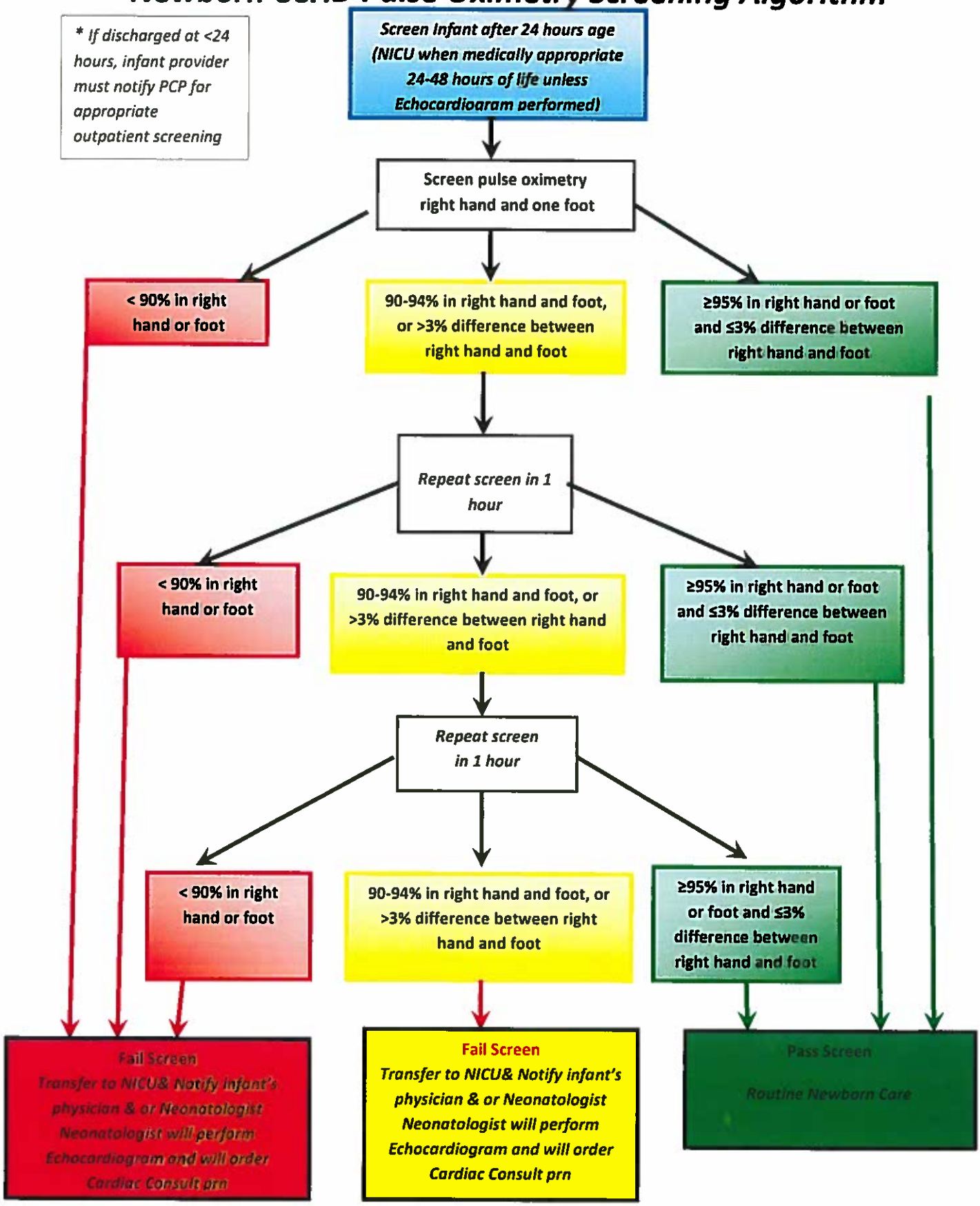
Tri-City Medical Center
4002 Vista Way • Oceanside • CA • 92056

PARENTAL REFUSAL
(REHÚSO DE LOS PADRES)

7400-1071
(Rev. 12/13)

White - Chart Yellow - Patient

Newborn CCHD Pulse Oximetry Screening Algorithm



Tri-City Medical Center	Patient Care Services

PROCEDURE:	**VENIPUNCTURE FOR SPECIMEN COLLECTION**
Purpose:	To establish a standard of care for the process of venipunctures for blood specimen collection.
Supportive Data:	The RN/Phlebotomist needs to be prepared with the proper equipment and supplies. The RN/Phlebotomist must choose the best site for the phlebotomy; positioning both, the patient and themselves, to facilitate a successful blood draw. Proper specimen collection is of the utmost importance to assure quality laboratory specimens.
Equipment:	1. Safety needles: Syringe, Multidraw Vacutainer and Butterfly and Blood Transfer Device, Luer-lok access device 2. Plastic Holder used for Vacutainer needles 3. Syringes – Sterile ~~and non-sterile~~ 4. Vacuum Tubes within expiration dates a. Blood Cultures b. Blue Stopper (sodium citrate) c. Red Stopper (no additive) d. Green Stopper (lithium heparin) e. Lavender Stopper (EDTA) f. Gray Stopper (sodium fluoride) 5. Tourniquets: a. Pre-cut tourniquet~~, a soft pliable non-latex bandage that is 1 inch wide and 15 inches long~~ b. Blood pressure cuff 6. Antiseptics: a. 70% isopropanol (alcohol) b. Chloraprep (Chlorhexidine Gluconate) ~~c. 2% Iodine Tincture SERP~~ 7. Non-sterile gauze pads: a. NICU: Saline Wipes 8. Puncture resistant disposal container 9. Adhesive bandages or Co-Flex flexible bandage, or gauze and paper tape 10. Non-latex gloves: ~~Blood Bank Armband if blood product(s) ordered~~

A. **POLICY:**

1. Non-Laboratory drawn specimens (by venipuncture only; excludes line draws) will be accepted by the laboratory if properly labeled blood specimen. Blood Cultures and Blood Bank Specimens will be accepted **from the following department**~~as follows~~:

Department	Blood Cultures	Blood Bank Specimens	Comments
Dialysis	no	~~yes~~**with phlebotomist present at bedside**	
Cardiac Cath Lab (CCL)	no	~~yes~~**with phlebotomist present at bedside**	
Emergency Department (ED)	no	~~yes~~**with phlebotomist present at bedside**	
Neonatal Intensive Care Unit (NICU)	yes	~~yes~~**with phlebotomist present at bedside**	
Intensive Care Unit (ICU)	no	~~yes~~**with phlebotomist present at bedside**	

Patient Care Services Content Expert~~Department Review~~	Clinical Policies & Procedures	Nursing Leadership	Department of Pathology	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
09/06, 10/10, 05/14, 04/17, 07/20, 09/22	10/10, 05/14, 06/17, 08/20, 10/22	11/10, 05/14, 07/17, 10/20, 11/22	08/17, 06/21, 11/22	n/a	11/10, 06/14, 09/17, 06/21, 01/23	08/21, 02/23	01/11, 07/14, 10/17, n/a	01/11, 07/14, 12/17, 09/21

Department	Blood Cultures	Blood Bank Specimens	Comments
Nursery	no	PKU only	~~PKU only~~
Operating Room Pre-op Hold	no~~yes~~	Yes ~~with properly labeled transfusion armband number~~	
Labor & Delivery (L&D)	no	Yes ~~with properly labeled transfusion armband number~~	
Physician Offices	yes	Yes ~~with properly labeled transfusion armband number~~	

~~a. The phlebotomist must be present at the bedside for blood bank specimens obtained by line draw.~~

~~b.~~a. The first blood culture may be obtained by line draw with physician order, and the second blood culture collection must be performed by venipuncture.

B. **PROCEDURE:**

1. ~~Stoplight – r~~Read patient notices at the door or at the bedside, **verify information with the patient**.
2. Choose the appropriate personal protective equipment (PPE).
3. ~~Introduce yourself, your reason of visit and your department.~~
4. ~~3.~~ Identify the patient using two identifiers depending on inpatient or outpatient status. Refer to Patient Care Services: Identification, Patient Policy
5. ~~4.~~ Verify patient diet restrictions have been followed if applicable.
6. ~~5.~~ Select Needle, System, and Collection Tubes:
   a. Select the appropriate type of needle and equipment for the blood draw based on the patient's physical characteristics and the amount of blood to be drawn.
      i. Vacutainer System: It is generally preferable to use the needle and syringe because it allows the blood to pass directly from the vein in the tube.
      ii. Plastic Syringe: In general, a syringe is used when drawing a specimen from individuals with fragile, thread or "rolly" vein walls and is used in conjunction with blood transfer device.
      iii. Butterfly Needle System: The butterfly system is used on infants and ~~extremely difficult~~ patients **difficult to draw**.
7. ~~6.~~ Perform hand hygiene and don gloves.
8. ~~7.~~ Provide patient education which may include:
   a. Although slightly painful, the venipuncture will be of short duration.
   b. Blood cultures require 2 separate draws ~~(when applicable). This is always two separate draws.~~ **Can~~Could~~ be the same site if necessary but at different times.**
   c. Provide expectations for future repeat draws.
   ~~c.~~**d. ABO check requires separate collection time.** ~~of blood specimen~~
9. ~~8.~~ Position the patient:
   a. Sitting patient:
      i. Have the patient position his or her arm on the slanting on a slanting armrest and extend the arm to form a straight line from the shoulder to the wrist with no bend at the elbow.
   b. Lying down patient:
      i. Ask the patient to lie on his or her back in a comfortable position.
      ii. Have the patient extend his or her arm to form a straight line from the shoulder to the wrist.
      iii. Place a pillow under the arm if additional support is needed.
   c. No food, thermometer or chewing gum should be in the patient's mouth.
10. ~~9.~~ Select site for venipuncture:
   a. First choice is the arm without an intravenous (IV) access.

b. Although the larger and fuller median cubital and cephalic veins are used most frequently, wrist and hand veins are also acceptable for venipuncture.
c. Factors to consider in site selection:
    i. Extensive scarring: avoid burn areas
    ii. Mastectomy: specimens from this side may not be a representative specimen.
        1) In emergency situation, you may proceed without physician/Allied Healthcare Professional (AHP)'s order.
        2) For bilateral mastectomy, get approval from ordering physician/ AHP, then select site based upon their recommendation.
    iii. Hematoma: may cause erroneous test results. If not other site available, collect specimen below the hematoma
    iv. Cannula, Fistula, Vascular Graft: use a cannulated arm only after consulting with the attending physician/AHP
    v. Foot draw:
        1) Must not be attempted as a routine collection site, other than NICU.
        2) A physician/AHP must give written permission before this procedure is started.
    vi. A finger stick may be possible for some tests if no other site available.
    vii. The nurse or physician/AHP may draw blood through the needle or catheter following insertion of IV catheter.
    viii. Blood transfusions:
        1) It is preferable to wait until the transfusion is completed before the blood is drawn, but orders regarding the timing of the blood draw would be followed.
        2) When specimens are collected during the time that blood is being transfused, a comment "drawn during TXN" should be entered in the computer after each test.
d. If a patient has bilateral IV sites or the only arm available has an IV site:
    i. Never place a tourniquet or draw above an active IV site.
    ii. The site should be as far as possible below (distal) the IV.
    iii. When the site is within 3 inches of the active IV, the phlebotomist will need to free-text "DRAWN BELOW BUT NEAR IV" in the computer after each test.
        1) Venipuncture above an inactive heparin lock is acceptable.
    iv. IV fluids should be turned off a minimum of three (3) minutes as patient status permits.
        1) Phlebotomist will ask the nurse to turn off or inactivate the IV fluids and inform the nurse when the draw is complete
        2) Do not apply tourniquet until 3 minutes is over
        3) The phlebotomist will need to free-text "IV OFF 3 MIN DRAWN ABOVE"
e. Close the patient's hand to make veins more prominent and easier to enter.
    i. Avoid having the patient pump the hand which can cause the release of potassium from the muscle tissue.
f. Palpate and trace the path of veins several times with the index finger.
    i. Arteries pulsate, are more elastic and have a thick wall.
    ii. Thrombosed veins lack resilience, feel cordlike and roll easily.
    iii. Lowering the extremity will allow the veins to fill to capacity.
    iv. If superficial veins are not readily apparent, massage the arm from the wrist to the elbow to force blood into the vein wall.
    v. Tapping sharply at the vein site with the index finger a few times will cause the vein to dilate.
    vi. Applying a warming device, to the site for 4 minutes may have the same result.

~~11.~~**10.** Cleanse the venipuncture site with an alcohol pad using a circular motion from the center to the periphery. Allow area to dry.

a. For NICU infants see NICU Standards of Care
b. Allowing the site to dry prevents the patient from having a burning sensation when the venipuncture is preformed and hemolysis of the specimen.

~~12.~~**11.** Apply the tourniquet:
a. Wrap the tourniquet around the arm three to four inches above the venipuncture site.
b. The tourniquet should be tight but not painful.
c. The tourniquet should be released after no more than one minute.
d. If the tourniquet must be applied for preliminary vein selection, it should be released and reapplied after two minutes.
e. When drawing a Lactic Acid level:
   i. With other labs, collect the lactic acid level last and remove tourniquet before collection.
   ii. Without other labs do not use tourniquet.

~~13.~~**12.** Inspect the Needle and Syringe:
a. Visually determine that the needle is free of hooks at the end of the point and free from small particles that could restrict the flow.
b. Move the plunger within the barrel of the syringe to show syringe and needle patency and freedom of plunger movement.

~~14.~~**13.** Perform the Venipuncture:
~~With thumb and forefinger, Ssecure the vein by placing the forefinger 1 to 2 inches above the venipuncture site and the thumb just below the site.~~
a. **Anchor the vein from below the intended puncture site. Never place your finger in front of the needle.**
b. If unable to obtain a blood sample:
   i. Change the position of the needle.
      1) If the needle has penetrated too far into the vein, pull it back a bit.
      2) If it has not penetrated the vein far enough, advance it farther into the vein.
   ii. Try another tube, the tube being used may not have sufficient vacuum.
   iii. Probing is not recommended.
   iv. Loosen the tourniquet; it may have been applied too tightly thereby stopping the blood flow.
c. If the Registered Nurse (RN)/Phlebotomist is unsuccessful after 2 attempts, it is suggested that he or she shall contact another person to attempt venipuncture.
d. Factors to consider during venipuncture:
   i. To prevent hematoma:
      1) Puncture only the uppermost wall of the vein
      2) Remove the tourniquet before removing the needle
      3) Use major superficial veins
   ii. To prevent hemolysis:
      1) Mix anticoagulated specimens thoroughly by inverting tubes gently 5 to 10 times
      2) Avoid drawing blood from a hematoma
      3) Avoid drawing the plunger back too forcefully when using a needle and syringe
      4) Avoid using a needle that is too small
      5) Make sure the needle is fitted securely on the syringe to avoid frothing
      6) Without touching, ascertain that the venipuncture site is dry

~~15.~~**14.** Vacuum Method:
a. Thread the appropriate needle into the vacutainer holder until it is secure.
~~b. Tap all the tubes that contain additives to ensure that the entire additive is dislodged from the stopper and the wall of the tube.~~
c. Tube order for multiple collection draws:

i. Blood Culture Bottles (Aerobic and Anaerobic)
ii. Blue stopper (sodium citrate)
iii. Red stopper (non-additive)
iv. Green stopper (lithium heparin)
v. Lavender stopper (EDTA)
vi. Gray stopper (oxalate/sodium fluoride)

d. Insert the blood collection tube into the holder and onto the needle up to the recessed guideline on the needle holder. Do not push the tube beyond the guideline.
   i. Do not preassemble supplies outside the patient area.
e. With the bevel up, line up the needle with the vein. The needle should be held in one hand at a 15 to 30° angle to the arm. Penetrating the vein at the proper angle will prevent penetrating both blood vessel walls. The skin and vein should be entered in one smooth motion until the needle is in the center of the vein. Push the tube forward until the end of the needle punctures the stopper. Blood should flow immediately into the tube.
f. Fill the tube until the vacuum is exhausted and blood flow ceases. This will ensure that there is a correct ratio of anticoagulant to blood.
g. When the blood flow ceases, remove the tube from the holder. The shut-off valve recovers the point, stopping blood flow until the next tube is inserted.
h. Mix immediately after drawing each tube that contains an additive by gently inverting the tube 5 to 10 times. To avoid hemolysis, do not mix vigorously.
i. To obtain additional specimens, insert the next tube into holder. When the proper amount of blood has been obtained, the tourniquet should be released and patient's hand opened.
j. Before removing the needle from the vein, pull back slightly on the tube to release any remaining vacuum left in the tube.
k. The needle may then be withdrawn from the vein while gauze is placed over the puncture site.
l. Engage the safety mechanism on the needle. Dispose directly into sharps container.

~~16.~~**15.** Syringe and needle method:
a. Insert the appropriate safety needle onto the syringe.
b. Place the patient's arm in a downward position if possible.
c. Line up the needle and syringe with the vein from which the blood will be drawn.
d. Turn the needle so the bevel is in an upward position.
e. Push the needle into the vein.
f. Pull back on the syringe plunger until the desired amount of blood has been obtained.
g. Release the tourniquet and open the patient's hand.
h. The needle may now be withdrawn from the vein while gauze is placed over the venipuncture site.
i. Lock the safety mechanism of the needle into place. Remove the needle from the syringe and dispose of the needle into the sharps container.
   i. Note: Never transfer blood by inserting the needle directly into the vacuum tubes.
j. Attach a blood transfer device to the tip of the syringe and insert the vacuum tubes in order of blood draw to transfer the blood into the tubes.
k. Gently mix tubes by inversion after transferring the blood into the tubes.
l. Dispose of the syringe and transfer device into the sharps container.

~~17.~~**16.** Venipuncture using a butterfly needle:
a. Attach appropriate syringe or vacutainer holder to tubing.
b. Follow standard venipuncture technique until needed amount of blood is obtained.
~~c. Follow proper process for needle withdrawal.~~
~~d.~~**c.** Remove butterfly, engage safety mechanism on the needle, and dispose in a sharps container.

i. If syringe method is used, attach a blood transfer device to the syringe and fill the appropriate tubes with blood as outlined above.

~~18.~~**17.** Coagulation Studies:

a. In-House Routine Tests:

i. All the tests below are collected in a 2.7 ml sodium citrate (blue top) vacuum tube.

1) PT (Prothrombin time and INR)
2) PTT
3) Fibrinogen
4) D-Dimer
5) TT (Thrombin Time)
6) 1:1 Mixing Studies

ii. DIC screens (Include PT/INR, PTT, Fibrinogen, FDP, D-dimer, Platelet Count and smear for schistocytes) require:

1) 2.7 ml Sodium Citrate tube (Blue Top)
2) EDTA tube (Lavender Top)

b. In House Special Tests:

i. The coagulation Department will provide tubes for the following tests:

1) Infant Coagulation Studies: The coagulation Department will prepare special tubes for all children less than 1 year of age.

c. Send out Special Coagulation Tests:

i. The following will be drawn in 2.7 ml sodium citrate (Blue Top) tubes.

1) AT3 (Antithrombin III)
2) Protein C
3) Protein S
4) Activated Protein C Resistant Factor V
5) Factor Assays
6) Hemostasis A Panel
7) Refer to Laboratory Services Quick Reference Adult Patients Specimen Requirements for the number of tubes required for each test(s) requested

d. Special Considerations:

i. It is very important to perform an atraumatic venipuncture, because any tissue fluid contamination will activate the clotting system.

ii. It is critical that all tubes be filled to the required capacity. Overfilled tubes may clot and under filled tubes will give a false result

iii. Line Draws: Coagulation studies are not to be drawn from A-lines unless ordered by a physician/AHP, except for NICU.

1) The first 10 mL of blood must be discarded before blood is used to fill the coagulation tubes
   a) NICU: When utilizing venipuncture, do not discard any amount of specimen. Lines utilized for NICU Lab draws (in order of preference) should only be Umbilical Arterial Lines, Peripheral Arterial Lines, or Umbilical Venous lines.
2) Phlebotomist/NICU RN must inform the Coagulation Department if a line draw must be done for a coagulation test.
3) Must append a comment "line draw" to each test in the computer using FUNCTION: RE.
4) Heel sticks and finger sticks are not allowed under any circumstances.
5) Central Venous Access Devices: See Patient Care Service: Central Venous Access Devices, Adult Procedure.

iv. Syringe draw: The last blood into a syringe will offer the best results for coagulation tests, so fill the blue top first.

1) If only coagulation tests are ordered, draw an extra 1-2 mL to leave in the syringe.

v. Butterfly draw: If the coagulation tube is the only tube to be drawn, a small red top tube should be drawn with at least 1 mL before filling the citrate tube (Blue Top).

~~19.~~**18.** Blood Cultures:

a. Use appropriate equipment and draw appropriate volume of blood based on patient's age/weight:

i. Newborns (less than 4 kilograms [kg]):

1) Collect 1 mL of blood in a Peds Plus bottle from one site only.

ii. Children 2 years of age or less:

1) Collect 5 mL of blood in a Peds Plus bottle from one site only.

iii. Children 2-6 years of age or weighing 30 – 80 pounds (lbs.):

1) Use one aerobic and one anaerobic bottle and collect 5 mL of blood for each bottle

iv. Adults and children weighing greater than 80 lbs.:

1) Use 2 sets of aerobic and anaerobic bottles, each bottle containing 8-10 mL of blood.

2) Select a different venipuncture site for each blood culture.

a) If poor access requires that blood for culture be drawn through a port in an IV or indwelling catheter, the second must be drawn from a peripheral site as cultures drawn through catheters can indicate catheter colonization.

b) Do not draw blood from a vein into which an IV solution is infusing.

c) If venipuncture must be performed at the same site (usually due to bad veins), perform the second venipuncture at that site.

b. Once a site is selected, clean site as follows and avoid touching site after cleansing.

i. For adults, children, and infants greater than 2 months old:

1) Using Chloraprep, cleanse with gentle, repeated back and forth strokes for 30 seconds and allow to dry.

2) For infants less than 2 months old and NICU infants: disinfect skin surfaces with Chlorhexadine Gluconate prep pads (available in NICU). Wipe away all disinfectant with saline wipe after procedure is complete. Alcohol should not be utilized for NICU infants.

c. Use a new needle with each venipuncture attempt.

i. Do not palpate the skin after it is disinfected.

d. Pop the cap of the blood culture bottle and inoculate first the aerobic bottle and then the anaerobic bottle with the appropriate amount of blood.

i. If the cap has been off the blood culture bottle for any amount of time, the rubber stopper on the bottle must be cleaned with an alcohol prep pad.

ii. For direct inoculation into the bottles from the needle apparatus, mark the side of the bottle with the recommended draw.

1) For Aerobic bottles, mark 3rd lines down from top of bottle.

2) For anaerobic bottles, mark 2nd lines down from top of bottle.

iii. If using a needle and syringe, use the volume markings on the syringe to note the volume.

1) Hold the syringe plunger during transfer to avoid transfer of excess blood into bottles having significant vacuum.

iv. There is no need to change the safety device between inoculations.

~~20.~~**19.** Bandage the site:

a. Patients not on anticoagulants:

i. Apply tape or an adhesive over the venipuncture site after checking that all bleeding has stopped. Ask the patient to leave the pressure dressing on for at least 30 minutes.
ii. If the patient continues to bleed, apply pressure to the site with a gauze pad until the bleeding stops. Then apply clean folded gauze as a pressure dressing to the site. Ask the patient to leave on the bandage for at least one hour.

b. Patients on anticoagulants:
i. Apply pressure for 2 minutes and then check for bleeding.
ii. Watch the venipuncture site for an additional 30-second interval until bleeding has stopped.
iii. Place clean gauze pad on the site and tape to create a pressure bandage.
1) Note: Patients on tPA will require additional pressure up to 20 minutes.

~~21.~~**20.** Disposal of Needle:
a. Dispose of needles promptly to prevent their reuse or accidental injury. The vacutainer needle and vacutainer holder assembly are disposed of in the sharps container. The syringe and needle should all be discarded in the sharps container.
i. Note: The vacutainer needle and holder will never be reused.
ii. Never clip, bend, recap, unscrew or otherwise manipulate a needle by hand.

~~22.~~**21.** Labeling:
a. Refer to Patient Care Services: Specimen Labeling Procedure.

~~23.~~**22.** Specimen Handling:
a. Follow any special specimen handling requirements for the specimens drawn such as protecting from light, placing on ice, or keeping at body temperature.

~~24.~~**23.** Specimen Transport:
a. When transporting from patient location to the Lab, place the specimens in a secondary container.
b. When using the pneumatic tube system, place the specimens in a zip lock, leak proof bag with the requisition or labels in the side pocket or clipped to the outside of the bag.

C. **RELATED DOCUMENT(S):**
1. Order of Draw
2. Patient Care Services: Central Venous Access Devices Procedure
3. Patient Care Services: Identification, Patients Policy
4. Patient Care Services: Specimen Labeling Procedure
5. Laboratory Pre-Analytical Phlebotomy: Adult Specimen Requirements

D. **REFERENCE(S):**
1. CLSI (2010) Procedures for the Handling and Processing of Blood Specimen for Common Laboratory Tests; Approved Guideline – Fourth Edition. CLSI document GP44-A4. Wayne, PA: Clinical and Laboratory Standards Institute
2. CLSI (2010) Tubes and Additives for Venous and Capillary Blood Specimen Collection; Approved Standard – Sixth Edition. CLSI document GP39-A6. Wayne, PA: Clinical and Laboratory Standards Institute
3. CLSI (2017) Collection of Diagnostic Venous Blood Specimens. 7th ed. CLSI standard GP41. Wayne, PA: Clinical and Laboratory Standards Institute
4. CLSI (2017) Essential Elements of a Phlebotomy Training Program. 1st ed. CLSI document GP48. Wayne, PA: Clinical and Laboratory Standards Institute

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE ~~POLICY~~
DISTRICT OPERATIONS

ISSUE DATE: 02/15

SUBJECT: Authorized Access - Medications

REVISION DATE~~(S)~~: 12/18

POLICY NUMBER: 8610-298

Administrative ~~District Operations~~ Content Expert Approval:	**~~08/18~~09/22**
Administrative Policies & Procedures Committee Approval:	**~~09/18~~11/22**
Pharmacy &Therapeutics Committee Approval:	**~~11/18~~01/23**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~12/18~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/18**

A. **PURPOSE:**

1. To define categories of personnel who have authorized access to secure medication storage areas.

B. **DEFINITION(S):**

1. Secure Area: a secure area means that drugs and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals. Drugs and biologicals must not be stored in areas that are readily accessible to unauthorized persons. Areas where patients and visitors are not allowed without the supervision or presence of a health care professional are considered secure. Areas restricted to authorized personnel only are generally considered "secure areas".

C. **POLICY:**

1. Medications and biological are stored in a secure environment:
   a. Controlled substances are locked.
   b. Both controlled substances and non-controlled medications are locked when a patient care area is not staffed.
2. Only authorized personnel have access to secure areas where medications and biologicals are stored.
3. Categories of personnel are authorized access to secure medication areas based on the organization's need for individuals to perform their assigned duties and in accordance with federal, state and local regulations.
4. Non-licensed authorized personnel are identified by job classification and job description with competencies related to their specific role.

D. **PROCESS:**

1. The following personnel are authorized by licensure, certification, or policy to have responsibilities within the medication use system as defined by their regulating boards or agencies and hospital policy:
   a. Registered Nurses (RN)
   b. Licensed ~~Practical~~**Vocational** Nurses (LV~~P~~N)
   ~~c. Graduate Nurses (GN)~~
   ~~d.~~**c.** Physicians (MD, DO)
   ~~e.~~**d.** Pharmacists and Pharmacy Technicians
   ~~f.~~**e.** Respiratory Therapists (RT) (RT related medications only)
   ~~g.~~**f.** Radiology and Interventional Radiology Technologists (Radiology related medications only including contrast).

~~h.~~g. Cardiac Catherization Lab Technician.
~~i.~~h. Operating Room Technicians.
~~j.~~i. Anesthesia Technicians.
~~k.~~j. Physical Therapists (PT) (PT related medications only)
~~l.~~k. Speech Therapist (ST) (ST related medications only)
~~m.~~l. Materials Management Staff (IV fluids, skin antiseptics, etc.)
~~n.~~m. Transporters (transfer of medications from licensed professional to licensed professional- transfer only).
~~o.~~n. Physician's Assistant (PA)
~~p.~~o. Nurse Practitioner (NP)
~~q.~~p. Doctor of Podiatric (DPM)
~~r.~~q. Doctor of Dental Science (DDS)
~~s.~~r. Doctor of Dental Medicine (DMD)
~~t.~~s. Certified Nurse Midwife (CNM)
~~u.~~t. Medical Assistants (MA)

E. **REFERENCE(S):**

1. CMS State Operations Manual- Appendix A Interpretive Guidelines for Hospitals §482.25(b)(2)(i)
1. The Joint Commission Standards MM 03.01.01 EP 6
2. CMS Conditions of Participation §482.25(b)(2)(iii)
3. Healthcare Facilities Accreditation Program (HFAP) 25.01.03
4. DNV National Integrated Accreditation for Healthcare Organizations MM.1 SR.4b

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH & WELLNE

~~ISSUE DATE: 11/94~~ ~~SUBJECT: Employee Health – Bloodbo~~

~~REVISION DATE: 05/02, 06/02, 09~~

Move to Related Document to Employee Health and Wellness Policy: ~~Occupational Exposure to Blood Body~~Management of Bloodborne Pathogen Exposure

Bloodborne Pathogen Exposure Protocol

Exposed Patient	Baseline Tests on Exposed Patient	Tests on Source	Initial Treatment of Exposed Patient	Follow-up Treatment and Testing of Exposed Patient
No HBV vaccine or incomplete vaccine series	•HIV •HBs-AG •HC-AB	•HIV •HBs-AG •HC-AB	•Tdap or Td if > 5 years •HBIG •Initiate or complete HBV vaccine series, if desired •Consider HIV PEP	•HIV at 6 wks, 3 mths, 6 mths* •HC-AB at 6 mths if source HC-AB positive or unknown •Complete the HBV vaccine series, or HBIG at 1 mth
Complete HBV vaccine series – known responder (adequate HBs-AB within 4 years)	•HIV •HC-AB	•HIV •HC-AB	•Tdap or Td if > 5 years •Consider HIV PEP	•HIV at 6 wks, 3 mths, 6 mths* •HC-AB at 6 mths if source HC-AB positive or unknown
Complete HBV vaccine series – response unknown	•HIV •HBs-AB •HBs-AG •HC-AB	•HIV •HBs-AG •HC-AB	•Tdap or Td if > 5 years •Consider HIV PEP	•HIV at 6 wks, 3 mths, 6 mths* •HC-AB at 6 mths if source HC-AB positive or unknown •HBIG and HBV vaccine booster if HBs-AB inadequate

*If source is co-infected with HIV and hepatitis C, check HIV at one year

Abbreviations

HIV:	Human immunodeficiency virus
HIV PEP:	HIV postexposure prophylaxis (see separate protocol)
HBV:	Hepatitis B virus
HBs-AB:	Hepatitis B virus surface antibody (adequate ≥ 10 mIU/mL)
HBs-AG:	Hepatitis B surface antigen
HC-AB:	Hepatitis C virus antibody
HBIG:	Hepatitis B immune globulin (dose 0.06 mL/Kg IM)
PEP:	Postexposure prophylaxis
Tdap:	Tetanus -diphtheria- pertussis vaccine

Obtaining Source Blood

- The ED physician or physician assistant should attempt to obtain the appropriate source blood samples from source patients hospitalized at TCMC or being treated in the TCMC ED.
- **Employee Health**~~WORKPARTNERS~~ **will attempt**~~pursue~~ **to obtain**~~ing~~ source blood samples from source patients not being treated at TCMC.

Follow-up

- **The occupational healthcare provider**~~WORKPARTNERS~~ will notify exposed patients of test results and arrange for follow-up testing.
- Patients prescribed a 4-week course of HIV PEP will be followed by the treating physician.

- Patients prescribed HIV PEP pending HIV testing on the source patient will be followed by **the occupational healthcare provider**~~WORKPARTNERS~~. If a full 4-week course of PEP is later indicated, the patient will be referred back to the treating physician for follow-up.

~~Approvals~~

~~Infection Control Committee~~

~~Medical Executive Committee~~

~~Board of Directors~~

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE:	**01/81**	**SUBJECT:**	**Employee Health Infection Control Program~~General Guidelines~~**
REVISION DATE:	**09/04; 10/07, 10/09, 10/12**		

Employee Health Department Approval:	**10/22**
Infection Control Committee Approval:	**12/22**
Environmental Health and Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**10/12**

A. **PURPOSE**:

1. **Screening programs (tuberculosis [TB], latex, National Institute for Occupational Safety & Health [NIOSH] approved respirator medical evaluation and vaccine preventable diseases), pre-exposure prophylaxis, and post-exposure prophylaxis are offered through** Employee Health Services **(EHS) in an effort to control communicable diseases risks to both personnel and patients. However, EHS does not evaluate or treat health care personnel (HCP) for health problems or conditions that are not work-related~~.~~. ~~I~~In** conj~~d~~unction with the ~~Districts~~ Human Resource Department **and Infection Prevention, the following specific program objective s~~ and Occupational Health Services~~** haves been developed to **include**~~meet the following objectives~~:
   a. **Pre-employment screening to ensure safe, appropriate placement of personnel to minimize their risk of contracting or spreading communicable disease.**~~Post Offer History and Physical Exam and Annual Reviews.~~
   b. Personnel health and safety education.
   c. **Manage bloodborne pathogen exposures, including identifying and communicating exposure risks and trends, promoting exposure prevention, and post-exposure case management.**~~Protocols for surveillance and management of work related injuries, illnesses and exposures to Infectious diseases.~~
   d. **Identify health, safety and infection risks related to employment and institute preventative measures to identify and prevent injury and illness.**~~Counseling for personnel regarding infection risks related to employment or special conditions.~~
   ~~d.~~**e. Monitor and investigate communicable diseases, potentially harmful exposures, and outbreaks among personnel.**
   f. Maintenance of employee health records.
   ~~e.~~**g. Report on the elements of the Employee Health Infection Control Program to the Infection Prevention Committee quarterly.**
   ~~f. Management of the Leave of Absence Program - See Administrative Policy 435, Leave of Absence~~

B. **POLICY**:

1. **Immunization Program**~~Post Offer Evaluation~~
   a. **Evidence of Immunity (See Screening and Immunization Program in related documents)**~~History~~
      i. **All new personnel working at TCMC, including rehired personnel are required to complete an immunization screen before new employee orientation. Failure to provide proof of immunization and to complete EHS screening will prevent the HCP from working at TCMC until these**

requirements are met. All HCP must be immune (unless there is a medical contra-indication, as described by CDC/ACIP, or religious objection) to measles, mumps, rubella, varicella, and pertussis. All HCP~~HCW~~s must receive influenza vaccine annually and COVID-19 vaccines per California Department of Public Health guidelines. Vaccine exemptions will be evaluated on an individual basis each year and must be resubmitted annually.

~~i.~~ii. The following immunizations are offered at the employer's expense: Pertussis (Tdap); tetanus (Td); measles, mumps, rubella (MMR); hepatitis B; influenza, varicella, and COVID-19. Hepatitis A vaccine will be offered to any personnel who handles or assists in food preparation or who may be exposed to raw sewage, e.g., Engineering. Live-attenuated virus vaccines (varicella, MMR) will not be given to pregnant HCP or immune-compromised persons. Other vaccines (e.g., smallpox) may be offered at the discretion of the Medical Director. ~~Determinations of conditions that predispose the employee to transmit or acquire disease.~~

~~ii. Determination of employee ability to perform job-related functions with or without reasonable accommodation.~~

~~b. Evidence of Immunity – See Immunization Policy IC.14~~

~~c. Respiratory Fit Testing – See Respiratory Protection Program IC 14.1~~

~~d. Physical Evaluation~~

2. Employment and Annual Health Screening
   a. TCMC HCP, volunteers, and contract employees shall have initial infectious disease screening and/or immunization review. The screening will include tuberculosis screening as specified in the ATD and TB Exposure Control Plan.
      i. ~~Annual s~~Screening will be directed by EHS and will include a review of symptoms for tuberculosis as per the TB Surveillance Policy and an immunization review.
   b. All HCP will complete a respirator medical evaluation form and specific job classifications will be required to comply with respirator training and fit-testing (refer to Respiratory Protection Program Policy IC 14.1). Fit testing is not required for use of a powered air purifying respirator (PAPR) by HCP.
   c. Contract HCP who provide patient care, whether in a clinical area or in an administration office, must comply with OSHA standards and this Infection Control and Screening Program. It is the responsibility of the hiring department to assure compliance with this policy.
   d. HCP providing high-level disinfection (HLD) who may be color blind should be referred to EHS for further evaluation. In order to assess minimum effective concentrations (MEC) of HLD chemicals, HCP must be able to discern colors since chemical indicators demonstrate MEC via a color-changing strip or vial. HCP performing HLD may "color-blind", however, another HCP would be required to read the strips or vial.
3. Screening of Personnel with Infectious Diseases or Exposures to Communicable Diseases ~~Post-exposure follow up – See Guidelines for Reporting Exposures IC 14~~
   a. See Post-Exposure Prophylaxis for Vaccine Preventable Diseases for specific protocols.
   b. All HCP with a potentially communicable disease (e.g., shingles, conjunctivitis, norovirus) must notify EHS. The EHS provides free medical screening for health problems encountered by HCP for the purpose of infection prevention. If necessary, EHS may order work restrictions (refer to Work Restrictions for Personnel with Infectious Diseases).
   c. Blood Exposure – Refer to Occupational Exposure to Blood/Body Fluid Secretions Policy and Bloodborne Pathogen Exposure Control Plan for management guidelines. For treatment guidelines see the Bloodborne Pathogen Exposure Protocols (HBV and HIV)

~~2.~~

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

1. ~~Tuberculosis Control Plan – See Aerosol Transmissible Diseases and Tuberculosis Control Plan~~**Screening and Immunization Program**
2. **Employee Health and Wellness Policy: Respiratory Protection Program**
3. ~~Guidelines for~~ Work Restrictions for Personnel with Infectious Diseases
4. **Infection Control Policy: ATD and TB Exposure Control** ~~See Recommendations and Work Restrictions for Personnel with Infectious Diseases IC 14.~~
5. **Post-Exposure Prophylaxis for Vaccine Preventable Diseases**
6. **Employee Health and Wellness Policy: Management of Bloodborne Pathogen Exposure** ~~Occupational Exposure to Blood/Body Fluid Secretions~~
7. **Bloodborne Pathogen Exposure** ~~Treatment~~ **Protocols Grid (HBV and HIV)**
5. ~~Management of Work Related Injury/Illnesses, - see Administrative Policy 477, Employee Health and Safety~~

~~C. APPROVALS:~~

~~1. Infection Control Committee~~
~~2. Medical Executive Committee~~
~~3. Board of Directors~~

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH AND WELLNE

RETIRE – incorporated into Employee Health and Wellness Policy: Management of Bloodborne Pathogen Exposure

ISSUE DATE: 01/81
REVISION DATE: 06/01, 09/04, 10/07, 10/09, 10/12, 04/15

SUBJECT: Guidelines for Reporting Exposures

Employee Health & Wellness Approval:	09/19
Infection Control Committee Approval:	11/22
Environmental Health and Safety Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Human Resources Committee Approval:	n/a
Board of Directors Approval:	

~~A. **INTRODUCTION**~~

~~1. Healthcare workers are at risk of exposure because of their contact with patients or infective material. This policy provides general guidelines for reporting exposures to infectious diseases.~~

~~B. **PROCEDURE**~~

~~1. All potential exposures should be iImmediately reported the exposure to your Supervisor or Manager. Prompt reporting is essential because, in some cases, post exposure treatment may be recommended and it should be started as soon as possible.~~

~~The Infection Control Preventionist and Employee Health Services:~~

~~2. aAre contacted for assistance to determine risk of exposure and potential risks to others.~~

~~3. Employee Health Services wWill notify involved departments of the potential exposure and appropriate next steps to take.~~

~~4. Department Directors or designee are required to complete and submit to the Infection Preventionist~~Employee Health, a list of employees who were exposed.

~~5. Employee Health Services will follow through institutewith plan and appropriate follow up.~~

~~C. Approvals~~

~~a. Infection Control Committee~~
~~b. Medical Executive Committee~~
~~c. PAC~~
~~d. Board of Directors~~

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

~~1. Control of Communicable Diseases Manual, D.L. Heymann, Ed. 198th edition, 20084~~
~~2. APIC Text of Infection Control and Epidemiology, revised4th edition, 201402~~
~~3. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection - MMWR 2000; 49 (No. RR-6)~~
~~4. Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis Recommendations from the national Tuberculosis Controllers Association and CDC/ Guidelines for Using the QuantiFERON-TB Gold Test for Detection Mycobacterium tuberculosis Infection, United States MMWR 2005; 54 (No. RR-15)~~

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH & WELLN

Move to Related Document to Employee Health and Wellness Policy: ~~Occupational Exposure to Blood Body~~Management of Bloodborne Pathogen Exposure

~~ISSUE DATE: 11/94~~ ~~SUBJECT: Employee Health – Bloo~~
~~Postexposure Prophyla~~
~~REVISION DATE: 5/02, 6/05, 4/08, 10/12~~

Guide to Human Immunodeficiency Virus (HIV) Postexposure Prophylaxis (PEP)

NOTE: 24-hour expert consultation on the management of bloodborne pathogen exposure and PEP can be obtained at the **National Clinicians' Postexposure Prophylaxis Hotline (PEPline)** at 1-888-448-4911.

Exposure Types	Infection Status of Source				
	HIV-positive, class 1	**HIV-positive, class 2**	**Unknown HIV status**	**Unknown source**	**HIV-negative**
	Asymptomatic HIV infection or known low viral load (e.g., <1,500 RNA copies/mL)	Symptomatic HIV infection, AIDS, acute seroconversion, or known high viral load	E.g., deceased source person with no samples available for HIV testing	E.g., needle from a sharps disposal container, or splash from inappropriately disposed blood	
Percutaneous Exposure					
Less Severe • Solid needle • Superficial injury	Recommend basic 2-drug PEP¶	Recommend expanded ≥3-drug PEP§	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ for source with HIV risk factors	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ in settings where exposure to HIV-infected persons is likely	No PEP warranted
More Severe • Large-bore, hollow needle • Deep puncture • Visible blood on device • Needle used in patient's artery or vein	Recommend expanded 3-drug PEP§	Recommend expanded ≥3-drug PEP§	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ for source with HIV risk factors	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ in settings where exposure to HIV-infected persons is likely	No PEP warranted
Mucous Membrane and Nonintact Skin¶¶ Exposures					
Small Volume • A few drops	Consider basic 2-drug PEP*¶	Recommend basic 2-drug PEP¶	Generally, no PEP warranted	Generally, no PEP warranted	No PEP warranted
Large Volume • Major blood splash	Recommend basic 2-drug PEP¶	Recommend expanded ≥3-drug PEP§	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ for source with HIV risk factors**	Generally, no PEP warranted; however, consider basic 2-drug PEP*¶ in settings where exposure to HIV-	No PEP warranted

				infected persons is likely	

Source: *Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis.* MMWR 2005; 54 (No. RR-9):1-17.

*The recommendation "consider PEP" indicates that PEP is optional; a decision to initiate PEP should be based on a discussion between the exposed person and the treating clinician regarding the risks versus benefits of PEP.

¶Consider expert consultation when considering basic 2-drug PEP. Basic 2-drug regimens include: (1) zidovudine 300 mg BID + lamivudine 150 mg BID (available in a combination as Combivir®, given one tablet BID); (2) zidovidine 300 mg BID + emtrictabine 200 mg QD; (3) tenofovir DF 300 mg QD + lamivudine 300 mg QD or 150 mg BID; (4) tenofovir DF 300 mg QD + emtrictabine 200 mg QD (available in a combination as Truvada®, given one tablet QD).

§ Obtain expert consultation,when considering expanded 3-drug PEP or expanded ≥3-drug PEP.

¶¶For skin exposures, follow-up is indicated only if evidence exists of compromised skin integrity (e.g., dermatitis, abrasion, or open wound).

Additional notes:

1. Potentially infections fluids include blood, semen and vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, and amniotic fluid. Feces, nasal secretions, saliva, sputum, sweat, tears, urine, and vomitus are not considered potentially infectious unless they are visibly bloody.
2. Laboratory testing for those receiving PEP should include at a minimum a CBC, renal and hepatic function tests, pregnancy test when appropriate, and baseline tests for HIV, Hepatitis B, and Hepatitis C.
3. PEP is given for 28 days, if tolerated, or until the source is determined to be HIV-negative.
4. Consider expert consultation when considering PEP in the following circumstances: delayed presentation (>24-36 hours from exposure), unknown source, pregnancy, breastfeeding, drug-resistant source virus, toxicity of initial PEP regimen.

~~Approvals~~

~~Infection Control Committee~~

~~Medical Executive Committee~~

~~Board of Directors~~

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE:	**01/81**	**SUBJECT:**	**~~Occupational Exposure to Blood/Body Fluid Secretions~~Management of Bloodborne Pathogen Exposure**
REVISION DATE:	**09/04, 05/05, 10/07, 10/09, 10/12, 10/13 04/15**		

Employee Health Department Approval:	**~~02/20~~10/22**
Infection Control Committee Approval:	**12/22**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/15**

A. **PURPOSE:**
1. To provide guidelines for treatment and management of employees in the event of an exposure to- blood and body fluids.
2. An occupational exposure is defined as contact with blood/body fluids during the performance of job duties and may occur in the following manner:
   a. Percutaneous injury – needlestick or cut with sharp object.
   b. Mucous membrane contact – eye, mouth or nasal opening
   c. Nonintact skin – exposed skin that is chapped, abraded skin, or afflicted with dermatitis.
   d. Human bite

B. **PROCEDURE:**
1. **Exposure Reporting**~~Immediately following an exposure to blood or other potentially infectious body fluids:~~
   a. **Introduction**
      i. **Any healthcare personnel (HCP) who has an exposure to blood or body fluids should take immediate action.**
         1) **Exposed skin and any puncture sites should be thoroughly** ~~W~~**washed** ~~injured area~~ with soap and water.
         2) **Eyes are to be rinsed thoroughly with water at an eyewash station or if a station is not available, using sterile saline, eye irrigation, or clean water. The eyes should be flushed for a minimum of five minutes.**
         3) **If the mouth is exposed, rinse/flush with clean water.**
         ~~a.~~4) **The application of caustic agents (e.g., bleach) or the injection of antiseptics or disinfectants in the wound is not recommended.**
   ~~b. Exposures to the nose mouth, or skin should be flushed thoroughly with water~~
   ~~c. Irrigate eyes with clean water or saline.~~
   ~~d. Note: Scientific evidence shows that using antiseptics or squeezing the wound will not reduce the risk of transmission of a bloodborne pathogen. Using a caustic agent such as bleach is not recommended.~~
   b. **Reporting an Exposure**
      i. If an occupational exposure has occurred the **HCP**~~employee~~ must **immediately** report the incident to their **manager/**supervisor and report immediately to **Employee Health Services. If the occupational exposure occurs during the periods of time when Employee Health Services is closed, the employee**

should be evaluated at TCHD's preferred occupational provider or the Emergency Department.

ii. **HCP must complete an Employee Injury Illness Incident Report**

iii. **HCP should refer to the Bloodborne Pathogen Exposure Protocol Grid.** Post exposure prophylaxis **(PEP)** should be initiated within 2 hours. PEP after 72 hours is probably not effective.

~~2.~~iv. **Following an exposure incident**

1) **Following an exposure incident, the occupational healthcare provider ~~(WorkPartners)~~ will provide ~~the HCP with~~ an exposure evaluation report regarding the incident and ~~occupational healthcare provider will~~ arrange for follow-up testing.**

2) If the source is known, data collection of the source patient will include medical history to determine the risk level and if the source is known to be positive for Human Immunodeficiency Virus (HIV), Hepatitis B Virus (HBV), and Hepatitis C Virus (HCV). If the source is known, the attending physician should be contacted for **sampling** orders.

3) **A sharps injury log is maintained by TCMC Employee Health Service as well as the OSHA 300 Log. The sharps injury log includes information on the injury, including the type and brand of device involved in the incident, the department or work area where the exposure incident occurred, and an explanation of how the incident occurred. Medical records are kept confidential for all HCP.**

~~3. The employee's Assistant Nurse Manager, Manager/Supervisor, Designee, or Administrative Supervisor will assist the employee in obtaining orders. Details of the exposure including amount of fluid or material; type of fluid, or material, severity of the injury, device and brand involved in the injury, mechanism of the injury and comments from the healthcare worker with regard to how the injury may have prevented.~~

~~4.~~2. ~~Source~~**Post-Exposure** T~~t~~esting **and Prophylaxis**~~includes~~:

a. **See Bloodborne Pathogen Exposure Protocol grid:** ~~Rapid HIV Antibody (ordered STAT)~~

~~b. Hepatitis B Antigen~~

~~c. Hepatitis C Antibody~~

~~5.~~**b.** Administrative **Policy** #385 outlines HIV consent and requirements to test and release HIV results after ~~–~~an occupation exposure. The Rapid HIV antibody test should be ordered stat. **See HIV Guideline grid**

~~6.~~3. Employee Health Services is responsible for:

a. Investigating the circumstance surrounding the exposure incident. This investigation is documented ~~–~~on the OSHA Sharps Injury Log. Reporting quarterly to the Environment of Care Committee and the Infection Control Committees data from the Sharps Injury Log.

b. Employee Health Services is also responsible for ensuring that employees receive medical consultation and treatment (if required) as expeditiously as possible.

c. Employee Health Services is responsible to meet OSHA regulations that require that an attempt must be made to determine the source's hepatitis B, hepatitis C, and HIV status.

C. **RELATED DOCUMENT(S) ~~AND FORMS~~:**

1. **Employee Health and Wellness: Bloodborne Pathogen (BBP) Exposure Protocol Grid**
2. **Employee Health and Wellness: Human Immunodeficiency Virus (HIV) Guideline Grid**
3. **Employee Health and Wellness: Employee Injury Illness Incident Report**
4. **Infection Control Policy: Bloodborne Pathogen Exposure Control Plan**

~~C. Approvals~~

~~1. Infection Control Committee~~

~~2. Medical Executive Committee~~

~~3. PAC~~

~~4. Board of Directors~~

D. **REFERENCE(S):**

1. **APIC Text of Infection Control and Epidemiology, 4th edition, 2014**
2. **Updated U.S. Public Health Service Guidlelines for the Management of Occupational Exposures to HBV, HCV, & HIV & Recommendations for Postexposure Prophylaxis CDC MMWR June 29, 2001/50 (RR11); 1-42**
3. **Occupational Safety and Health Administration. Occupational exposure to bloodborne pathogens; Final rule (29 CFR Part 1910.1030). Federal Register 2001; 66:5317-5325. Also available via link: https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=standards&p_id=10051~~Centers for Disease Control and Prevention (CDC), HIV/AIDS, Recommendations and Guidelines, *Occupational Exposure and Post-Exposure Prophylaxis*, http://www.cdc.gov/hiv/resources/guidelines/index.htm#occupational~~**
~~1.~~4. **Bloodborne Infectious Disease: HIV/AIDS, Hepatitis B, Hepatitis C https://www.cdc.gov/niosh/topics/bbp/emergnedl.html**

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH AND WELLNESS

ISSUE DATE: 01/81 **SUBJECT: TB Surveillance**

REVISION DATE: 10/10, 06/01, 09/04, 10/07, 10/12, 04/15

Employee Health Department Approval:	**06/20**
Infection Control Committee Approval:	**11/22**
Environmental Health and Safety Committee Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/15**

A. **PURPOSE:**
1. Define a policy for Tuberculosis surveillance of new hire candidates and employees.

B. **INITIAL TEST OF NEW EMPLOYEE:**
1. New employees who cannot provide documentation of a negative TB skin test within the past year will receive Two-Step Tuberculin Skin Testing.
2. If the initial TB skin test is negative, it will be repeated within one (1) week to three (3) weeks using the same dose and strength of tuberculin.
   a. If the second test is positive, this will be interpreted as a boosted reaction and will be classified as previously infected. A Quantiferon-TB Gold blood test will be done to confirm.
   b. If the second test remains negative, the employee will be classified as negative.
3. New employees who can provide documentation of a negative TB skin test within one year will receive only one TB skin Test.
4. New employees with a History of BCG Vaccination and/or a history of positive PPD, who cannot provide documentation on a positive TB skin test, will be required to have a Quantiferon-TB Gold blood test to verify current status.

C. **SCREENING:**
1. TB Screening is a mandatory requirement and all **Tri-City Healthcare District (TCHD)**~~Medical Center~~ employees will receive a TB test ~~annually~~ **every 2 years** and complete the review questionnaire. Failure to meet this requirement will be subject to disciplinary action up to and including termination. **Remote TCHD employee may be exempt from the ~~annual~~required! TB testing if the employee only works from home.**
2. Employees with a previously documented positive tuberculin skin test **or proof of a positive Quantiferon-TB Gold test** are required to complete the review questionnaire annually.

D. **MANAGEMENT OF EMPLOYEES WITH A POSITIVE TB SKIN TEST:**
1. Verify positive TB test by Quantiferon-TB Gold blood test.
   a. If Quantiferon-TB Gold test results are positive, refer to Imaging for a chest x-ray- and a medical evaluation for TB preventive therapy.
2. Investigate reason for the conversion and follow up as indicated.
3. Counsel regarding symptoms of and risk of developing active disease.

E. **CONTACT INVESTIGATION:**
1. Employee Health Services will send managers/directors notification of potential exposure to TB.

Managers/directors are responsible for notifying employees who might have had contact with the patient. Whenever possible TB Skin Tests are administered immediately and 10 weeks post exposure.

2. Positive TB skin tests are managed as per Section D.
3. No further follow up is required for employees with a negative post exposure TB skin test.

F. **RECORD KEEPING:**

1. Employee Health Services will document all TB skin tests, including the name of the employee, the date of the test, the result of the test in millimeters of induration, and the interpretation of the result.
2. Contact or exposure documentation shall include the name of the employee exposed, the date and location of the incidents, and all follow up evaluation and treatment.

G. **MANAGEMENT OF EMPLOYEES WITH EVIDENCE OF ACTIVE TUBERCULOSIS:**

1. Employees who exhibit symptoms of Tuberculosis, i.e. fever, night sweats, Hemoptysis, malaise, etc., or is diagnosed with Tuberculosis, will not be allowed to work until medical treatment and counseling is completed.
   a. If an employee has active Tuberculosis or suspected active Tuberculosis, Employee Health Services will immediately notify the Infection Preventionist and Public Health within one day of diagnosis or suspicion under Title 17, California Code of Regulations, Section 2500.

H. **AUXILIARY TB TESTING:**

1. TB Screening is a mandatory requirement for the Auxiliary as outlined in this policy.

I. **CRITERIA FOR POSITIVE TUBERCULIN SKIN TEST:**

1. Negative Reactions – For each of the categories, reactions below the cutting point are considered negative.

~~2.~~

5 or more millimeters induration is considered positive for the highest risk groups, which include: Person with HIV infection; Persons who have had close contact with an infectious tuberculosis case Person who have chest x-rays consistent with old, healed tuberculosis Intravenous drug users whose HIV status is unknown	10 or more millimeters induration is considered positive for other high risk groups, which include: Foreign-born person from high prevalence areas (such as Asia, Africa, and Latin America) Intravenous drug users known to be HIV seronegative Medically-underserved low income populations, including high-risk racial or ethnic minority populations (especially blacks, Hispanics, and Native Americans) Residents of long-term care facilities (such as (correctional institutions, nursing homes, mental institutions) Person with medical condition which have been reported to increase the risk of tuberculosis such as silicosis, chronic renal failure, diabetes mellitus, high dose corticosteroid and other immunosuppressive therapy, some hematologic disorders (such as leukemias and lymphomas), and other	15 or more millimeters induration is considered positive for persons with no risk factors for tuberculosis.

	malignancies Locally identified high risk populations Children who are in one of the high risk groups listed above Health care workers who provide services to any of the high-risk groups	

~~J. Approvals~~

~~a. Infection Control Committee~~
~~b. Medical Executive Committee~~
~~c. PAC~~
~~d. Board of Directors~~

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

1. Control of Communicable Diseases Manual, D.L. Heymann, Ed. ~~18th~~ 19th edition, 2008
2. APIC Text of Infection Control and Epidemiology, ~~revised 4~~th edition, ~~2002~~2014
3. Targeted Tuberculin Testing and Treatment of Latent Tuberculosis Infection - MMWR 2000; 49 (No. RR-6)
4. Guidelines for the Investigation of Contacts of Persons with Infectious Tuberculosis Recommendations from the national Tuberculosis Controllers Association and CDC/ Guidelines for Using the QuantiFERON-TB Gold Test for Detection Mycobacterium tuberculosis Infection, United States MMWR 2005; 54 (No. RR 15)

Tri-City Healthcare District
Oceanside, California

EMPLOYEE HEALTH & WELLNESS

Move to Related Document to Employee Health and Wellness Policy: Employee Health Infection Control Program

~~Issue Date: 01/81~~

~~Subject: Work Restrictions for Personnel~~ **Employees** ~~With Infectious Diseases~~

~~Revision Date: 6/02, 9/04, 10/07, 4/09, 4/12, 04/15~~

Work Restrictions for Employees with Infectious Diseases

1. Purpose: Transmissible infection may occur in the community at large or within the hospital and can affect both employees and patients. If **Tri-City Healthcare District (TCHD)** ~~personnel~~ **employees** contract a serious infection that is potentially transmissible or are exposed to an illness that leads to a period during which infection may be spread, it is ~~TCMC's~~ **TCHD's** responsibility to prevent the spread of infection to patients and other personnel and may sometimes require that these employees be excluded from work or from direct patient contact.
2. If an employee has a communicable disease or skin infection, he or she may be required to leave the hospital and may not return until cleared by Employee Health Services.
3. ~~See~~ **Refer to** ~~NBC Manual and~~ Disaster Manual for guidance regarding Bioterrorism Agents.
4. The following chart is a summary of recommendations and work restrictions for personnel with infectious diseases.

Disease/Problem	Work Restriction	Duration
Conjunctivitis, Infectious	Restrict from patient contact & contact with the patient's environment	Until discharge ceases
Cytomegalovirus Infections	No Restriction	
Diarrheal Diseases Acute stage (diarrhea)	Restrict from patient contact, contact with the patient's environment or food handling.	Until 48 hours after symptoms resolve
Convalescent stage, *Salmonella* species	Restrict from care of high risk patients	Until symptoms resolve
Diphtheria	Exclude from duty	Until antimicrobial therapy completed and 2 cultures obtained ≥24 hours apart are negative
Enteroviral Infections	Restrict from care of infants, neonates, and immunocompromised patients and their environments	Until symptoms resolve

Disease/Problem	Work Restriction	Duration
Hepatitis Hepatitis A	Restrict from patient contact, contact with patient's environment and food handling	Until 7 days after onset of jaundice
Hepatitis B Acute or chronic hepatitis B surface antigemia and **does not** perform exposure-prone procedures	No restriction*.	Standard Precautions should always be observed.
Acute or chronic hepatitis B antigenemia and **does** perform exposure-prone procedures	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought. Panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker.	Until hepatitis B antigen is negative. Standard Precautions should always be observed.
Hepatitis C	No restriction*.	Standard Precautions should always be observed.
Herpes Simplex Genital	No Restriction	
Hands	Restrict from patient contact and contact with the patient's environment	Until lesions heal
Orofacial	Evaluate for need to restrict from care of high-risk patients	
Human Immunodeficiency Virus	Do not perform exposure-prone invasive procedures until counsel from an expert review panel has been sought. Panel should review and recommend procedures the worker can perform, taking into account specific procedure as well as skill and technique of worker.	Standard Precautions should always be observed.

Disease/Problem	Work Restriction	Duration
Measles Active	Exclude from duty	Until 7 days after the rash appears
Postexposure (susceptible)	Exclude from duty	From 5th day after 1st exposure through 21st day after last exposure and/or 4 days after rash appears
Meningococcal Pneumonia or Meningitis	Exclude from duty	Until 24 hours after start of effective therapy
Mumps Active	Exclude from duty	Until 9 days after onset of parotitis
Postexposure (susceptible personnel)	Exclude from duty	From 12th day after 1st exposure through 26th day after last exposure or until 9 days after onset of parotitis
Pediculosis (Lice)	Restrict from patient contact	Until treated and observed to be free of adult and immature lice.
Pertussis Active	Exclude from duty	From beginning of catarrhal through 3rd week after onset of paroxysms or until 5 days after start of effective antibiotics.
Postexposure (asymptomatic)	No restriction, prophylaxis recommended	
Postexposure (symptomatic)	Exclude from duty	Until 5 days after start of effective antimicrobial therapy.
Rubella Active	Exclude from duty	Until 5 days after rash appears
Postexposure (susceptible)	Exclude from duty	From 7th day after 1st exposure through 21st day after last exposure
Scabies	Restrict from patient contact	Until cleared by medical evaluation.
Staphylococcus aureus Active, draining skin lesions	Restrict from contact with patients and patient's environment or food handling	Until lesions have resolved
Carrier State	No restriction, unless personnel are epidemiologically linked to transmission of the organism	

Disease/Problem	Work Restriction	Duration
Streptococcal Infection, group A	Restrict from contact with patients and patient's environment or food handling	Until 24 hours after adequate treatment started
Tuberculosis Active disease PPD converter	 Exclude from duty No restriction	 Until determined by TB control
Varicella Active Postexposure (susceptible)	 Exclude from duty Exclude from duty	 Until all lesions dry and crusted over From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure
Zoster Localized in healthy person Generalized of localized in immunosuppressed person Post exposure (susceptible)	 Cover lesions; restrict from care of high-risk patients+ Restrict from patient contact Restrict from patient contact	 Until all lesions dry and crusted over Until all lesions dry and crusted over From 10th day after 1st exposure through 21st day (28th day if VZIG given) after last exposure
Viral respiratory infections, acute febrile	Consider excluding from the care of high risk patients# or contact with their environment during community outbreak of RSV and influenza	Until acute symptoms resolve

*Unless epidemiological linked to transmission of infection.
*Unless epidemiologically linked to transmission of infection
+Those susceptible to varicella and who are at increased risk of complications of varicella, such as neonates and immunocompromised person of an age.
#High-risk patients as defined by the ACIP from complications of influenza

REFERENCE(S):

1) APIC Text of Infection Control and Epidemiology, 4th edition, 2014
2) Centers for Disease Control and Prevention: Guideline for Infection Control in Healthcare Personnel. Revised 2008
3) www.osha.gov 20139 **Occupational Safety and Health Administration**

Tri-City Medical Center
Oceanside, California

ENGINEERING
SAFETY AND SECURITY

ISSUE DATE: 08/89

SUBJECT: Lockout/Tagout Procedure

~~REVIEW DATE(S):~~
REVISION DATE~~(S)~~: 09/94, 02/97, 05/00, 05/03, 06/06, 06/12, 12/19

Department Approval:	**~~03/19~~12/22**
Environmental Health & Safety Committee Approval:	**~~09/19~~12/22**
Administration Approval:	**~~11/19~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/19**

A. **DEFINITION(S):**

1. Lockout – An Occupational Safety and Health Administration (OSHA) safety regulation so that anyone working on equipment or a utility system is safe during a service or repair. A lockout involves placing a lock on the part of the machine that controls the energy (i.e. circuit breaker, switch, block, valve, etc.) in order to lock the energy control device in an "off" position to prevent the machine from starting up or releasing energy accidentally. A lockout lock may utilize a key or a combination. However, it cannot be a lock that is used for any purpose other than lockout.
2. Tagout – in the event a lockout is not possible, a warning tag may be applied to the device to serve as a tagout.
3. Energy – the quantitative property that must be transferred to an object in order for it to perform work. That energy can be electrical, mechanical, hydraulic or pneumatic. Sometimes the energy is stored, as in springs, steam, or as pressurized air or liquids. Any type of energy, however, can be a serious safety hazard, especially if it powers on a device or is released unexpectedly while servicing or maintaining equipment.

B. **PURPOSE:**

1. To define Lockout/Tag out procedures that should be taken to ensure that the appropriate lockout or tagout devices are utilized to disable machines, equipment or utility systems and prevent unexpected start-up.

C. **GENERAL INFORMATION:**

1. Lockout/tagout training:
   a. Lockout/tagout training will be conducted for all new employees. Retraining will be conducted when there is:
      i. A change in job assignment;
      ii. New hazard due to a change in machine, equipment or process;
      iii. Change in procedure; or
      iv. Annual evaluation reveals inadequacies in lockout/tagout procedures or employee knowledge.
   b. When outside contractors are to be used, Contractor needs to follow Engineering Department's lockout and tagout procedures.
2. Authorized personnel:
   a. Personnel authorized to perform lockout/tagouts will be assigned by Engineering Management. Those assigned this responsibility will be trained in specific lockout/tagout procedures and will learn how to recognize the type and amount of energy used by the

machines and equipment and how to control that energy.

b. If a team is used for lockout/tagout, one member of the group must have primary responsibility. That person makes sure that all group members are safe during lockout. Each authorized group member puts his or her own lock or tag on during the group lockout.

c. Always use **designated**~~your own~~ lock and key.

d. Never remove anyone else's lock or permit anyone else to do so.

3. All personnel:

a. All personnel who work with equipment must be trained in basic lockout procedures. They need to understand why lockout/tagout is important, how the procedure works, and the importance of not attempting to repair or service machinery without going through proper procedures. Other personnel need to be familiar with lockout/tagout procedures, and know the importance of not trying to restart locked or tagged equipment.

b. Never remove, ignore or bypass locks or tags **found**~~you find~~ on machinery.

4. Lockout locks must be:

a. Durable enough for the heat, cold, humidity or corrosiveness in the area where it's used - for as long as it is needed.

b. Standardized by color, shape or size throughout the facility.

c. Strong enough so it cannot be removed without a heavy force or tools like bolt cutters.

d. Identified by the name of the employee who installs and removes it.

e. Report lost keys to ~~your~~ supervisor immediately and have lock destroyed.

D. **PROCEDURE:**

1. Lockout:

a. All shut downs are to be approved by Engineering Management.

b. Locate and identify power sources, potential hazards and all control devices.

c. Notify all personnel involved and affected by the shutdown.

d. Turn off all power controls.

e. Isolate all power sources by blocking, bleeding and venting energy that may be stored in springs, hydraulic systems and pneumatic systems.

f. Lockout all switches and power controls in the "Off" or "Safe" position.

g. Test for safety with operating controls in the "On" position. Before testing, always insure that nobody is in danger of injury.

h. Return all operating controls to the off position.

i. Perform necessary work.

2. Tagout:

a. Some equipment cannot be locked out. This does not mean it cannot be dangerous if it starts or is energized accidently. That is where tagout would be required. Tagout means using special tags that warn people of the danger of starting up the machine. A tag has a printed warning about what could happen if the equipment starts up. The tags must be special tags, used only for this purpose. Remember, tags do not provide physical restraints - they are simply warning devices. Do not let tags provide a false sense of security.

b. Tagout tags must meet the same standards that the locks do, such as they must be durable, strong, standardized and show the identity of the person doing the work. They must also have the same print and format throughout the facility and be tough enough so they cannot be accidentally removed. The law also states that they must be attached with something similar to nylon cable and cannot be reused. They also must be self-locking and cannot be released with less than 50 pounds of strength. A tagout must be attached at the same location as a lockout device would have been attached.

3. Removing a Lockout or Tagout:

a. When maintenance or service is done, only the same authorized person who installed the lock or tag may remove it.

i. Special circumstances may apply during shift changes or unavailability and in this case Engineering Management is to give direction on removing the lock or tag.

b. Make sure all personnel are a safe distance from equipment.
c. Remove tools from machine or equipment.
d. Reinstall any machine guards.
e. Remove lockout devices.
f. Turn on energy.
g. Notify other personnel that the machines are working again.

Tri-City Medical Center
Oceanside, California

ENGINEERING
SAFETY AND SECURITY

RETIRE – follow Engineering Policy: Utility Management Plan

ISSUE DATE: 03/90

SUBJECT: The Operation of the Hospital Electrical Distribution System

REVIEW DATE~~(S)~~:
REVISION DATE~~(S)~~: 09/94, 02/97, 05/00, 05/03, 06/06, 06/12 12/19

Department Approval:	~~07/19~~11/22
Environmental Health & Safety Committee Approval:	~~09/19~~12/22
Administration Approval:	~~11/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/19

~~A. POLICY:~~

~~1. The Hospital Electrical Distribution System is expected to meet the following conditions:~~

~~a. Transformers:~~

~~i. Clean and cool~~
~~ii. Locks in place~~
~~iii. Area or vault clean and free from storage~~

~~b. Main switchboards:~~

~~i. Inaccessible to unauthorized persons~~
~~ii. Area clean, dry and free from combustible storage~~
~~iii. Circuit breakers (switches) clearly marked~~
~~iv. Panels secured in place~~
~~v. Circuit breakers cool and clean~~
~~vi. Open breakers tagged~~
~~vii. Overcurrent protection provided~~
~~viii. Panelboards grounded~~
~~ix. Voltages, current ratings and phases in compliance with panels original design~~

~~c. Conduits and junction boxes:~~

~~i. Exposed rigid metal conduits and/or raceways in good condition~~
~~ii. Conduits and/or raceways grounded~~
~~iii. Junction box covers in place~~
~~iv. Boxes and fittings waterproof where exposed to weather or damp conditions~~

~~d. Branch circuits:~~

~~i. Panels in good condition~~
~~ii. Latches (locks) on doors in good condition~~
~~iii. Breakers properly marked~~
~~iv. Open breakers tagged~~
~~v. Conductors proper size for listed load~~
~~vi. Unused (disconnected) conductors in panels~~
~~vii. Panels cool~~
~~viii. Check for evidence of breakers arcing~~
~~ix. Breakers clean~~
~~x. Lockout/tagout policy~~

~~e. Based on frequency determined by the Director of Engineering or designee schedule a contractor to perform infrared testing of the electrical distribution system to identify troubles before failure occurs.~~

~~i. Correct all troubles by following the priority list produced by the contractor.~~

Tri-City Medical Center
Oceanside, California

ENGINEERING
SAFETY AND SECURITY

ISSUE DATE: 11/87

SUBJECT: Use of Extension Cords

~~REVIEW DATE(S):~~
REVISION DATE~~(S)~~: 09/94, 02/97, 05/00, 05/03, 06/06, 06/12, 12/19

Department Approval:	~~07/19~~11/22
Environmental Health & Safety Committee Approval:	~~09/19~~12/22
Administration Approval:	~~11/19~~02/23
Professional Affairs Committee Approval ~~Date(s)~~:	n/a
Board of Directors Approval ~~Date(s)~~:	12/19

A. ~~PROCEDURE~~EXTENSION CORDS:

1. ~~Extension cords are not to be issued to the nursing floors or other departments without approval of the Engineering Director or his/her designee.~~Extension cords are ONLY allowed as long as they are:
   a. Used in temporary application (less than 90 days)
   b. Checked for frayed or damaged cord prior to use
   c. Discarded if frayed/damaged extension cords
   d. Not run through walls, above ceiling, through window openings, under rugs and floor mats, or in any other manner that poses risk of damage to the cord.
   e. Secured to prevent a tripping hazard if running along or across areas of foot traffic
   f. ~~Are n~~Not to be used as substitute for fixed wiring in a building

~~1.~~2. Shop made extension cords with receptacle boxes do not meet electrical code requirements and cannot be used.
   ~~a. When there is a life and safety issue, extension cords are permissible, but their use shall be reported to the Engineering Director or his/her designee.~~

B. POWER STRIPS:

1. Power strips are allowed for use in hospital as long as they are:
   a. Hospital grade, provided and mounted by Facilities
   b. UL Listed
   c. Have a built in over current protection
   d. Have cords that are no longer that necessary for application
   e. Are not used for appliances or equipment requiring a large electrical load (e.g. refrigerators/microwave ovens)
   f. Are used within manufacturer's guidelines
   g. Are not used in series with other power strips, extension cords or to supply Uninterruptable Power Supply (UPS).
2. Do not plus critical patient care equipment into power strips
   a. Exception: power strips may be, mounted on some patient care equipment (e.g. crash carts/IV poles). These mounted power strips are hospital approved, UL listed and are listed on the Facilities inventory for corrective/preventive maintenance.
   b. Do not remove or relocate existing power strips

~~2. All extension cords shall be made of minimum 16 gauge SWG, SO, STO, SJO or STO type, three conductor grounding flexible cord. The plug and connector shall be of the 2 pole, 3 wire grounding type, rated for hospital use (green dot).~~

~~3. All extension cords shall be inspected for proper polarity and ground continuity prior to being issued.~~

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

1. National Electrical Code

Tri-City Healthcare District
Oceanside, California

~~FACILITIES~~ENGINEERING
EQUIPMENT

ISSUE DATE: 09/94

SUBJECT: Utility Management Plan

REVIEW DATE: 08/15
REVISION DATE: 02/97, 05/00, 05/03, 06/06, 05/09, 06/12, 06/15, 10/15, 01/17, 03/19 03/22

Department Approval:	04/22
Environmental Health & Safety Committee Approval:	~~03/22~~12/22
Administration Approval:	~~03/22~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/22

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care (EOC) and the range of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The specific utility system risks of the environment are identified by conducting and maintaining a proactive risk assessment. A Utility Systems Management Plan based on various risk criteria including risks identified by outside sources such as, The Joint Commission (TJC) is used to eliminate or reduce the probability of adverse patient outcomes.
2. The Utility Systems 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. The management plan and the Utility Systems Management program are evaluated annually to determine if they accurately describe the program and that the scope, objectives, performance, and effectiveness of the program are appropriate.
3. The program is applied to the TCHD and all outlying facilities operated and or owned by TCHD. The Utilities Management Plan and associated policies extend to all inpatient and outpatient service line programs, ancillary services, support services and all facilities including patient care and business occupancies of TCHD. The plan also affects all staff, volunteers, medical staff and associates including contracted services of TCHD.

B. **PRINCIPLES:**

1. Utility systems play a significant role in supporting complex medical equipment and in providing an appropriate environment for provision of patient care services.
2. Orientation, education, and training of operators, users, and maintainers of utility systems is an essential part of assuring safe effective care and treatment are rendered to persons receiving services.
3. Assessment of needs for continuing technical support of utility systems and design of appropriate calibration, inspection, maintenance, and repair services is an essential part of assuring that the systems are safe and reliable.

C. **OBJECTIVES:**

1. The objective of the Utility Management Plan is to assure the operational reliability and assesses the special risks and responses to failures of the utility systems, which support the facility's patient care environment.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. The Director of Facilities or Designee assures that an appropriate utility system maintenance program is implemented. The Director of Facilities or Designee also collaborates with the **Environment of Care**/Safety Manager to develop reports of Utility Systems 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 utility systems issues.
2. The Hospital's Board of Directors receives an Annual Report of the activities of the Utility Systems Management program from the Safety Manager unless other reports are requested. The Board of Directors reviews the Annual Report and, as appropriate, communicates concerns about identified issues back to the Director of Facilities and appropriate clinical staff. The Board of Directors collaborates with the Chief Executive Officer (CEO) and other senior managers to assure budget and staffing resources are available to support the Utility Systems Management program.
3. The Hospital's Chief Operating Officer (COO) or designee receives reports of the activities of the Utility Systems Management program as needed. The COO or designee collaborates with the Director of Facilities and other appropriate staff to address utility system issues and concerns. The COO or designee also collaborates with the Director of Facilities to develop a budget and operational objective for the program.
4. The facility maintenance technicians and selected outside service company staff schedule and complete all calibration, inspection, and maintenance activities required to assure safe reliable performance of utility systems in a timely manner. In addition, the technicians and service company staff perform necessary repairs.
5. Individual staff members are responsible for being familiar with the risks inherent in or present in their work environment. They are also responsible for implementing the appropriate organizational, departmental, and job-related procedures and controls required to minimize the potential of adverse outcomes of care and workplace accidents.

E. **PROCESSES OF THE UTILITY SYSTEMS PLAN:**

1. Plan for the Safe, Reliable, Effective Operation of Utility Systems
   a. The Utility Systems Management Plan describes the procedures and controls in place to minimize the potential that any patients, staff, and other individuals coming to the facilities of TCHD that may experience an adverse event while being monitored, diagnosed, or treated with any type of medical equipment or being housed in an environment supported by the utility systems of TCHD.
2. Design and Installation of Utility Systems
   a. The Director of Facilities or Designee works with qualified design professionals, project managers and the intended end users of the space of TCHD to plan, design, construct, and commission utility systems that meet codes and standards and the operational needs of the patient care and business activities of TCHD. The construction and commissioning procedures are designed to assure compliance with codes and standards and to meet the specific needs of the occupants of every space. In addition, the design process is intended to assure performance capability meets current needs and sufficient additional capacity is available to manage unusual demands and to help assure that future demands on utility systems can be met.

   ~~a.~~
3. Determining System Risks and Developing and Inventory of Utility Systems and Equipment
   a. All utility systems components and equipment are included in a program of planned calibration, inspection, maintenance, and testing. The components and equipment are inventoried at the time of installation and acceptance testing. The inventory is maintained on an ongoing basis by the Plant Operations staff. The inventory includes utility system equipment maintained by the Facilities and Maintenance staff and equipment maintained

by vendors.

4. Maintenance Strategies
   a. The Director of Facilities or Designee evaluates all utility system equipment to determine the appropriate maintenance strategy for assuring safety and maximum useful life. The Director of Facilities or Designee uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance strategy for assuring safety and maximizing equipment availability and service life. The strategies may include fixed interval inspections, variable interval inspections, preemptive maintenance, predictive maintenance, and corrective maintenance.
5. Inspection, Testing, and Maintenance Intervals
   a. The Director of Facilities or Designee uses manufacturer recommendations, applicable codes and standards, accreditation requirements, and local or reported field experience to determine the appropriate maintenance intervals for assuring safety and maximizing equipment availability and service life.
   b. A maintenance management system is used to schedule and track timely completion of scheduled maintenance and service activities.
   c. The Director of Facilities or Designee is responsible for assuring that the rate of timely completion of scheduled maintenance and other service activities meets regulatory and accreditation requirements.
6. Management of Water Systems
   a. The Director of Facilities or Designee and Infection Prevention are responsible for identifying needs for procedures and controls to minimize the potential for the spread of infections through or by the utility systems.
   b. Each clinical care service and support service is evaluated to determine the potential for hospital-acquired illness. Each potential is further evaluated to determine what role physical barriers and utility systems can play in contributing to or minimizing the potential.
   c. The Director of Facilities or Designee and Infection Prevention are responsible for developing procedures and controls to manage any identified potential for growth and/or transmission of pathogenic organisms in the domestic hot water system, cooling tower water, and other potential sources of waterborne pathogens.
   d. The procedures may include periodic testing or treatment to control the risk and to inhibit the growth and spread of waterborne pathogens.
7. Management of Ventilation Systems
   a. The Director of Facilities or Designee and Infection Prevention are responsible for designing procedures and controls for monitoring the performance of air handling equipment. The procedures and controls address maintenance of air flow rates, air pressure differentials in critical areas, and managing the effectiveness of air filtration systems.
   b. Air handling and filtration equipment designed to control airborne contaminants including vapors, biological agents, dust, and fumes is monitored and maintained by Plant Operations.
   c. The performance of all new and altered air management systems is verified by a qualified service provider. At a minimum flow rates and pressure relationships are measured as part of the commissioning of all new building projects and major space renovations.
   d. Periodic measurements of air volume flow rates and pressure relationships are tested in sensitive areas throughout the hospital. When the measured system performance cannot be adjusted to meet code requirements or occupant needs, the Director of Facilities or Designee and Infection Prevention develop, when appropriate, a temporary Infection Control Risk Management plan to minimize the potential impact of the deficient performance.
8. Mapping of Utility Systems
   a. The Director of Facilities or Designee is responsible for maintaining up-to-date documentation of the distribution of all utility systems. The documents include as-built

and record drawings, one-line drawings, valve charts, and similar documents. The documents include original construction documentation and documentation of renovations, alterations, additions, and modernizations. Hard copies of the documentation are maintained in the Plant Operations department. Documents that are available in electronic format are maintained on the Facilities Shared Drive.

9. Labeling of Controls for System Shutdown and Recovery
   a. The Director of Facilities or Designee is responsible for assuring that current documents showing the layout of utility systems and the locations of controls that must be activated to implement a partial or complete shut-down of each utility system are available at all times.
   b. The documents must include the original layout of the systems and all modifications, additions, and renovations that affect the process for implementing a partial or complete shutdown of a system. The documents must include information that can be used to identify specific controls. The controls must be identified by a label, numbered tag or other device that corresponds to the information on the documents.
10. Emergency Procedures
   a. The Director of Facilities or Designee and appropriate clinical caregivers collaborate to identify life-critical medical equipment supported by the utility systems. Life-critical equipment is defined as equipment, the failure or malfunction of which would cause immediate death or irreversible harm to the patient dependent on the function of the equipment.
   b. The Director of Facilities or Designee and the caregivers are responsible for developing appropriate resources to manage the response to the disruption of the function of the identified life-critical equipment. The resources are designed to minimize the probability of an adverse outcome of care.
   c. The resources must include but are not limited to information about the availability of spare or alternate equipment, procedures for communication with staff responsible for repair of the equipment, and specific emergency clinical procedures and the conditions under which they are to be implemented.
   d. Copies of applicable emergency procedures are included in the emergency operations manual of each clinical department. Training addressing the medical equipment emergency procedures is included in the department or job-related orientation process. All utility systems emergency procedures are reviewed annually.
11. Inspection, Testing, and Maintenance of Emergency Power Systems
   a. The Director of Facilities or Designee is responsible for identifying all emergency power sources and for developing procedures and controls for inspection, maintenance, and testing to assure maximum service life and reliability. TCHD uses battery-powered lights, engine driven generators, and large UPS stored energy systems to provide power for emergency lighting, operation of critical systems, and operation of information systems equipment.
   b. Each required battery powered emergency lighting device is tested for 30 seconds each month and for 90 minutes annually.
   c. The Emergency Power Supply Systems (EPSS) supply power for emergency exits, patient ventilation, fire and life safety equipment, public safety, communications, data and processes that if disrupted would have serious life safety or health consequences. Each required EPSS system is tested in accordance with the code requirements for the class of device.
   d. The Director of Facilities or Designee is responsible for assuring that appropriate inspection, maintenance, and testing of the essential electrical system is done. Each motor/generator set serving the emergency power system is tested under connected load conditions 12 times a year. All automatic transfer switches are tested as part of each scheduled generator load test.
   e. Testing parameters are recorded and evaluated by the Plant Operations staff. All deficiencies are rectified immediately or a temporary secondary source of essential

electrical service is put in place to serve the needs to critical departments or services until the primary system can be restored to full service.

f. If a failure during a planned test occurs, a full retest will be performed after appropriate repairs are made and essential electrical system is functional again.

g. Each diesel engine powered motor/generator not loaded to 30% or more of its nameplate capacity during connected load tests undergoes further evaluation to determine if the exhaust gas temperature reaches or exceeds the manufacturer's recommended temperature to prevent wet stacking. Each diesel engine failing to meet the temperature recommendation will be exercised annually by connecting it to a dynamic load bank and performing the three-step test process specified by NFPA 99 and NFPA 110.

h. Batteries, fuel stored on site, controls, and other auxiliary emergency power equipment is inspected, maintained, and tested as required. The Director of Facilities or Designee Facilities staff and contracted service providers are responsible for assuring the reliability of each component part of the emergency power systems by performing all required calibration, inspection, maintenance, and testing in a timely manner.

12. Utility Systems Inventory and Initial Testing
    a. The Director of Facilities or Designee establishes and maintains a current, accurate, and separate inventory of all utility systems equipment included in a program of planned inspection or maintenance. The inventory includes equipment owned by TCHD and leased or rented equipment.
    b. The Director of Facilities or Designee is responsible for implementation of the program of planned inspection and maintenance. All utility systems equipment is tested for performance and safety prior to use.
13. Testing of Life Support Equipment
    a. The Director of Facilities or Designee assures that scheduled testing of all utility systems that play a role in life support is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Facilities or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
14. Testing of Infection Control Support Equipment
    a. The Director of Facilities or Designee assures that scheduled testing of utility systems equipment that supports critical infection control processes is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Director of Facilities or Designee will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
15. Testing of Non-Life Support Equipment
    a. The Director of Facilities or Designee assures that scheduled testing of all non-life support equipment is performed in a timely manner. Reports of the completion rate of scheduled inspection and maintenance are presented to the EHSC each quarter. If the quarterly rate of completion falls below 95%, the Facilities will also present an analysis to determine what the cause of the problem is and make recommendations for addressing it.
16. Medical Gas System Testing
    a. All medical gas systems are maintained and periodically tested to assure system performance. All testing and inspection are done in accordance with the requirements of the current edition of NFPA 99.
17. Modifying / Repairing Medical Gas Systems
    a. When a new medical gas system is installed or an existing system is breached for any reason, the Director of Facilities or Designee coordinates certification of the system

by a qualified service provider. The certification testing is done in accordance with the requirements of the current edition of NFPA 99. The Director of Facilities or Designee maintains a permanent record of all certification testing.

18. Labeling & Accessibility of Medical Gas Controls
    a. The Director of Facilities or Designee is responsible for assuring that all medical gas system control valves and monitoring stations are identified appropriately.
    b. In addition, the Director of Facilities or Designee is responsible for assuring that each monitoring station and valve is accessible. Accessibility is evaluated during scheduled tours.

F. **ANNUAL GOALS/OBJECTIVES FOR 2023:**

1. Fully implement the new preventive maintenance system which means having every piece of equipment in the system and schedule for a preventative maintenance work order.
2. Update and modify existing air handler units to improve air flow throughout the facility.
3. Identify/locate any gaps in air ducts, seal the gaps and provide increased air flow.

G. **REFERENCE(S):**

1. The Joint Commission (2017). *Hospital Accreditation Standards*. Illinois: Joint Commission Resources.

Tri-City Healthcare District
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE:	**NEW**	**SUBJECT:**	**Emergency Management Plan**
REVISION DATE:			

Environment of Care Content Expert Approval:	**01/23**
Environmental Health and Safety Committee Approval:	**01/23**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **EXECUTIVE SUMMARY:**

1. The Environment of Care and the of patient care services provided to the patients served by Tri-City Healthcare District (TCHD) present unique challenges. The emergencies are identified by an all- hazards approach. The emergency management plan provides a systematic analysis for planning, shared decision-making, internal and external collaborations.
2. The Emergency Management Plan provides a comprehensive approach to meeting health, safety, and security needs of the facility, its staff and its patient population and community prior to, during and after an emergency.
3. The Emergency Management Plan critical components include emergency policies and procedures; communication and coordination of response activities; education and training; testing and evaluating exercises; and resources.

B. **PRINCIPLE(S):**

1. Emergency Management plays a significant role in guiding the hospital response to and recovering from a variety of emergencies and disaster incidents that could impact hospital operations and the ability to continue providing services.
2. Emergency Management plan utilizes an all-hazard approach. An all-hazard approach focuses on developing emergency preparedness capacities and capabilities that can address a wide range of emergencies or disasters that may significantly impact the hospital's ability to continue to operate and provide services.
3. Emergency Management Plan consists of four phases: Mitigation, Preparedness, Response, and Recovery.

C. **OBJECTIVE(S):**

The objective of the Emergency Management Plan is to prevent incidents before they happen. If an incident occurs, the goal is to respond safely and effectively.

D. **PROGRAM MANAGEMENT STRUCTURE:**

1. Tri City Healthcare District multidisciplinary committee assures that an appropriate emergency management plan is implemented. The Safety Manager collaborates with the Environmental Health and Safety Committee (EHSC) committee to evaluate the program to ensure the hospital complies with all applicable federal, state, and local emergency preparedness laws and regulations.
2. Tri City Healthcare District (TCHD) utilizes the Hospital Incident Command System (HICS) structure for Incident Command.
3. The Board or designee receives regular reports of the activities of the Emergency Management Plan. The CEO or designee will collaborate with EHSC to address any issues or concerns with the Emergency Management Plan.

E. **ELEMENTS OF THE EMERGENCY MANAGEMENT PLAN:**

1. Emergency Management Plan
   a. The Emergency Management Plan describes the procedures and approach to handling any emergencies or disasters that effect TCHD facilitates.
2. Processes for identifying emergencies and disasters.
   a. The Safety Manager or designee are responsible for coordinating the development of design, operations, and training processes to minizine the possibilities of emergency incidents or preparedness for disasters.
   b. Emergency Management is accomplished by hospital both as individual entity and integrated participant in a larger emergency response community.
3. Design
   a. The Safety Manager in collaboration with EHSC committee to ensure the plan consists of:
      i. Leadership Structure and program accountability
      ii. Hazard Vulnerability Analysis (HVA)
      iii. Mitigation and preparedness activities
      iv. Emergency Operating Plan (EOP), policies and procedures.
      v. Education and training
      vi. Exercises and testing
      vii. Continuity of operations plan
      viii. Disaster recovery
      ix. Program Evaluation
4. Management
   a. The Safety Manager or designee oversees the design, implementation and documentation of processes designed to assure optimal performance and continual compliance with standards of Emergency Management.

F. **EFFECTIVENESS:**

1. Program effectiveness will be regularly monitored using significant incidents as well as training activities. Performance monitoring and assessments of program effectiveness will be reported to EHSC 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 GOAL(S)/OBJECTIVE(S) 2023:**

1. Complete a comprehensive inventory of all disaster supplies.
2. Complete Hazard Vulnerability Analysis for facility/ and off sites.
3. Complete Code Silver "Live-Action" exercise.

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

1. Emergency Operations Procedure Manual: Emergency Operations Plan

Tri-City Medical Center
Oceanside, California

ENVIRONMENT OF CARE
SAFETY MANAGEMENT

ISSUE DATE:	**11/87**	**SUBJECT:**	**Environmental Health And Safety Committee Charter**
REVISION DATE:	**01/97, 07/00, 05/15, 12/21**	**POLICY NUMBER:**	**1001**

Department Approval:	**~~10/24~~01/23**
Environmental Health and Safety Committee Approval:	**~~11/24~~01/23**
Administration Approval:	**~~11/24~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/21**

A. **PURPOSE**

1. The purpose of the Environmental Health and Safety Committee (EHSC) includes the following:
   a. Serve as a communication center for various departments and individuals who are responsible for the environment.
   b. Develop, implement, evaluate, and maintain the organization-wide safety programs
   c. Review policies and procedures and the results of semiannual emergency preparedness drills or the implementation of the emergency preparedness program during actual emergencies.

B. **SCOPE :**

1. The EHSC is empowered to provide a safe, functional, and effective environment for patients, Workforce Members (WFM), and other individuals in the hospital.
2. The Safety **Manager~~Officer~~** or designee will review all Environment of Care Management Plans for their effectiveness and submit an Executive Summary report at the end of the fiscal year to the EHSC Committee.

C. **FUNCTION:**

1. Ensure all newly constructed and existing environments of care are designed and maintained to comply with the Life Safety Code.
2. Develop written policies and procedures to enhance safety and cleanliness within the Tri-City Medical Center (TCMC) and its grounds.
3. Provide reports to the Board of Directors, Administration, Medical and Nursing and all pertinent departments and services.
4. TCMC safety policies and department specific safety policies are reviewed per hospital policy (at least every three years and as frequently as necessary.
5. Maintain ongoing hazard surveillance programs including response to product safety recall.
6. Oversee the planning and execution of disaster and fire drills. Ensures drills are conducted according to The Joint Commission, Local, State, and Federal requirements.
7. Review summary reports of accidents or injuries to patients, visitors, or WFM identifies risks and makes recommendations as required.
8. Oversee safety orientation and continuing education of employees in collaboration with the Education Department.
9. Periodically inspects TCMC's premises for assuring compliance with safety policies.
10. Oversee maintenance of a current reference library of pertinent documents and publications dealing with facets of hospital safety.

D. **MEMBERSHIP:**

1. The EHSC membership shall include all levels of hospital management and employees who have a primary responsibility for the safety, health, and well-being of patients, visitors, and hospital staff.
2. Core membership shall include, but is not limited to, representation from the following:
   a. Administration
   b. Facilities
   c. Laboratory
   d. Risk Management
   e. Employee Health
   f. Food and Nutrition Services
   g. Nursing
   h. Environmental Services (EVS)
   i. Infection Prevention.
3. Attendance:
   a. Membership Implies A Commitment To Attend All Meetings Or Send A Representative If Unable To Attend.
4. Meeting Date And Time:
   a. The Committee Will Meet Quarterly Or More Often At The Direction Of The Safety **Manager**~~Officer~~/ Designee.
5. **Managers**~~Officers~~:
   a. The Safety **Manager**~~Officer~~ Or Designee Is Appointed By Administration For An Indefinite Term.
   b. The Safety **Manager**~~Officer~~ Or Designee Has The Authority To Intervene Whenever Conditions Exist That Pose An Immediate Threat To Life, Health, Or Threaten Damage To Equipment Or Buildings. .
6. Sub-Committees:
   a. Sub-committees or task force shall be established as needed.

E. **DECISION MAKING**

1. Decisions will be made by consensus of members present.

F. **REPORTING MECHANISM:**

1. Reports will be submitted to the Quality Assurance Performance Improvement Committee (QAPI) and the Board of Directors.

Tri-City Healthcare District
Oceanside, California

ENVIRONMENT OF CARE MANUAL

ISSUE DATE: 09/01 **SUBJECT: Waste Management**

REVISION DATE~~(S)~~: 10/03, 01/07, 07/09, 11/12, 09/16

Department Approval:	**~~10/15~~10/20**
Environmental Health and Safety Approval:	**~~07/16~~11/21**
Infection Control Committee Approval:	**~~10/1504/22~~11/22**
Medical Executive Committee Approval:	**~~08/16~~01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**~~09/16~~ n/a**
Board of Directors Approval:	**09/16**

A. **POLICY:**

1. The Medical Waste Management Act provides the legislative definition of medical waste (California Health and Safety Code, Section 117690). ~~In lay terms, w~~Waste must satisfy three critical criteria in order to be classified as medical waste. These three criteria are:
   a. The material must actually be a waste product.
      i. This precludes materials that have intrinsic value (such as outdated pharmaceuticals that are returned for credit) from being classified as a medical waste.
   b. The waste can be either biohazardous or sharps waste.
      i. Various forms of waste are defined as biohazardous because of the actual or presumed presence of pathogenic microorganisms.
      ii. Such wastes as laboratory waste and fluid blood fall into this category and are therefore biohazardous waste.
      iii. Trace amounts of chemotherapeutic agents, outdated pharmaceutical wastes and tissues with trace amounts of fixatives also fall into the category of biohazardous waste.
      ~~i.~~iv. Objects that have been used in invasive procedures such as hypodermic needles and broken glass items contaminated with blood or other biohazardous waste are considered to be sharps waste.
   c. The waste must be produced as a result of a specified action in the delivery of health care.
      i. The Medical Waste Management Act (section 117690) defines this as the "...diagnosis, treatment, or immunization of human beings..."
2. Most waste generated during the direct patient care is not biohazardous. Examples of biohazardous waste that might be generated at our facility that requires special disposal includes:
   a. Human specimen cultures, culture dishes and devices used to transfer, inoculate and mix cultures from medical and pathology laboratories.
   b. Surgery specimens or tissues suspected of being contaminated with infectious agents known to be contagious.
   c. Waste containing recognizable fluid blood, fluid blood products, and containers or equipment containing fluid blood.
   d. Waste containing materials that are required to be isolated by the infection control staff, attending physician and surgeon or local health officer to protect others from highly communicable diseases (such as smallpox or the hemorrhagic fevers: Ebola, Lassa, Marburg, or Crimean-Congo).

B. **PROCEDURE:**

1. Segregation of other medical waste is accomplished by staff (see Decision Table for Medical Waste). All regulated medical waste will be collected within the area of origin in a biohazard bag or sharps container as appropriate.
2. Biohazardous bags are disposable, red in color, impervious to moisture with strength sufficient to preclude ripping, tearing, or bursting under normal conditions of usage and handling. They must pass the 165-gram dropped dart impact resistant test as prescribed by Standard D 1709-85 of the American Society for Testing and Materials and certified by the bag manufacturer.
   a. Red biohazardous bags shall be securely tied at the top so as to prevent leakage or expulsion of solid or liquid during storage, handling or transport.
   b. All items in a red bag must be managed as biohazardous. Red-bagged waste are handled by a contract service as biohazardous and never sent to the landfill.
3. Storage
   a. Red biohazardous bags shall be placed in rigid containers for storage, handling and transport.
   b. Containers holding red biohazardous bags shall be leak-resistant, have tight fitting covers and are kept in good repair. These containers are not required to be red in color but must be labeled on the cover and sides with the words "Biohazard"
   c. The bag shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the bag
   d. Any enclosure or designated collection area used for the storage of medical waste containers shall be secured so as to deny access to unauthorized persons. Signs worded "Caution-Biohazardous Waste Storage Area- Unauthorized Persons Keep Out" in English and Spanish. must be posted on the entry doors.
4. Transportation to Final Storage
   a. Covers are required where biohazardous material is being stored after collection or during transport.
   b. Intermediate holding areas for red-bagged wastes are located in designated Patient care areas. Daily, Environmental Services staff will check waste levels and when necessary, transport all wastes, including red-bagged wastes to the holding area for pick-up by the contract service, Stericycle.
   c. Biohazardous wastes may be stored on the premises no longer than seven days.
   d. Biohazardous wastes stored for final disposition and transport offsite must be stored in secured storage area so as to deny access to unauthorized persons. Storage areas shall be marked with warning signs on or adjacent to exteriors of doors or gates and provide protection from animals, vermin and natural elements.
   e. This area will display prominent warning signs in English: "Caution: Biohazardous waste storage area. Unauthorized persons keep out." and in Spanish: "Cuidado: Zona de resides infectados. Prohibida la entrada a personas no authorizadas." Warning signs shall be readily legible during daylight from a distance of at least 25 feet. This area will be well ventilated and kept clean at all times.
   f. Unless protected by disposal liners, reusable rigid containers shall be washed and decontaminated by a hospital-approved disinfectant every time they are emptied.
   g. During transport, medical wastes shall be separated from other wastes in the same vehicle by use of containers or barriers.
5. Certain hazardous wastes may be solidified for disposal. An EPA approved product (i.e. Isosorb) is used to solidify contents of suction canisters. After treatment is done, this waste must be put in a red bag to be discarded.
6. Patients' rooms shall have waste containers lined with regular plastic bags. Environmental Services staff accomplishes disposal of waste from patients' rooms.
7. Sharps waste:
   a. All used needles and syringes will be disposed of at the point of origin in an appropriate sharps collection container. All sharps container will be checked for fill level daily and exchanged appropriately by our outside vendor or Environmental Services Department.

b. Sharps waste shall be contained in sharps containers, which are rigid, puncture-resistant, leak-resistant when, sealed, labeled with biohazard signs and red in color. Full sharps containers shall be tightly lidded. Tape may not serve as lid. Sealed sharps containers may be placed in red biohazard bags.

c. The container shall be legibly labeled with the hospital's name, address, and phone number and easily visible on the outside of the container.

8. Each newly hired Environmental Services employee will receive orientation to the procedure for the in-house collection, transportation, and storage of regulated and non-regulated waste at the medical center prior to handling any waste materials. Training must include legal definitions, separation and proper storage, transportation, treatment and disposal of biomedical waste. Training will be the responsibility of the manager /supervisor in charge of this area.

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

1. Administrative Policy: Handling of Pharmaceutical Waste, Expired Medications, and Expired Iv Solutions 276

D. **REFERENCE(S)**:

1. **San Diego County Code of Regulatory Ordinance. Chapter 12 Medical Waste. Retrieved from https://codelibrary.amlegal.com/codes/san_diego/latest/sandiego_regs/0-0-0-107237**
~~1.~~**2.** Ordinance No. 7646 of San Diego County, Department of Health Services regulating the storage and disposal of medical wastes
~~2.~~**3.** **California Health and Safety Code. Division 104. Environmental Health, Part 14.** Medical Waste ~~Management Act,~~ Sections 117600-118360 ~~in Chapter 6.1, California Health and Safety Code.~~
4. Official California Code of Regulations (CCR), Title 22, Division 4.5
~~3.~~**5.** **California Department of Public Health (CDPH). (2017, January). Medical waste management act. California Health and Safety Code Sections 117600-118360**

Decision Table for Medical Waste

Type of Waste	Red Bag	Regular Bag	Sharps Container
Fluid blood, blood elements, vials of blood, specimens for culture, used culture media, and stock cultures.	X		
Bloody body fluids or disposable drapes saturated and/or dripping with bloody body fluids such as CSF, synovial, pleural, pericardial, amniotic.	X		
Bloody body fluid filled containers from nursing units, ED, PACU, outpatient areas not treated with Premicide.	X		
Materials used to clean up fluid blood or bloody body fluid spills that are dripping.	X		
Surgical specimens.	X		
Wound dressings, bandages, wrappings saturated and/or dripping with blood.	X		
Food waste such as soda cans, paper cups, cutlery, including food or service items from isolation rooms.		X	
Empty urine and stool containers, empty colostomy and urinary drainage bags, empty bedpans, breathing circuits, surgical drapes.		X	
Flexi Seal Fecal Management Bags	X		
Gastric washings, dialysate, vomitus, feces, urine, diapers. Please empty in toilet.		X	
Tracheal and bronchial secretions, sputum, IV tubing without the needles.		X	
Soiled but not dripping items such as dressings, bandages, cotton balls, peripads, chux, cotton swabs.		X	
Suction Canisters, treated with solidifying agent.	X		
Used gloves, aprons, masks, goggles, respirators.		X	
Broken glass, guide wires.			X
Uncapped Needle/syringe units, needles, scalpels, vials from live or attenuated vaccines.			X

TCMC Waste Disposal Guidelines

						 
Regular Waste NO NEEDLES	**Biohazardous Waste** NO NEEDLES	**Sharps** NEEDLES OK	**Pharmaceuticals** NEEDLES OK	**Controlled Substances** NO NEEDLES	**RCRA Pharmaceuticals** NO NEEDLES	**Chemo/Hazardous Waste** NEEDLES OK IN BIN, NOT BAG
▫ Empty IV bags, Piggyback bags/tubing without PHI or PHI covered ▫ Empty medication vials without PHI or PHI covered ▫ Trash ▫ Dressings ▫ Chux ▫ Diapers ▫ Sanitary napkins ▫ Gloves ▫ Empty foley bags and other drainage bags ▫ Disposable patient items ▫ Empty irrigation syringes ▫ Empty syringes (without needles) **NO PHI**	▫ Blood and all OPIM (Other Potentially Infectious Material) ▫ Blood tubing/ bags/hemovacs/ pleurevacs ▫ Intact glass or plastic bottles with bloody fluid or OPIM ▫ Suction liners with bloody fluid or OPIM ▫ Soaked/dripping bloody dressings ▫ All disposable items soaked or dripping with blood or OPIM **When in doubt, use red bag.**	▫ **All sharps** *Example: needles (including needles from insulin pens), lancets, broken glass vials, ampules, blades, scalpels, razors, pins, clips, staples* ▫ Trocars, introducers, guide wires, sharps from procedures etc.	▫ Syringes, needles, tubexes, carpujects with pourable medication (pourable means there is enough liquid to pour it out, not just residual amount) ▫ Partially used or wasted prescription or over-the-counter medication ***Examples: vials, tablets, capsules, powders, liquids, creams/lotions, eye drops, suppositories, patches (fold in half)*** ▫ Inhalers with no propellants *Examples: Advair, Foradil* **NO PHI**	**ALL Controlled Substances and propofol ONLY** ▫ Solid controlled substances -Tablets, capsules, suppositories, lozenges, and patches. Fold patch in on itself prior to disposal ▫ Liquid controlled substances -Intravenous & oral ▫ Propofol **No needles, syringes, ampules, vials, bottles, or tubing** **NO PHI**	**EPA designated R.C.R.A. Pharmaceuticals only:** *Examples:* ▫ *Insulin/Insulin Pen (needles removed)* ▫ *Inhalers -only those w/ propellant e.g Ventolin, Atrovent, Flovent, Symbicort* ▫ *Warfarin /Coumadin* ▫ *Used & Unused nicotine gum or patches, (include empty wrappers)* ▫ *Silver sulfadiazine cream* ▫ *Silver nitrate applicators (unused)* ▫ *Selenium sulfide shampoo* ▫ *Multiple trace elements* ▫ *Unused& residual alcohol/acetone/acetic acid* **No Needles** **NO PHI**	**Trace Chemo:** All supplies used to make and administer chemo medication *Example: tubing, empty bags/ bottles/ vials, syringes, needles, pads, wipes, contaminated gloves, gowns, masks etc.* **Hazardous Waste:** All supplies used to make and administer hazardous meds. **Bulk Chemo:** Return to pharmacy all unused bulk chemo in original pharmacy bag for disposal into RCRA container **NO PHI**

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

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

Revised Date: 04/2017 pharmacy

Tri-City Healthcare District
Oceanside, California

HOME HEALTH CARE

RETIRE –follow Home Health Care Policy: Disposal of Needles & Syringes, Hazardous Materials

ISSUE DATE: 03/06

SUBJECT: Hazardous Infectious Materials Management

REVISION DATE~~(S)~~: 04/06, 11/06, 11/07, 02/09, 09/11, 03/21

POLICY NUMBER: 503

Home Health Care Approval:	~~06/20~~05/22
Infection Control Committee Approval:	~~08/20~~11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~01/21~~01/23
Administration Approval:	~~03/21~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	03/21

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

~~1. To provide a policy delineating the process of the storing and disposal of hazardous infectious waste in the Home Health environment.~~

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

~~1. It is the policy of the Agency to protect both the patient and staff by providing guidelines for the proper disposal of infectious waste and sharps in the patient's home, and the storage of infectious waste in the Agency that protects both patient and staff.~~

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

~~1. Unused sharps containers are stored in a locked cabinet in the front office area. Two unused sharps containers are stored in the Pyxis for emergency use. Staff requiring a sharps container must log the numbered container in the logbook and sign their name and date of receipt. This is monitored by two designated office staff with keys to the locked container. When the container is dispensed, the Tri-City Medical Center ID sticker is placed on the container and the "open" date is written on the container in indelible ink.~~

~~2. When the container is two thirds full it is returned to one of the two designated office staff maintaining the log. The designated office staff individual will then write the "closed" date on the container and place a label over the opening indicating the open and closed date. The designated staff member then transports the used container to the Tri-City Radiation department for containment and disposal. All employees transporting sharps must carry a copy of the Medical Waste Management Plan.~~

~~All infectious material generated in the patient's home is disposed of in accordance with the California Health and Safety Codes prohibiting the disposal of "home generated sharps waste," such as hypodermic needles, pen needles, intravenous needles, and lancets, in trash or recycling containers. It requires that all sharps waste be transported to a collection center in an approved sharps container. Information regarding sharps disposal is in the Tri-City Home Health Patient Admissions Booklet.~~

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 09/95

SUBJECT: Aerosol Transmissible Diseases and Tuberculosis Control Plan

REVISION DATE(S): 09/01, 09/02, 10/03, 10/06, 10/08, 07/09, 10/09, 07/11, 08/14, 01/16 01/17, 02/18, 09/18, 08/19, 09/20

Infection Control Department Approval:	~~05/20~~11/22
Infection Control Committee Approval:	~~05/20~~12/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~08/20~~01/23
Administration Approval:	~~09/20~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	09/20

A. **TUBERCULOSIS AND AEROSOL TRANSMISSIBLE EXPOSURE CONTROL PLAN**
INTRODUCTION:

1. Legal mandates and regulatory agencies such as California Code of Regulation Title 8, Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention (CDC) have set the standards for the implementation of an Aerosol Transmissible Diseases (ATD) including Tuberculosis Exposure Control Plan.

B. **PURPOSE AND POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) to provide care to patients with ATDs with a minimum risk of transmission to others. The Infection Control Committee will provide assistance in ensuring compliance with the policy. The plan includes:
   a. Source Control Procedures including cough etiquette / respiratory hygiene.
   b. Implementation of an effective triage system and early identification of suspects and active cases
   c. Engineering control measures
   d. Respiratory protection programs
   e. Education and training of employees
   f. Evaluation and treatment of employees exposed to ATDs
   g. Protection of patients, employees and visitors from exposure to ATDs. These include:
      i. Pathogens requiring Airborne Precautions;
      See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
      ii. Diseases requiring Droplet Precautions;
      See Type and Duration of Precautions - Disease Specific (formerly Short Sheet)
      iii. Ebola disease: Requires special considerations: Please see Infection Control Ebola Plan policy for management of a patient with suspected or confirmed Ebola. *Requires a negative pressure room.

C. **SCOPE:**

1. The Tuberculosis Control and Aerosol Transmissible Diseases Plan applies to all inpatient and outpatient services

D. **RESPONSIBILITY:**

1. The Tuberculosis Control and Aerosol Transmissible Disease Program will require the participation of the following personnel:
   a. The Infection Control Officer and the Infection Preventionist are responsible for overseeing the plan. This includes, but is not limited to implementation of the plan for the facility; development of policies and procedures to support the implementation of the

plan; reporting of suspected and diagnosed cases of ATDs and Tuberculosis as defined in under CA title 22 to the Infection Control Committee and county department of health. It is also the responsibility of the Infection Preventionist to evaluate the risk assessment at least annually.

b. The Environment of Care Officer is responsible for implementation and maintenance of current standards to meet the requirements of the California Code of Regulation Title 8, Title 24 and the guidelines from the Centers for Disease Control and Prevention.

c. Employee Health Services is responsible for employee TB skin testing and interpretations; conducting investigation regarding employee exposure to ATDs and TB; maintaining employee TB skin test conversion data; reporting employee conversion and diagnosed cases to the Infection Control and Safety committees annually; and managing and counseling staff who have active ATDs. Employee Health is responsible for developing and implementing policies and procedures related to the respiratory protection program. Employee Health is also responsible for screening, testing, and provision of immunizations as indicated and seasonal influenza vaccination administration and declination statement documentation.

d. Department Directors and Managers are responsible for implementation of the TB and ATD Control Plan in their respective areas, providing educational training to all employees before exposure to a source case; maintaining documentation of personnel training; .

e. Administrative Supervisor is responsible for patient placement in a negative pressure room.

f. Case Management reports to the County TB Control for suspected and confirmed TB cases, during the weekdays, weekends and holidays.

g. The Director of Education is responsible for including TB and ATD control plan in orientation of new employees and annual OSHA required training related to ATDs.

h. The Manager of Environmental Services is responsible for developing, implementing and monitoring procedures for cleaning rooms occupied by a patient with ATDs.

i. The Facilities Manager is responsible for monitoring and verifying air pressures daily on Airborne Infection Isolation Rooms (AIIR), when in use, and reporting of air changes and air pressures to the Infection Control and Safety committees annually.

j. The Manager of Pulmonary Services is responsible for training, implementing and monitoring respiratory staffs' adherence to the ATD and TB Control plan including protection for high-hazard procedures.

k. The Facilities Manager is responsible for maintaining and cleaning of portable HEPA recirculators and providing portable HEPA recirculators to units as needed.

l. Microbiology Supervisor is responsible for the notification to the local health authority according to California and Federal regulations of ATDs and TB.

m. The Employees are responsible for early identification of suspects and active cases of ATDs and TB; early implementation of Airborne Precautions; knowledge of Tuberculosis and ATD control plan; compliance with all protective practices; attendance of New Employee Orientation Program and annual OSHA required education; and reporting noncompliance and unusual occurrences using a quality review report.

n. The Physicians play an important part in TB and ATD Control by maintaining a high index of clinical suspicion.

   i. Physicians should place all HIV positive patients with infiltrates in Airborne Precautions until three sputum concentrated smears are negative for AFB or until a diagnosis other than tuberculosis is clearly established.

   ii. Place all new admits with a history of fever, weight loss and cough or pneumonia greater than 2-3 weeks in Airborne Precautions if no clear etiologic agent is identified.

   iii. Treat all highly suspected tuberculosis cases with anti-tuberculosis medications pending sputum results.

   iv. Consider ATD in patients with temperature greater than 100 degrees F and cough. ATD may also be considered in the presence of rash with fever.

v. Implement control measures when ATD is suspected.

E. **AVAILABILITY OF THE PLAN:**

1. The Tuberculosis and ATD Control Plan will be available via the Intranet in the Infection Control Manual for all staff. . OSHA required education will be conducted at the new employee orientation program and all other employees are required to complete an annual review. The written plan will be reviewed and updated annually and as indicated by regulations.

F. **FUNDAMENTALS OF TUBERCULOSIS INFECTION CONTROL:**

1. Some segments of the U.S. population have a higher risk for TB because they are more likely to have been exposed or because their infection is more likely to progress to active TB after infection. TB is carried in the air after being generated when persons with pulmonary or laryngeal TB sneeze, cough, speak or sing. These particles are carried on air currents and stay afloat for a long time. Infection occurs when a person inhales the germs into their lungs. Usually within 2-10 weeks after infection, the immune response limits further multiplication and spread but some bacteria can remain dormant for years (latent infection). People with normal immune systems have a 5-10% lifetime risk of the latent infection progressing to active disease. Factors that influence infection include the concentration (number) of the bacteria in the air and duration of exposure. Exposure in a relatively small space with inadequate ventilation can increase the risk of infection. Persons who are immunocompromised are more likely to become infected and to also develop active disease. The transmission, epidemiology and pathogenesis of TB were all considered in our plan. An effective program requires early identification, isolation and effective treatment of persons who have active disease.
   a. The most effective control measure is to ensure rapid identification, isolation, diagnostic evaluation and treatment of persons likely to have TB.
   b. The next level of effective control is the use of engineering controls (i.e. airflow, dilution, filtration and exhaust of air)
   c. The final and least effective control is the use of respiratory protection.

G. **TUBERCULOSIS RISK ASSESSMENT:**

1. Risks assessment will be performed annually by the Infection Preventionist and reviewed by the Infection Control and Environment of Care Committees. The purpose of this assessment is to evaluate the risk of transmission of Tuberculosis so that appropriate interventions can be developed. The assessment will include:
   a. Community TB profile from public health department data
   b. Number of infectious TB patients treated in outpatient and inpatient areas.
   c. Drug susceptibility patterns of TB patients
   d. Analysis of staff PPD test results by area
   e. Review medical records for appropriate precautions, timing of specimens, duration of precautions and timely communication with public health.
   f. Observation of practice and review of engineering controls.
2. Considerations for determining the hospital's risk classification will be based on the following:

VERY LOW RISK	There are no TB patients admitted to the facility during the preceding year
LOW RISK	The employee PPD conversion rate in an area is not higher than in areas with increased occupation exposure to Tuberculosis Fewer than 6 patients were admitted to area during the preceding year There is no evidence of person-to-person transmission No clusters of staff PPD conversion
INTERMEDIATE RISK	Same as Low Risk with the addition of six or more TB patients admitted to the area during the preceding year.
HIGH RISK	PPD conversion rate is higher in areas without occupational exposure to Tuberculosis.

	Clusters of staff PPD conversion. Evidence of person-to-person transmission. More than 6 patients admitted to an area.

3. Early identification of suspected and active TB patients can initiate prompt treatment and prevent transmission of the disease. This is the most effective method for controlling the spread of tuberculosis, an Administrative Control. A suspected case of TB is defined as:
   a. A patient with unexplained cough, cough with bloody sputum, and/or a cough lasting longer than 3 weeks
   b. A patient with unexplained fever, night sweats, weight loss and anorexia
   c. Readmission of patients recently diagnosed with Tuberculosis
4. A high index of suspicion for Tuberculosis should be maintained for the following
   a. Patients requiring high-risk procedures such as aerosolized pentamidine and sputum induction for Acid Fast Bacilli (AFB)
   b. Patients who belong to a group with a higher prevalence of TB infection: medically under-served, foreign born from a developing country, homeless, current or past justice involved, alcoholic, injecting drug-user, elderly, or extended contact with an active TB case.
   c. Patients who belong to a group with a higher risk to progress from latent TB to active disease: immunocompromised (HIV, organ transplant, or on high dose steroids), silicosis, status post gastrectomy or jejuno-ileal bypass surgery, >10% below body weight, chronic renal failure, diabetes mellitus, infected within past two years, or child >5 years old.
5. In outpatient areas where patients with undiagnosed Tuberculosis may be present, precautions must be taken to minimize the risk of transmission.
   a. Instruct patients to cover their mouths with a handkerchief or tissue, and give them a surgical mask to wear. Tissues and masks must be readily available in the waiting areas.
   b. Questionnaires will be utilized in all outpatient areas and Emergency Department to assist in the early identification of suspected cases.
   c. Patients with symptoms suggestive of Tuberculosis will be removed from the common area and placed in a designated waiting area.
   d. Patients unable to wear a mask can be placed outside with appropriate supervision until an appropriate room is available.
6. For departments in main hospital building without a built in negative pressure room, staff can obtain a HEPA filter (recirculator) from the Engineering department to enhance circulation in the exam or treatment room. Contact Engineering for placement assistance. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
   a. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this area.
   b. If the patient is suspected or known to have infectious TB, the room must remain vacant per **Section M: Room Shut Down Time**. The door is to remain closed and the filter running.
   c. Personnel may enter the area but must continue to wear respiratory protection until the time has lapsed.
7. For off-site areas, the patient will be asked to wear a surgical mask while inside the building.
8. Any possibility of TB as a diagnosis should be communicated by telephone to other departments, prior to transporting the patient to those areas.
9. Patients seen in the ED with confirmed or suspected pulmonary TB are masked and placed in C-26, a negative pressure room. Staff must wear an N95 respirator when entering the room.
   a. These patients might require hospitalization to control the spread of infection. Patients confirmed or suspected with pulmonary TB, will be masked if transporting throughout the facility.

H. **MANAGEMENT OF HOSPITALIZED PATIENTS WHO MAY HAVE ACTIVE TB:**

1. Staff who are the first points of contact should ask questions that will facilitate identification of

patients with signs and symptoms suggestive of TB. See the Admission Assessment Patient History form>TB Screening form>to assess for TB risk factors and symptoms.

2. Upon identification of a patient with active or suspected Tuberculosis, the nurse must place the patient in an AIIR (i.e. negative pressure room: C-26, 143, 243, 287, 387, 443, 487, Maternal Child room 200, 201and Progressive Care Unit (PCU) Rooms 301, 312 and 326,) The door must be closed . Post the Airborne Precautions sign outside the room.
3. If a negative pressure room is not available, Administrative Supervisor of the need for an Airborne Precautions room. Contact Engineering for a HEPA filter for the current room, until a negative pressure room is available. Keep the door closed and post the Airborne Precautions sign. Staff wear N95 particulate respirators and visitors wear surgical masks when entering this room. Please note: The patient must be placed in an AIIR room within 5 hours of identification.
4. Cohorting TB patients:
    a. Patients with TB must not be placed together in the same room unless they have culture- confirmed TB, have drug susceptibility test available on current specimens obtained during the present hospitalization, have identical drug susceptibility patterns on these specimens and are on effective therapy.
5. Reporting:
    a. The Unit Secretary notifies Engineering (by placing a worker order) that an Airborne Precautions room is in use for tuberculosis.
    b. On weekends and holidays, the Case Manager will notify the County Public Health TB Control by calling phone number (619) 540-0194. Go to http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/TB-216TBSuspectCaseReport.pdf for a copy of the report.
    c. Laboratory Results: Hospitals and staff are required by law to report TB to protect the public. This must be done within one day of identification of the case or suspected case.
    d. The Microbiology department will notify the nursing unit and the Infection Preventionist of a positive AFB smear or culture results. A fax report of all positive AFB smears and cultures are sent to Public Health TB Control.
    e. The Infection Preventionist (x 5696) or designee is responsible for reporting to public health. County Public Health TB program nurses are available 8:00am to 5:00pm, 7 days a week and all holidays at (619) 540-0194. TB Control does not have personnel available between the hours of 5:00 pm and 8:00 am. Persons with routine questions about TB exposure should call (619) 692-8610 after 8:00am on the following day.
    f. To report a case of TB after 5:00pm do one of the following:
        i. Call pager (619) 540-0194 after 8:00 am the following day to report directly to TB Control RN if they feel there is urgency about reporting; or
        ii. Leave a message on the TB Control RN voice mail (619) 692-8610 and their call will be returned on the next working week day. Message should include patient's name, date of birth, facility name, reporter's name and phone number, and contact person at facility who will be available for more patient information.
    g. Persons requesting Discharge Approval should:
        i. Contact TB Control RN between 8:00am and 5:00pm
    h. Physicians from emergency rooms requesting recommendations regarding patients they suspect may be infectious after 5:00pm, should do the following:
        i. If patient is homeless or from congregate setting (SNF, school dormitory, etc.) and has clinical picture consistent with TB, we recommend to admit and rule out infectiousness.
        ii. If patient has a home and is otherwise medically stable (not in need of admission) patient can be sent home, obtain one sputum for AFB smear and culture prior to release, start on medication if indicated. Direct caller to contact TB Control RN on phone number (619) 692-8610 after 8:00am on the following day.
    i. Persons calling about patients who are leaving against medical advice (AMA):
        i. Have facility get as much locating information as possible on patient (including address/phone of relatives or friends)

ii. Call intake RN between 8:00am and 5:00pm; after hours call 8:00am the next day

6. Staff (fit-tested and approved for use) will wear an N95 respirator when entering the patient's room. See the Respiratory Protection Program under the Employee Health & Wellness Policy Manual.
7. Pediatric patients with suspected or confirmed TB must be evaluated for potential TB according to the same criteria, as adults. Parents and other visitors of pediatric patients must be evaluated for TB as soon as possible. Until they are evaluated, they must wear surgical masks when in areas of the facility outside of the child's room.
8. Diagnostic and treatment procedures must be performed in the Airborne Precautions rooms to prevent transporting to other areas of the facility. If the procedure cannot be done in the isolation room, the patient must wear a surgical mask during transport. Procedures should be scheduled at times when they can be performed rapidly and when the areas are less crowded.
9. Limit the number of persons entering an isolation room to a minimum. All visitors (except staff who have been fit-tested for an N95 respiratory) wear a surgical mask when entering an Airborne Precautions room.
10. Facilities will verify airflow rates and negative pressures at the time the negative pressure room is established. Negative pressures will be verified daily and a log maintained by Facilities department.
11. Cough-inducing procedures will not be performed on patients who have or may have active Tuberculosis unless the procedures are absolutely necessary and can be performed with appropriate precautions.
    a. The patient is in an Airborne Precautions room.
    b. The portable air filtration system has been set-up in a regular room.
12. Staff must wear respiratory protection (N95 respiratory or Powered Air Purifying Respirator-PAPR) when present in rooms or enclosures in which cough-inducing procedures are being performed on patients who are being ruled out for Tuberculosis. See High Hazard Procedures.
13. After completion of the cough-inducing procedures, patients who may have infectious Tuberculosis will remain in the Airborne Precautions room until the coughing subsides. (If transport is necessary, patient will be provided with a surgical mask to wear.) Outpatients will wear surgical masks until they are outside of the hospital.
14. Before the Pulmonary Function Testing room is used again, after the booth has been in use, the HEPA filter is kept on and the door to the room closed for 1.5 hours. Staff entering the room before the 1.5 hours are over will wear an N95 respirator. See High Hazard Procedures.
15. Bronchoscopy considerations
    a. The bronchoscopy room for all inpatient and outpatient procedures will be a negative pressure room. The air filtration system will remain in use whenever performed on a suspect TB patient. Respiratory protection must be worn. An N95 Respirator or Powered Air Purifying Respirator-PAPR must be worn by staff performing a Bronchoscopy on a suspect TB patient. The patient waiting for bronchoscopy will be provided a surgical mask and escorted to a non-communal waiting room.

I. **ADDITIONAL CONSIDERATIONS FOR SELECTED AREAS:**

1. Surgery/Peri-Anesthesia Nursing Services
    a. Postpone non-urgent or elective procedures on suspected/confirmed TB patients until the patient is no longer infectious.
    b. If procedures must be performed, they should be done in OR rooms with door closed and traffic at a minimum.
    c. Procedures should be done when other patients are not present in the operating suite e.g., end of day) and when minimum number of personnel are present. This applies to pulmonary and non-pulmonary surgical sites.
    d. Utilize the portable HEPA unit in the operating room during intubation and extubation. Turn off the HEPA unit during the procedure.
    e. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR). Order PAPRs from SPD (xt 7728)

i. PAPRs cannot be used near the sterile field, wear N95 mask in place of PAPR.

f. For additional information see Surgery Protocol for Active/Rule Out Tuberculosis (TB).

g. Airborne Precautions are maintained in the Post Anesthesia Care Unit. Post-operative patients are placed in a private recovery room with a portable HEPA unit.

2. Home Health Services

a. Staff entering the home of a patient with confirmed or suspected TB or ATD should wear appropriate respiratory protection.

b. The patient should be taught to cover mouth and nose with a tissue when coughing or sneezing.

c. Educate patient regarding importance of taking medication (and administering directly observed therapy).

d. Immunocompromised persons or young children living in home with TB patient should be temporarily relocated until patient is no longer infectious.

e. Cough-inducing procedures should be performed on patients with infectious tuberculosis only if absolutely necessary. If their performance is required a well-ventilated area away from other household members should be used (for example, go outside or open a window). Staff will wear respiratory protection during the procedure

f. Specific processes and procedures pertaining to ATDs in the home are found in the Home Health Care policy manual.

J. DIAGNOSTIC EVALUATION:

1. Diagnostic evaluation should include the following:

a. Medical history and evaluation - The probability of TB is greater among patients who have positive PPD test results or a history of positive PPD results, who have previously had TB or who have been exposed to someone with TB, or who belong to a group at high risk for TB.

b. Mantoux skin test (PPD skin test) – is placed by the specially trained staff and read at 48- 72 hours after injection. Results are to be documented in the Medical Record.

c. QuantiFERON-TB Gold (QFT-G) test can be used in any situation a Mantoux PPD skin test is indicated. A positive result has the same significance as a positive PPD skin test, and neither a positive PPD nor a positive QFT-G by itself warrants Airborne Precautions.

d. Chest radiograph - radiographic abnormalities that strongly suggest active TB include upper lobe infiltrates, particularly if the cavitations are seen, and patchy or nodular infiltrates in the apical or sub apical posterior upper lobes or the superior segment of the lower lobe. The MD may include the words "cavitary lesion", "granuloma disease" or "suspected tuberculosis" in the results.

e. Microscopic examination and culture of sputum or other appropriate specimen. Three sputum specimens should be collected 8–24 hours apart, and at least one should be an early morning specimen, induced, or bronchoalveolar lavage (BAL).Although direct AFB smears are available in house, concentrated smears performed by our reference laboratory are preferred and are included with orders for a TB culture. Since neither a direct nor a concentrated smear has sufficient sensitivity to exclude a diagnosis of tuberculosis, cultures must also be ordered.

f. Initiating Treatment: Patients who have confirmed active TB or who are considered highly likely to have active TB should be started promptly on appropriate treatment in accordance with the current guidelines.

g. Drug susceptibility should be performed on all initial isolates from patients with TB.

h. Contact Infection Prevention at Ext. 5696 for the latest recommendations.

K. AIRBORNE PRECAUTIONS:

1. Airborne Precautions can be discontinued as soon as the diagnosis of TB has been ruled out, when another diagnosis is confirmed, or when the patient is no longer infectious.

a. Airborne Precautions can be discontinued:

i. In a patient with active tuberculosis when the patient is on effective therapy, improving clinically, and has had three consecutive negative concentrate sputum

AFB smears

ii. In a patient with suspect tuberculosis as soon as the diagnosis of TB has been excluded by three negative AFB sputum smears taken 8-24 hours apart with at least one from an early morning specimen, induced specimen, or BAL or when another diagnosis is confirmed

2. Continued isolation throughout the hospitalization should be considered for patients who have multi-drug resistant tuberculosis (MDR-TB) because of the tendency for treatment failure or relapse.

L. **DISCHARGE:**

1. Before leaving the hospital, TB patients must be approved for discharge by the Public Health Department. A discharge plan must include all of the following prior to approval from the TB Control Officer. TB Control can be contacted at: 619-692-8610 or 619-540-0194.
   a. Patients in the Progressive Care Unit (PCU): Specific notification(s) must be obtained prior to discharging justice involved patients:
      i. The Department of Health TB Control to the specific county in which the justice involved patient is residing.
      ii. The Public Health Department of the prison.
   b. For all other inpatient units:
      i. Three consecutive negative sputum smears from concentrate or approved living arrangements so that TB isolation can be maintained. For example, the accepting facility has an airborne precautions room available or the house and household contacts have been evaluated and cleared by the TB County public health nurse.
      ii. A confirmed outpatient appointment (date/time/place) with a provider (name and phone number) who will manage the patient's care until cured.
      iii. Sufficient medication to take until the outpatient appointment. Contact Pharmacy for assistance with take-home medications.
      iv. Placement into case management (e.g. DOT) or outreach programs of the public health department.
      v. The charge nurse, patients nurse or Case Manager, will notify the Public Health TB Control Department at (619) 692-8610 prior to the anticipated discharge and obtain approval.
      vi. Public Health requires at least two days prior to discharge to review the case. On weekends and holidays, obtain approval from the on-call TB County public health nurse at cell phone number (619) 540-0194
2. Cleaning of the room after a known or suspected TB patient is moved or discharged:
   a. If the suspected or confirmed TB patient was NOT in a negative pressure and HEPA filtered room:
      i. Post the Airborne Precautions sign and keep the door closed.
      ii. Call Engineering for a HEPA filter. To enter the room staff must wear an appropriate respirator (i.e. N95 or PAPR). Plug in the filter, turn it on and close the door. Post a sign that specifies the appropriate time period from the table below. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed. After the time period has ended, discontinue Airborne Precautions and return the HEPA filter to Engineering.

M. **ROOM SHUT DOWN TIME:**

1. Keep the Airborne Precautions sign posted
2. Leave the HEPA filter running with door closed for specified time. Post a sign that specifies this time period.
   a. AIIR Negative Pressure Room

AIIR/Negative Pressure Rooms	Length of Time AIIR Negative Pressure Room is Closed
ED-C26, 143, 243, 443, 287, 387, 487, NICU	30 min
Bronchoscopy, 200, 201	1 hour
PCU 301, 312, 326	2 hours

b. Non-Negative Pressure room

Location in Non-Negative Pressure Rooms	Length of Time Non-Negative Pressure Room is Closed
Surgery	30 min
1N/S, MCH, Pavillion, East/West Tower, Radiology/MRI/CT, ED	1 hour
PCU 3N/S	2 hours

3. Staff may enter the room during this time (i.e. to clean) but must wear an N95 respirator until the time period has elapsed.
4. After the time period has ended, discontinue Airborne Precautions.
5. If the patient is no longer infectious or TB has been ruled out: No special precautions needed. The door may be immediately opened and the room cleaned as usual.

N. **ANNUAL TUBERCULOSIS SCREENING:**

1. Auxiliary and Employees: See the Employee Health & Wellness Policy Manual: TB Surveillance and Respiratory Protection policies.
2. Physicians: the Medical Staff Office sends an annual screening survey to each physician on staff. PPD testing for physicians is required and available in Work Partners. It is highly recommended that all active medical staff be fit-tested upon hire and annually.

O. **AEROSOL TRANSMISSIBLE DISEASE CONTROL EXPOSURE DETERMINATION:**

1. A list of all job classifications in which employees have occupational exposure is available in the Employee Health & Wellness Policy Manual: Respiratory Protection Program (see Appendix C).

P. **ISOLATION PRECAUTIONS:**

1. Standard Precautions and Transmission based precautions including cough etiquette, Airborne Precautions, Droplet Precautions and Contact Precautions are outlined in the Infection Control Manual: Standard and Transmission based Precautions (IC.5), Type and Duration of Precautions for Selected Infections and Conditions (IC.5.1); Pregnant staff (IC.5.2).

Q. **HIGH HAZARD PROCEDURES:**

1. High hazard procedures include but not limited to
   a. Intubation and Extubation
   b. Sputum Induction
   c. Endotracheal & Tracheostomy Tube Care
   d. Bronchoscopy
   e. Pulmonary Function Tests
   f. Aerosolized administration of pentamidine or other medication
   g. Autopsy
2. For patients with known or suspected Droplet infectious diseases staff must wear an N95 respirator.
3. For patients with known or suspected airborne infectious diseases staff must wear a N95 Respirator or Positive Air Purifying Respirator (PAPR) except in an operating room or procedure

room during an invasive procedure where there is a sterile field wear a N95 mask.

a. Contact Materials for PAPRs supplies

4. Although Cal OSHA requires PAPRs for high hazard procedures on suspect/confirmed airborne disease patients, CDPH does allow the use of N95 Respirators instead of PAPRs if it interferes with the successful performance of the task or the procedure is performed with the patient in a ventilated enclosure.

R. **SOURCE CONTROLS AND ENGINEERING CONTROLS IN SPECIFIC HOSPITAL AREAS:**

1. Throughout the facility cough etiquette is used in waiting areas. Signs with instructions are posted in these areas in Spanish and English. Patients are provided tissues and are asked to wear surgical masks to prevent droplets from disseminating into the environment. Alcohol hand hygiene solutions are made available for patient use. Bilingual signs are posted in waiting areas instructing patients to "Cover your cough."
2. Emergency Department
   a. Engineering Controls during a surge of patients with ATD is addressed in the TCHD Infection Control Policy IC15.0 Influx of Infectious Patients: *Epidemic Influenza or other respiratory transmitted disease*.
   b. At the point of triage, ED staff shall screen and identify patients with symptoms of ATD and implement source control by placing a surgical mask on the patient and asking the patient to keep the mask on during their visit. If the patient cannot tolerate a surgical mask, tissues shall be provided and patients shall be instructed to cover their cough.
   c. Staff wears PAPRs or N95 Respirator during high hazard procedures (listed above) for disease spread by the airborne route.
   d. N95 respirators or PAPRs are used during patient contact for diseases spread by airborne route.
   e. Surgical masks are used during patient contact for diseases spread by the droplet route. N95 mask is used by staff during high hazard procedures for disease spread by the droplet route.
   f. Patients with diseases known to be transmitted by the airborne route, including novel viral infections, will be prioritized for AIIR C-26.
   g. When room C-26 is not available a private room is used.
   h. When there are no private rooms available, patients are asked to keep their mask in place and use tissues to prevent droplet aerosolization.
   i. Patients may be cohorted in designated rooms or bays when indicated.
   j. Patients suspected of having ATDs are provided with disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
   k. There are no special environmental cleaning recommendations for TB or r/o TB patients.
   l. Rooms shall be cleaned between patients using the hospital approved disinfectant.
   m. When used for a patient with ATD, room C-26 shall remain empty with Airborne Precautions sign posted and door closed for 30 minutes prior to being used by another patient.
3. Nursing Units
   a. Patients who are admitted with airborne transmissible diseases are admitted to AIIRs on nursing units.
   b. Airborne Precautions are initiated and followed in accordance with CDC recommendations for Transmission Based Precautions.
   c. Doors are kept closed.
   d. Patients in Droplet precautions do not need AIIRs for routine care. However, high hazard and cough inducing procedures performed as part of the clinical care of patients in both Airborne and Droplet Precautions will be done in AIIR. See chart above for selection on type of respirator.
   e. AIIRs shall remain empty with Airborne Precautions sign posted and door closed for designated time when a patient with airborne transmissible disease has occupied the room. (See Room Shut Down Time)
4. Pulmonary Services

a. Bronchoscopy for patients in Airborne or Droplet Precautions will be performed in an AIIR.
b. N95 respirators or PAPRs are used during Bronchoscopy.
c. In areas where AIIR is not available, aerosolized medications are administered using disposable nebulizer units with expiratory filters or multi-dose inhalers as clinically indicated.
d. Aerosolized medications may be administered using traditional routes while the patient is in an AIIR. The staff should wear an N95 or PAPR during this treatment (see High Hazard Procedures).
e. Bronchoscopy suite will remain closed for the designated time when procedure is performed on a patient with known or suspected ATD.
f. Expiratory filters are used for intubated patients with known or suspected ATD during transport.

5. Women and Newborn Services (WNS)
   a. Neonatal Intensive Care Unit (NICU)
      i. The NICU has a dedicated AIIR.
      ii. Neonates born to mothers with diseases known to be spread by airborne route are placed in the AIIR until the neonate is found to be non-infectious.
      iii. Prior to entering the unit, visitors are screened for signs of ADT and immunization history. Visitors are asked not to visit for duration of illness.
   b. Labor and Delivery
      i. Operating Room Suites may have portable HEPA units installed for mothers who have suspected ATD.
      ii. Staff are to follow Standard and Transmission based Precautions as indicated using the appropriate N-95 respirators or PAPRs for Airborne Precautions.
6. Laboratory Services
   a. Methods of implementation for ATD exposure control in are found in the Laboratory Medicine Biosafety Plan.
   b. For respiratory protection in Laboratory Services: See Employee Health & Wellness Policy: Respiratory Protection Program Policy
7. Facilities Management Staff
   a. Facilities Management staff will wear N-95 respirators when entering an AIIR housing patient(s) with known or suspected ATD.
   b. N95 respirators are required when repairing, replacing, or maintaining air systems or equipment that may contain or generate aerosolized pathogens.
8. Personal Protective Equipment
   a. The respiratory protection program policy (Employee Health and Wellness Manual) describes requirements of PPE used for ATD protection in accordance with 29CFR1910.134 and CCR Title 8, section 5144.
   b. Respiratory Protection including N95 respirators or PAPRs is required in any hospital location in the following circumstances:
      i. Entering an Airborne Precaution Room that is occupied or has been recently occupied (refer to Section M: Room Shutdown Time) by a patient with suspected or known Airborne transmitted ATD.
      ii. Attending high hazard procedure
   c. Respirator Shortages
      i. In the event of reported shortages of N95 respirators the following is recommended (notification received from supplier but still able to meet historic usage):
         1) TCHD will maintain a cache of N95 respirators in accordance with the disaster plan.
         2) Materials Distribution staff will perform in-house inventory to determine available stock and develop a timeline for inventory depletion.
         3) According to available stock, N95 respirators will be prioritized for distribution to areas where high hazard procedures are performed.

4) Re-use of N95 respirators is acceptable for known or suspected Tuberculosis patients over a 12 hour shift unless the respirator is contaminated (e.g. visibly soiled) or the integrity of the respirator is disrupted (e.g. torn, cracked nose piece).
5) Reuse of N95 respirators is acceptable during the care of patients with other ATD's under the following circumstances:
   a) A protective face shield (no surgical mask) is donned over the respirator to protect the respirator from contamination of ATD.
   b) The respirator integrity remains intact
   c) During the care of intubated and ventilated patients (closed circuit suction systems).

ii. In severe respirator shortages (less than 30 days of stock available in house, when supplier cannot meet the demand or can only supply an alternative N95) the following steps may be considered:
1) Prioritize available N95 for high hazard procedures.
2) Provide surgical grade masks for employees who are not provided a respirator due to the implementation of prioritized respirator use.
3) Contact Local Public Health Officer for possible acquisition of N95 respirators from local or state stockpiles.
4) Alternate manufacturer's respirators may be used in cases of tuberculosis and other airborne illnesses. Fit testing will be waived in a declared state of emergency.
5) Except during high hazard procedures, surgical masks may be used for H1N1 influenza.
6) PAPRs may be used.
7) The Infection Control Officer, Infection Preventionist, and the Safety Officer will determine if Internal Disaster Code Orange is warranted based on patient surge, physical and staffing resources.
8) When there is no option for providing N95 respirators, surgical masks will be provided to the employee.

iii. Positive Air Purifying Respirators (PAPRs)
1) PAPRs used for bronchoscopy are maintained in Respiratory Care Department.
2) SPD stores and maintains all other PAPRs.
3) Units are cleaned; disinfected using a hospital approved disinfectant and tested after each use.
4) Disposable hoods are used.

9. Admissions and transfers of patients with known or suspected airborne transmissible ATD:
   a. Airborne transmissible ATD suspect cases shall be identified, and the individuals shall be given disposable tissues, hand hygiene materials and the patient will be masked until an AIIR is available. Transfer to an AIIR shall be facilitated within five (5) hours of identification.
   b. If an AIIR is not available, patients shall be transferred to a facility with AIIR availability.
   c. If the physician determines that transfer to another facility AIIR would be detrimental to the patient's condition the patient need not be transferred. In this case, employees will use N95 respirators when entering the room or area housing the individual. The patient's condition will be reassessed every 24 hours to determine if transfer is safe and the determination shall be documented.
10. Influenza Season
   a. From November 1 to March 31, all employees, volunteers, contract workers or others covered under the ATD standard must wear a standard surgical mask while on duty as directed by the facility. This requirement does not apply to anyone who has received the current influenza vaccine as recommended by the County of San Diego Public Health and Centers for Disease Control and Prevention.
   b. The enforcement dates are subject to change based on the recommendations of the

hospital's Infection Control Committee.

c. Non-compliance with this requirement is subject to discipline as outlined in the hospital's Human Resources policy.

S. **MEDICAL SERVICES:**

1. Vaccinations are offered to employees free of charge (Employee Health and Wellness Manual: Immunization Policy).
2. Medical Services shall be provided to employees who have occupational exposure to ATDs.
3. Medical Services may include vaccinations, tests, examinations, evaluations, determinations, procedures and medical management and follow-up.
4. Medical Services shall be conducted in accordance with EHS policies.

T. **TRAINING:**

1. Training is provided during the New Employee Orientation Process and annually through computer based education modules.
2. Opportunity is provided for questions to be answered by an infection control professional.
3. Respirator Fit testing
   a. Medical screening and training is performed in accordance with Employee Health and Wellness Manual: Respiratory Protection Program.

U. **REVIEW SCHEDULE:**

1. The ATD plan will be reviewed annually by the Infection Control Committee.
2. Employees will assess the effectiveness of the program in their respective areas annually during the Annual Work Survey and deficiencies will be corrected

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

1. Active/Rule Out Tuberculosis (TB) Surgery Protocol
2. Criteria for Infectiousness and Placement In High Risk Setting Table (PCU Unit Only)
3. Employee Health and Wellness Policy: Immunization
4. Employee Health and Wellness Policy: Respiratory Protection
5. Infection Control Policy: Risk Assessment and Surveillance Plan
6. Infection Control Policy: Epidemiologic Investigation of a Suspected Outbreak
7. Infection Control Policy: Healthcare Associated Infections, Defined
8. Infection Control Policy: Standard and Transmission-Based Precautions
9. Type and Duration of Precautions - Disease Specific
10. Infection Control Policy: Ebola Plan

W. **REFERENCE(S):**

1. Centers for Disease Control & Prevention, Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis In Health Care Settings, 2005. MMWR 2005; 54 (No RR-17). .
2. Centers for Disease Control & Prevention, Guideline for Environmental Infection Control in Health Care Facilities, 2003 (last updated 02/15/2017)
3. Centers for Disease Control & Prevention H1N1 guidance, Seasonal Influenza and vaccine Guidance https://www.cdc.gov/flu/professionals/index.htm, Accessed 2/14/19
4. California Department of Public Health, Occupational Health Branch. (2015, August). Respirator Selection Guide for Aerosol Transmissible Disease. https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-ATD-RespSelectGuide.pdf
5. CDPH Ebola Virus Disease for Healthcare Professionals https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx
6. Respiratory Hygiene/Cough Etiquette in Healthcare Settings www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm
7. CDPH: Cal-OSHA Aerosol Transmissible Diseases Standard, Title 8 CCR Section 5199 August 5, 2009 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ATDStd.aspx
8. CDC: Tuberculin Skin Testing for TB dated May 11, 2016.

https://www.cdc.gov/tb/publications/factsheets/testing/skintesting.htm

9. Cadena, J. (2014) Tuberculosis and other Mycobacteria. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology 4th Ed.*, 95:1-20.
10. Hospital Respiratory Protection Program Toolkit: U.S. Dept of Labor/CDC/OSHA/NIOSH. Dated May 2015. https://www.osha.gov/Publications/OSHA3767.pdf
11. CDPH/CTCA: California AdultTuberculosis Risk Assessment: September 2018 https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/TBCB-CA-TB-Risk-Assessment-and-Fact-Sheet.pdf
12. CDPH Respirator Toolkit August 2015 (CDC, OSHA, NIOSH May 2015) page 16 https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/HCResp-CARPPGuide.pdf

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/01**	**SUBJECT:**	**Bloodborne Pathogen Exposure Control Plan**
REVISION DATE~~(S)~~:	**09/02, 09/03, 09/04, 09/05, 10/06, 10/07, 10/08, 10/09, 10/10, 10/12, 10/15, 08/16, 10/17, 08/18, 12/19, 12/20**		

Infection Control Department Approval:	**~~10/20~~11/22**
Infection Control Committee Approval:	**~~10/20~~12/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/20~~01/23**
Administration Approval:	**~~12/20~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/20**

A. **INTRODUCTION:**

1. Legal mandates and regulatory agencies such as the California code of Regulation Title 8, Occupational Safety and Health Administration and the Centers of Disease Control and Prevention have set standards and published guidelines for the implementation of the Bloodborne Pathogen Exposure Control Plan.

B. **DEFINITION(S):**

1. Workforce Member: Employees, Medical Staff and Allied Health Professionals (AHP), volunteers, trainees, Business Visitors and other persons whose conduct, in the performance of work for Tri-City Healthcare District (TCHD), is under the direct control of TCHD whether or not they are paid by TCHD.

C. **PURPOSE:**

1. The purpose of the Bloodborne Pathogens Exposure Control Plan is to reduce occupational exposure and transmission of Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), Human Immunodeficiency Virus (HIV) and other bloodborne pathogens. The second purpose is to satisfy the Occupational Safety and Health Administration (OSHA) regulations (29 CFR 1910.1030). Our plan outlines the steps we take to protect healthcare workers from the health hazards associated with bloodborne pathogens and to provide appropriate treatment and counseling after an exposure.

D. **SCOPE:**

1. This plan applies to all inpatient and outpatient services of Tri-City Healthcare District (TCHD)

E. **AVAILABILITY TO HEALTHCARE WORKERS:**

1. To help them with their efforts, our facility's Bloodborne Exposure Control Plan is available to healthcare workers at any time. The policy can be accessed in the Infection Control Manual located on the Intranet. Information is presented in orientation and during annual reviews.

F. **PROGRAM ADMINISTRATION:**

1. Employee Health Services (EHS) with the Infection Preventionist will review and update the Exposure Control Plan at least annually and whenever necessary to include new or modified tasks and procedures. Employee Health Services is responsible for the implementation,

maintenance, and administration of the Injury Prevention Program.

2. The Management/Leadership Team will ensure each employee for their area/unit of responsibility is provided information and training on the potential for exposure to bloodborne pathogens.
   a. Registry and contract staff are oriented to the hospital's exposure control plan prior to working.
   b. Training records are maintained for three years and available for examination and copying to our employees, as well as OSHA representatives. The records contain the following information, dates of all training sessions, contents/summary of the training sessions, and names and qualifications of the instructors as well as the names and job titles of employees attending.
3. The Management/Leadership Team is responsible for compliance in their respective areas. They work directly with the Safety/Environment of Care (EOC) Officer, the Infection Control Department, Employee Health and our employees to ensure that proper exposure control procedures are followed.
   a. The Management/Leadership Team will support activities that encourage the active involvement of employees in education and safety programs. The Management/Leadership Team will oversee employees so that initial training and annual review of bloodborne pathogens are completed prior to annual job evaluations.
   b. The Management/Leadership Team will review quality review reports (RL Solutions) their employees complete to document any needlestick occurrence.
      i. The Management/Leadership Team will counsel employees who do not use safe practices, PPE, and/or safety devices.
4. Materials Management and Environmental Services will provide all necessary personal protective equipment (PPE), engineering controls (e.g., sharps containers and sharps safety devices), labels, and red bags as required by the standard.
5. The Product Steering Committee has been identified as the multi-disciplinary group with primary responsibility for introducing sharps safety products to TCHD. The committee will provide guidance in product selection, seeking to provide cost-effective safety devices.
   a. Review and selection Sharps Safety Products will follow established routes and include input from non-managerial employees responsible for direct patient care who are potentially exposed to contaminated sharps and injury. See Products Steering Committee Product Evaluation and User Product Evaluation.
   b. Product Selection will follow a hierarchy of risk (i.e. high-risk procedures and devices targeted first). The committee will act on recommendations from Environmental Health and Safety or Infection Control Committees related to health care injuries and need for alternative product.
   c. All products will be judged by specific criteria and selection will be guided by user recommendations.
6. Workforce Members who are determined to have occupational exposure to blood and other potentially infectious materials (OPIM) must comply with the procedures and work practices deemed appropriate. They are actively involved in reviewing and updating the exposure control plan with respect to the procedures performed in the course of their work.
   a. If an employee exposure occurs:
      i. Employees are to notify their Director/Manager/Supervisor of any exposure immediately.
      ii. Director/Manager/Supervisor will refer employee for follow to:
         1) Employee Health during business hours.
         2) Emergency Room after hour and weekends.
            a) Employee to notify Employee Health within 24 hours of exposure.
   b. If a Workforce Member other than an employee exposure occurs:
      i. Workforce Members must notify Director/Manager/Supervisor of the area of any exposure immediately.
      ii. Director/Manager/Supervisor will refer Workforce member to the Emergency

Room for follow up.

iii. The Workforce Member is to notify their employer/agency or workers compensation as appropriate.

c. They participate in updating the bloodborne pathogen standard with respect to the procedures performed in their work area or department. "Safer Work Practices" (Safer Work Survey).

c. Our employees are expected to complete initial bloodborne pathogens training and annual review.

7. Employees will participate in the trial and selection of new safety devices.
   a. Safety rounds are conducted on an annual or as needed (for patient care units or departments) schedule.
   b. Information from the annual "Safer Work Survey" is compiled by the Safety/Environment of Care (EOC) Officer or designee and reports the results to the Environmental Health and Safety Committee (EHSC), the Infection Control Committee, and Products Standards Committee.
   c. Risk, Legal and Regulatory Services forwards information from Incident and Quality Review Reports (RL reports) to the Safety/EOC Officer, Infection Preventionist and or Materials Management as appropriate.
   d. The information will be used to update the Exposure Control Plan with respect to:
      i. Areas where engineering controls are currently employed.
      ii. Areas where engineering controls can be updated.
      iii. Areas currently not employing engineering controls, but where engineering controls could be beneficial.
8. Employee Health and Infection Control will be responsible for ensuring that all medical actions required are performed and that appropriate employee health and OSHA records are maintained. See the Employee Health Services policy "Occupational Exposure to Blood/Body Fluid Secretions."
   a. Hepatitis B vaccination series is available at no cost and employees are encouraged to be vaccinated. See the Employee Health Policy "Hepatitis B Vaccine Immunization Protocol."
   b. Exposure incidents are evaluated to determine if the case meets OSHA's Record keeping Requirements (29 CFR 1904). The maintenance of the OSHA log is an Employee Health responsibility.
   c. Medical records are maintained for each employee with occupational exposure in accordance with 29 CFR 1910.20, "Access to Employee Exposure and Medical Records." These confidential records are kept in Employee Health for at least the duration of employment plus 30 years and are provided upon request of the employee or to anyone having written consent of the employee within 15 working days.
   d. Recommendations are made to the Materials Management- when a need for a safety device or alternative product is detected.
   e. Recommendations are made to service or department managers when issues related to unsafe work practices are identified. Referrals are made to appropriate Medical Staff Chairpersons.
   f. Employee Health will present sharps Injury data specific to TCHD at the Infection Control Committee meeting annually (i.e. safety devices, work practice changes or engineering).

G. **EXPOSURE DETERMINATION:**

1. The State of California (Cal/OSHA) requires employers to perform an exposure determination concerning which Workforce Members may incur occupational exposure to blood or other potentially infectious materials (OPIM). The exposure determination is made without regard to the use of personal protective equipment (i.e., Workforce Members are considered to be exposed even if they wear personal protective equipment).
2. See Potential Blood Exposure by Job Category for a list of the job classifications in our facility where all or some Workforce Members handle human blood and OPIM, which may result in

possible exposure to bloodborne pathogens.

3. Since not all of the Workforce Members in these categories would be expected to incur exposure to blood OPIM, examples of tasks/procedures that would cause these Workforce Members to have occupational exposure are listed in Potential Blood Exposure by Job Category.

H. **ENGINEERING CONTROLS:**

1. One of the key aspects to our Exposure Control Plan is the use of Engineering Controls to eliminate or minimize Workforce Member exposure to bloodborne pathogens. On December 17, 1998 the Cal/OSHA Standards Board adopted emergency regulation revisions to Title 8, Section 5193 to meet mandates of Assembly Bill 1208. On January 2001, Federal OSHA was instructed to add sharps safety to national requirements. The major purpose of the revisions is to increase protection from sharps injuries by supplying Workforce Members with engineered sharps safety devices.
   a. If available, needleless systems are required for withdrawal of body fluids after the initial venous or arterial access is established administration of medications or fluids, and other procedures with potential for exposure to a contaminated needle.
   b. If needleless systems are not used then needles with engineered sharps injury protection are required for withdrawal of body fluids, accessing a vein or artery, administration of medication or fluids, and other procedures with potential for exposure to blood or OPIM.
   c. Other sharp devices with potential for contamination with blood or body fluids (e.g. scalpels, lancets, broken capillary tubes, and drills) are also required to have engineered sharps protection.
   d. TCHD is exempt from implementation if at least one the following is applicable.
      i. The device is not available in the marketplace.
      ii. A licensed healthcare professional directly involved in a patient's care determines that the use of the engineering control will jeopardize patient care or safety.
      iii. An objective product evaluation has been completed indicating that the device is not more effective in reducing sharps injuries than the device currently used by TCHD;
      iv. There is a lack of sufficient information to determine whether a new device on the market will effectively reduce the chances of a sharps injury and an objective product evaluation is being conducted.
   e. Contaminated needles and other contaminated sharps are not sheared or broken. They are not bent, recapped, or removed unless it can be demonstrated that there is no feasible alternative. Recapping or needle removal is accomplished using a mechanical device or a one-handed technique.
   f. Containers for contaminated sharps are easily accessible to personnel and located as close as is feasible to the area where sharps are used or can be reasonably anticipated to be found.
      i. Contaminated reusable sharps are placed in appropriate containers immediately, or as soon as possible, after use.
      ii. Sharps containers have the following characteristics: rigid, puncture-resistant, portable, if it is necessary to ensure easy access by user, color-coded and labeled with a biohazard warning label, and leak-proof on the sides and bottom. These containers lock when closed and do not reopen easily
      iii. The sharps containers for single use items are disposable and are not opened, emptied, or manually cleaned. In the event of a special circumstance when it would be necessary to access the container, it would be reprocessed or decontaminated.
      iv. The containers are maintained upright throughout use and are replaced as needed when ¾ full. A contract service is responsible for replacing containers as needed.

g. In addition to the engineering controls identified on these lists, the following engineering controls are used throughout our facility.
   i. Hand washing facilities and waterless hand cleansers are readily accessible to Workforce Members with potential for exposure.
   ii. Specimen containers are leak-proof. No special label/color coding is required for intra-facility specimens as Standard Precautions are utilized in the handling of all specimens and containers are recognizable as containing specimens.
   iii. Secondary containers are used if the specimen could puncture primary container or outside contamination.

I. WORK PRACTICE CONTROLS:

1. In addition to engineering controls, our facility uses a number of Work Practice Controls to help eliminate or minimize Workforce Member exposure to bloodborne pathogens.
   a. Workforce Members follow Standard Precautions with every patient. As a result, we treat all human blood and the following other potentially infectious materials (OPIM) as if they are known to be infectious for HBV, Hepatitis C Virus (HCV), HIV, and other bloodborne pathogens:
      i. Semen
      ii. Vaginal Secretions
      iii. Peritoneal fluid
      iv. Tissue and Organs
      v. Amniotic fluid
      vi. Synovial fluid
      vii. Pleural fluid
      viii. Saliva with visible blood
      ix. Pericardial fluid
      x. Cerebrospinal fluid
   b. Eating, drinking, smoking, applying cosmetics or lip balm and handling contact lenses is prohibited in work areas where there is potential for exposure to bloodborne pathogens.
      i. Food and drink are not kept in refrigerators, freezers, on countertops or in other storage areas where blood or other potentially infectious materials are present.
      ii. For example, eating and drinking is not allowed at nurses stations, in patient rooms, on patient bedside tables, or other places where patients, specimens, or dirty instruments/devices might have touched.
   c. Mouth pipetting/suctioning of blood or other infectious materials is prohibited.
   d. All procedures involving blood or other infectious materials are performed to minimize splashing, spraying or other actions generating droplets of these materials.
   e. Equipment, which becomes contaminated, is cleaned with a hospital-approved disinfectant as soon as possible.
      i. If shipping of equipment for repairs is required, the device will be cleaned or an appropriate biohazard-warning label is attached to any contaminated equipment, identifying the contaminated portions.
      ii. Information regarding the contamination is conveyed to all affected Workforce Members, the equipment manufacturer, and the equipment service representative.

J. PERSONAL PROTECTIVE EQUIPMENT (PPE):

1. PPE is the Workforce Member's 'last line of defense' against bloodborne pathogens. Because of this, our facility provides (at no cost to our Workforce Members) the Personal Protective Equipment that they need to protect themselves against such exposure. See Standard Precautions-Personal Protective Equipment Table for tasks/PPE suggested. This equipment includes, but is not limited to:
   a. Gloves
   b. Fluid resistant gowns

c. Glove liners
d. Laboratory coats
e. Face shield
f. Resuscitation bags
g. Masks
h. Hoods
i. Safety glasses/goggles
j. Shoe covers
k. Mouthpieces
l. Pocket masks

2. Personal Protective Equipment is stocked on supply carts, Pyxis dispensing stations, or available from Materials Management.
   a. Reusable PPE is cleaned, laundered, or decontaminated as needed. The hospital provides laundry services for laboratory coats designated as PPE.
   b. Single-use PPE (or equipment that cannot, for whatever reason, be decontaminated) is disposed in the regular waste container. Only items saturated and/or dripping with blood are disposed of in 'red-bag' trash.
3. Protective clothing (such as gowns and aprons) is worn whenever potential exposure to the body is anticipated. See Standard Precautions-Personal Protective Equipment Table.
   a. Any garments penetrated by blood or other infectious materials are removed immediately or as soon as feasible and all personal protective equipment is removed prior to leaving a work area.
   b. Surgical caps/hoods and/or shoe covers/boots are used in any instances where gross contamination is anticipated (such as autopsies, deliveries, and orthopedic surgery).
4. Gloves are worn as outlined in Standard Precautions and Standard Precautions-Personal Protective Equipment Table.
   a. Hypoallergenic gloves, glove liners, and similar alternatives are readily available to Workforce Members who are allergic to the gloves our facility normally uses.
   b. Utility gloves are decontaminated for reuse. If they are cracked, peeling, torn or exhibit other signs of deterioration they are discarded.
5. Masks and eye protection (such as goggles, face shields, etc.) are used whenever splashes or sprays may generate droplets of infectious materials. See Standard and Transmission Based Precautions and Standard Precautions-Personal Protective Equipment Table.

K. **ENVIRONMENTAL SERVICES:**

1. Environmental Services plays an important role in maintaining our facility in a clean and sanitary condition and is an important part of our Bloodborne Pathogens Compliance Program.
2. The Supervisor of Environmental Services is responsible for setting up our cleaning and decontamination schedule and making sure it is carried out within our facility.
3. To facilitate this, we have set up a written schedule for cleaning and decontamination of the various areas of the facility. See the Environmental Services Unit Specific Standards.
   a. All Workforce Members are responsible for maintaining a clean work area, equipment, and have hospital-approved disinfectants readily available to use on small spills. Environmental Services is called for assistance as needed with larger spills or special cleaning.
   b. All equipment and surfaces are cleaned and decontaminated after contact with blood or other potentially infectious materials. Patient care equipment and devices are cleaned between patients and after the completion of medical procedures. Work surfaces that may have been contaminated are cleaned at the end of the work shift.
   c. All pails, bins, cans and other receptacles intended for use are routinely inspected, cleaned and decontaminated as soon as possible if visibly contaminated.
   d. Potentially contaminated broken glassware is picked up using mechanical means (such as dustpan and brush, tongs, forceps, etc.). Only broken glass is placed in a Sharps Container.

4. All regulated waste is safely handled by staff according to TCHD policies and procedures. Disposal of all regulated waste is in accordance with California, State, and local regulations. See the Environment of Care Manual Section 6: Hazard Material Management: Waste Management Policy.
   a. See TCMC Waste Disposal Guidelines.
5. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until our outside contractors pick it up for off-site processing. Environmental services aides should hold the bags away from their bodies when removing waste. During removal, use heavy gloves to protect their hands from possible sharps injury, and do not push down on trash in garbage containers.
6. Regulated waste is placed in containers that are closable, constructed to contain all contents, and prevent leakage. They are labeled or color-coded and closed prior to removal to prevent spillage or protrusion of contents during handling.
7. All used linen is presumed contaminated and placed in appropriate containers labeled 'soiled linen'. All linen is handled as little as possible and is not sorted or rinsed where it is used. Plastic bags are used to contain potential contaminants and these soiled linen bags are transported in secondary containers to prevent leakage.
   a. Workforce Members who contact contaminated linen wear appropriate protective equipment (gloves and gowns if soiling of clothes is possible).
   b. Plastic soiled linen bags can be taken into a patient's room to contain used linen. These bags are then placed in the hamper or directly in the soiled linen room.
   c. Linen hampers lined with the plastic bags can also be used. When hampers are ¾ full, nursing staff will remove the bag, tie it off, and take it to the soiled linen room.
   d. Environmental Services is responsible for the collection and handling of our facility's contaminated waste until pick-up by our outside contractors for off-site processing.

L. **FORM(S):**
1. Potential Blood Exposure by Job Category
2. Products Steering Committee Product Evaluation
3. Safer Work Survey
4. Standard Precautions – Personal Protective Equipment
5. User Product Evaluation

M. **RELATED DOCUMENT(S):**
1. Employee Health and Wellness Policy: Injury and Illness Prevention Program
2. Employee Health and Wellness Policy: Occupational Exposure to Blood/Body Fluid Secretions
3. Environment of Care Policy: Hazardous Material and Waste Management and Communication Plan
4. Environment of Care Manual: Waste Management
5. Infection Control Procedure: Hand Hygiene
6. Infection Control Policy: Standard and Transmission Based Precautions
7. TCMC Waste Disposal Guidelines

N. **REFERENCE(S):**
1. Cal OSHA BBP Standard §5193. Bloodborne Pathogens, Subchapter 7. General Industry Safety Orders Group 16. Control of Hazardous Substances Article 109. Hazardous Substances and Processes 1998. https://www.dir.ca.gov/title8/5193.html (accessed 10/13/2020)
2. Medical Waste Management Act, California Health and Safety Code, Sections 117600 – 118360 California Medical Waste Management Program Information Copy — January 2017 https://www.cdph.ca.gov/Programs/CEH/DRSEM/CDPH%20Document%20Library/EMB/MedicalWaste/MedicalWasteManagementAct.pdf (accessed 10/13/2020)

3. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc. Waste Management Chapter 113
4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings http://www.cdc.gov/ncidod/dhqp/pdf/isolation2007.pdf (accessed 10/13/2020)

Tri-City Healthcare District
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**09/01**	**SUBJECT:**	**Cleaning, Disinfection and Sterilization**
REVISION DATE~~(S)~~:	**03/05, 03/06, 10/06, 04/09, 04/12, 09/15, 09/18**		

Infection Control Department Approval:	**05/18**
Infection Control Committee Approval:	**~~07/18~~11/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~08/18~~01/23**
Administration Approval:	**~~09/18~~02/23**
Professional affairs committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **PURPOSE:**

1. To provide guidelines for uniform and complete cleaning and disinfection or sterilization of patient care items as indicated on the basis of each item's intended use. Using the Spaulding classification scheme instruments and items for patient care are categorized as critical, semi critical, and noncritical. Situations which may impact the choice of disinfection or sterilization method may include complicated medical equipment, heat sensitive devices, and inactivation of certain types of infectious agents. Manufacturer recommendations and **Food and Drug Administration** (FDA) cleared instructions for chemical sterilants/high level disinfectants are considered in these cases.

B. **INTRODUCTION:**

1. Meticulous physical cleaning must precede disinfection and sterilization procedures. Agents used on items are called sterilants or disinfectants. Agents used on skin or tissue are called antiseptics.
2. Sterilization is the complete elimination or destruction of all forms of microbial life. Before use on each patient, critical medical and surgical devices and instruments that enter normally sterile tissue or the vascular system or through which a sterile body fluid flows are sterilized.
   a. Sterilization is accomplished by either physical or chemical processes. Steam under pressure, dry heat, or chemical sterilants such as plasma sterilization are used to process "critical" items.
3. High-level disinfection can be expected to destroy all microorganisms, with the exception of high numbers of bacterial spores.
   a. Items determined to be "semi-critical" touch mucous membranes or non-intact skin.
   b. High-level disinfection is accomplished by the preferred method of heat sterilization between patients when possible. Medical instruments that are not heat-stable (for example endoscopy and ultrasound probes) are processed using high level chemical disinfectants.
4. Intermediate-level disinfection can be expected to destroy vegetative bacteria, mycobacteria, most viruses, most fungi but not bacterial spores. An example would be an **Environmental Protection Agency** (EPA)- registered hospital disinfectant with label claim regarding tuberculocidal disinfectant. Appropriate for "noncritical" patient care items or surfaces with visible blood.
5. Low-level disinfection is appropriate for "noncritical" items that come in contact with intact skin. Some items that may come in contact with non-intact skin for a brief period of time are usually considered noncritical surfaces and are disinfected with intermediate-level disinfectants.

C. **POLICY:**

1. Sterilization Process
   a. All patient care objects needing sterilization will be cleaned of gross contamination in the area used and sent to Sterile Processing Department for complete processing. Don protective gloves and other required PPE prior to touching patient care items potentially contaminated with blood or body fluids.
   b. Visually check for used sharps and safely dispose of in a sharps container.
   c. Pre-clean at the point of use (OR suite, procedure room) with water or a product recommended for pre-cleaning with manufacturer's instructions-for-use followed to remove blood, body fluids, and bioburden from instruments.
   d. Keep items moist during transport to prevent hardening of bioburden (e.g. foam/gel spray, moist towel, etc.)
   e. Place items in a leak proof, puncture proof, biohazard labeled container for transport or pick-up.
   f. Refer to Sterile Processing Department policies and procedures.
2. High Level Disinfection
   a. High-level disinfection is provided for processing semi critical patient-care equipment that touches either mucous membranes or nonintact skin.
   b. Refer to Patient Care Services Procedures Manual "High Level Disinfection Procedure" for detailed instruction.
3. Low level disinfection
   a. Environmental Services (EVS) cleans/disinfects surfaces (e.g., floors, tabletops) on a regular basis, when large spills occur, and when these surfaces are visibly soiled.
   b. EVS staff follows manufacturers' instructions for proper use of disinfecting products, such as recommended use-dilution, contact time, material compatibility, storage, shelf-life, and safe use and disposal.
   c. Walls, blinds, and window curtains in patient-care areas are cleaned when visibly contaminated or soiled.
   d. Privacy curtains in patient- care areas are cleaned on a routine schedule (most areas are quarterly), in addition they are cleaned when visibly contaminated or soiled.
   e. An EPA-registered hospital disinfectant designed for housekeeping purposes in patient care areas is used.
   f. Wet-dusting of horizontal surfaces regularly is accomplished using clean cloths moistened with an EPA-registered hospital disinfectant.
   g. An EPA-registered sodium hypochlorite product is used to clean rooms housing patients with *C. difficile* Infection
   h. Rolling stock and other equipment that is to remain on the unit or at the bedside will be low-level disinfected using an EPA registered hospital disinfectant between patients whenever possible and when visibly soiled. Some examples of equipment include blood pressure cuffs on portable machines, IV poles, ventilators or bedside commodes (cover with plastic bag); bed scales, wheelchairs, medication and supply carts.
4. Spills of blood and other potentially infectious materials are contained and cleaned as soon as possible.
   a. Promptly clean and decontaminate spills of blood and other potentially infectious materials. Disinfect areas contaminated with blood spills using an EPA-registered tuberculocidal agent, or products with specific label claims for HIV or HBV or freshly diluted hypochlorite solution. If the spill contains large amounts of blood or body fluids, clean the visible matter with disposable absorbent material, and discard the contaminated materials in appropriate, labeled containment.

b. Hospital-approved products (for example Sani cloth and Dispatch) are to be used by staff for cleaning of small spills.
c. Large spills (over 200cc) are cleaned by Environmental Services. A solidifying agent may be used for large spills.
d. Wear personal protective equipment to prevent exposure from touch or splashes. This should always include gloves and the addition of a plastic apron or gown and face protection as needed.
e. Contaminated glass or sharps are picked up with forceps or like instrument. Place in an emesis basin or other puncture proof container to carry to a sharps container for disposal.
f. If the paper towels are used to mop up the spill and they are saturated and/or dripping with blood, dispose of in red biohazard bag trash. Paper towels not saturated and/or dripping with blood are placed in a regular trash container. Cloth towels and linen used to clean spills are placed in the soiled linen containers.

5. Occupational Safety and Health Administration (OSHA) requires Environmental Protection Agency (EPA) approved products for cleaning of blood and other potentially infectious materials.
   a. These products are labeled as "tuberculocidal" or effective against Hepatitis B and HIV.
   b. Follow the manufacturer's instructions for how long the surface must stay wet to be effective (wet/contact time).

D. **REFERENCE(S)**:

1. Centers for Disease Control and Prevention. (2007). Guideline for Isolation Precautions in Hospitals.
2. BBP Standard, Title 8 California Code of Regulations, Updated 1999.
3. Centers for Disease Control and Prevention. Guidelines for environmental infection control in health-care facilities: recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). MMWR 2003;52 (No. RR-10)
4. Rutala, W., Weber, D., & the Healthcare Infection Control Practices Advisory Committee (HICPAC) (2008). Guideline for Disinfection and Sterilization in Healthcare Facilities, 2008. Retrieved from http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html
5. Friedman, C. (2014). Infection Prevention and Control Programs. In P. Grota (Ed.), *APIC Text of Infection Control and Epidemiology* (4th ed). Washington DC; 2014.

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE:	**07/02**	**SUBJECT: Infection Prevention Program Plan**
REVISION DATE~~(S)~~:	**04/09, 05/12, 09/15, 09/18, 05/22 09/18**	

Infection Control Department Approval:	**~~07~~5/22~~4~~**
Infection Control Committee Approval:	**~~11/21~~11/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/22~~01/23**
Administration Approval:	**~~03/22~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**09/18**

A. **PURPOSE:**

The purpose of the Infection Prevention (IP) Program Plan is to **outline the annual infection prevention priorities of Infection Prevention and Tri-City Medical Center (TCMC).** ~~. See Related Document: Responsibility and Scope of Service.~~

~~1.)reduce or limit the risks of acquiring or transmitting healthcare-associated infections (HAIs) and/or epidemiologically significant microorganisms among patients, healthcare workers, physicians, volunteers, visitors, and other guests.~~ In order to achieve ~~this goal~~, **an organized systematic plan is developed based upon the annual infection control risk assessment that provides the foundation for an effective infection prevention program.** ~~well defined policies and surveillance methodologies are employed to limit organism transmission:~~

~~a. During patient care activities,~~

~~b. During the use of hospital medical equipment, devices and supplies,~~

~~c. From the hospital environment, and~~

~~d. The hands of healthcare personnel~~

~~2. Effective infection prevention and control requires collaboration with leadership, risk management, performance improvement, patient safety, and clinical staff.~~

1.

B. ~~OPERATIONAL OBJECTIVES~~**GOALS:**

1. Overall

a. Reduce risk of healthcare-associated infections for all patients, employees, and visitors.

2. Targeted

a. Healthcare-associated infection reduction – at least ~~6~~20% reduction overall across the infection types that are reported to CMS (MRSA bacteremia, *C.difficile*, CLABSI; SSI Hysterectomy~~; SSI~~ and Colon surgery; CAUTI). (Note: ~~these~~ infection countes are based on CMS reaquired reporting regulations, not necessarily all hospital-wide infectiitons)

b. Clean in, Clean out hand hygiene compliance program

i. Incorporate patients and families

1) Develop a bundle of tools for patients and family involvement

ii. Consistently sustain ≥90 percent compliance across locations and job classes

1) At least 90 percent of all locations and job classes must sustain 90 percent compliance or higher (for all locations/job classes submitting at least 25 observations/month)

iii. Promote engagement
1) Develop tools for promoting involvement across all job categories
2) develop new incentives and rewards.~~The scope of the infection prevention program addresses all pertinent services and sites of care in the organization. It includes surveillance, prevention and control of infections in patients, healthcare workers and visitors in the inpatient and ambulatory outpatient care settings. See Related Document: Responsibility and Scope of Service~~

C. RISK ASSESSMENT:
1. See Attachment 1: Annual Facility Infection Risk Assessment
2. Patient Populations at Increased Risk of Infection
   a. All intensive care unit patients
   b. Immunosuppressed patients (e.g., absolute neutrophil count (ANC) <1000
3. Procedures/Devices that Increase Infection Risk
   a. Central venous catheters
   b. Indwelling urinary catheters
   c. Tubes, drains, other devices inserted percutaneously
   d. Intubation and prolonged ventilator support
   e. Surgical procedures
   f. ECMO/VAD
4. Epidemiologically Important Pathogens
   a. Legionella
   b. Aspergillus
   c. MRSA
   d. VRE
   e. *C. difficile*
   f. MDR Gram negative bacteria
   g. Carbapenem-resistant *Enterobacteriacae*
   h. *Candida auris*
5. Highly Communicable Diseases
   a. Novel Influenza virus
   b. SARS-CoV
   c. MERS
   d. Viral hemorrhagic fevers (e.g., Lassa fever, Ebola viral disease)
   e. Vaccine preventable disease (e.g., Measles, Pertussis)

D. ~~General Strategies to Reduce Infection Risk~~<u>GENERAL STRATEGIES TO REDUCE INFECTION RISK:</u>
1. Identify risk for acquiring and transmitting infections based geographic location, community and population served
   a. Receive public health alerts on community illnesses and trends from the California Department of Public Health (CDPH).
   b. Act as liaison between the medical center and the public health department.
   c. Attend monthly Association for Professional in Infection Control and Epidemiology (APIC) local chapter meetings with other facilities in our area.
2. Identify and control outbreaks
   a. Review of microbiology, immunology, molecular microbiology reports
   b. Institution of prevention and control measures as indicated (e.g., isolation, cohorting of patients and staff, improved hand hygiene, active surveillance cultures, assessment of environmental cleaning, enhanced environmental cleaning)
   c. Exposure follow-up (in conjunction with Employee Health~~OHS~~)
3. Perform surveillance for healthcare-associated infections
   a. Follow CDC National Healthcare Safety Network (NHSN) definitions

b. Comprehensive: inpatient-related and outpatient-detected
c. Calculation/distribution of monthly infection rates and line listing of infected patients for each inpatient unit/service line
d. Monthly and as needed analysis of potential for cross-transmission
e. Targeted surveillance for home health/hospice infections
f. Monitor incidence of healthcare-associated device-related or procedure-related infections
    i. Catheter-Associated Urinary Tract Infections (CAUTI)
    ii. Central Line-Associated Bloodstream Infections (CLABSI)
    iii. Ventilator-Associated Events (VAE)
    iv. Surgical Site Infections (SSI)

4. Conduct routine monitoring
    a. Biological indicators for sterilizers
    b. Endoscopes
5. Improve Hand Hygiene Compliance
    a. Support compliance monitoring and provide feedback to staff.
    b. Routinely evaluate the availability and acceptability of hand hygiene products.
    c. Provide just-in-time peer coaching.
    d. Provide frequent and tailored education on when and how to perform hand hygiene along with frequent visible reminders.
    e. Enlist organizational leaders to serve as role models.
    f. Ensure commitment of leadership to achieve and sustain compliance of $\geq$ 90%.
6. Develop and Support Infection Control Liaison Program
    a. Unit-based staff, outpatient care services clinical staff, and ancillary care staff (i.e., EVS, FNS, Patient Transport) with focused infection control training provided by Infection Prevention.
    b. Responsible for assessing their unit's compliance with infection control policies/procedures and conducting performance improvement activities related to infection prevention (e.g., reducing device-associated infections, monitoring and improving hand hygiene compliance)
    c. Serves as the contact person to disseminate infection control information, updates, and answer staff questions
7. Ensure compliance with TJC National Patient Safety Goals
    a. Comply with WHO/CDC hand hygiene guidelines
    b. Prevent HAIs due to multi-drug resistant organisms (MDROs)
        i. Annual risk assessment for MDROs
        ii. Implement and assess prevention strategies outlined in this plan and under NPSG 07.03.01
    c. Assess compliance with evidence-based practices for prevention of central line-associated bloodstream infections
        i. Compliance with Central Line Insertions, Access, and Maintenance Bundle
        ii. Standardized insertion training and checklist for providers.
        iii. Chlorhexidine bathing in intensive care units, and for all patients hospital-wide with a central line.
        iv. Daily assessment for central line need
        v. Provide Central Line-Associated Bloodstream Infection rate data and prevention process measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians
    d. Assess compliance with evidence-based practices for prevention of surgical site infections

i. Ensure patient education provided in Pre-op visit. Use LMS for staff education.
ii. Promote standardized, evidence-based practices for patient skin preparation prior to surgery.
iii. Ensure Peri-Operative Services and Anesthesia infection control policies support prevention strategies.
iv. Trend surgical procedure specific infection rates and unit rates and provide feedback to key stakeholders

e. Implement evidence-based strategies for prevention of catheter-associated urinary tract infections
i. Staff education regarding aseptic insertion of catheter
ii. Insertion order must include indication for catheter
iii. Daily assessment for urinary catheter need
iv. Appropriate maintenance of indwelling urinary catheters
v. Perform periodic audits on Indwelling Urinary Catheter Maintenance compliance and removal protocol and disseminate process measures on compliance to unit leadership quarterly.

8. Manage HAIs as Sentinel Events When Indicated
a. Review all HAIs for indications of an unanticipated death or permanent loss of function
b. Notify Risk Management of suspected sentinel event
c. Participate in root cause analysis and follow up as needed
9. Construction Rounds and Construction Risk Assessment Meetings
a. Walking rounds with Facilities Engineering monthly to active construction and renovation sites in the medical center and on an as needed basis.
b. Attend construction meetings held by Facilities and Contract services.
c. Review blueprints and risk assessments for all new construction and renovations in clinical areas.
10. Infection Control Rounds
a. Evaluate compliance with infection control policies/practices.
b. Written recommendations to manager with their follow-up documented.
11. Policy Review and Revision
12. Committee Participation: Refer to Infection Prevention Program Policy for committee information.
13. Periodic Comprehensive TB Risk Assessment
14. Consultation, Education/Training
a. In-services, presentations, educational material to staff, visitors/families, medical staff, contract employees, students, and volunteers
b. Computer-based training modules
c. Educational videos
d. Newsletter articles
e. Educational materials (e.g., brochures, booklets)
f. On-call availability 24/7 for Infection Prevention consultation
15. Additional Strategies to Reduce Infections for the Immunosuppressed Patient (e.g. absolute neutrophil count [ANC<1000], agranulocytosis)
a. Ideally a private positive pressure room
b. No live plants or fresh flowers
c. Patient must wear tight-fitting surgical mask when outside room
d. Child visitor restrictions during influenza and RSV season
16. Additional Strategies for Home Health and Hospice
a. Trend analysis of wound infections, device-related infections (urinary catheter-associated UTIs and central line-associated bloodstream infections)

b. Promote immunizations to prevent respiratory infections: influenza and pneumococcal pneumonia vaccines (as recommended by ACIP)

17. Additional Strategies for Outpatient Care Services
    a. Since most patient encounters with the healthcare system now take place in outpatient settings, TCMC will maintain infection prevention programs in Outpatient Care Services, and this will include
    b. Training and monitoring of practices on:
        i. the basic principles of disease transmission and the methods to prevent transmission
        ii. Safe injection practices and proper use of single use and single patient devices/ medications
        iii. principles of asepsis and hand hygiene
        iv. OSHA Bloodborne Pathogen Standard
        v. the principles of disinfection and sterilization
        ~~i.~~vi. TB and respiratory protection per OSHA

E. SPECIFIC STRATEGIES TO ADDRESS INFECTION RISKS:

1. Based on the Facility Risk Assessment, the following strategies will be employed in FY22 for elements with scores of >6:
    a. Central line Bloodstream infections (CLABSI)
        i. Multi-disciplinary workgroup
        ii. Vascular access assessment
        iii. Implementation of central line decision tool
        iv. Implementation of ICU nasal decolonization
    b. Water Intrusion
        i. Multi-disciplinary Workgroup
        ii. Trial wipe alternative for bathing
        iii. Policy development
    c. Personal Protective Equipment (PPE) Compliance
        i. Compliance monitoring
        ii. Staff education and competency check-off

F. EVALUATION OF PLAN EFFECTIVENESS:

1. Statistical analysis of infections
2. Trend analysis of infection rates
3. Healthcare-acquired infection rates to include home health.
4. Monthly infection reports to nurse managers, clinical directors, infection control liaisons
5. Quarterly infection reports to Infection Control Committee
6. Infection Control rounds report and annual compliance assessment
7. Support Employee Health Services to monitor compliance with required and recommended immunizations
8. Annual assessment of communicable disease exposures with trend analysis
9. Annual risk assessment for MDROs with trend analysis
10. Periodic assessment of process measures with staff feedback
    a. Evidence based processes to prevent surgical site infections
    b. Evidence based processes to prevent catheter associated bloodstream infections
    c. Evidence based processes to prevent catheter associated urinary tract infections
    d. Evidence based processes to prevent *Clostridioides difficile* infections
    e. Evidence based processes to prevent ventilator associated events
    f. Hand hygiene compliance

g. Isolation precautions compliance

G. RELATED DOCUMENT(S):

1. **TCMC Risk Assessment**
2. **Infection Prevention Program**

H. REFERENCE(S):

1. APIC Text of Infection Control and Epidemiology, 2021.
2. Joint Commission, Hospital Accreditation Standards, Chapter: Infection Prevention and Control, www.jointcommission.org
3. CMS Conditions of Participation: IC
4. Title 22, Calif. Code of Regulations

~~1. Epidemiological principles and methodologies are employed to achieve the following objectives:~~
~~a. Design systematic methods for managing resources and information in order to satisfy documentation requirements and generate useful infection surveillance data~~
~~b. Develop policies and procedures which are evidence-based and validate criteria and standards which delineate approved infection prevention and control practices in compliance with regulatory statutes and accrediting agency standards~~
~~c. Define and describe the distribution and determinants of infectious disease and epidemiologically significant microorganisms within the healthcare environment~~
~~d. Identify causal relationships and risk factors associated with disease acquisition and transmission.~~
~~e. Establish an ongoing program of self-assessment and continuous quality improvement based on a system of identifying, documenting, and resolving infection prevention and control issues and problems through a process of monitoring, analyzing, and evaluating sole and aggregate infection surveillance data~~
~~f. Design and implement effective infection control audits, tracer studies, corrective action plans, and outbreak management and intervention strategies which prevent or control the spread of infection, and promote a healthful environment~~
~~g. Develop an effective means of communicating infection control and prevention information and the infection surveillance status of the organization to the appropriate individuals, thereby creating a heightened awareness of infection control and prevention issues and engendering administrative action and resource support, when necessary~~
~~h. Promote an infection control program and plan design which is cost effective and in compliance with the Centers for Disease Control and Prevention (CDC) guidelines, applicable laws and regulations, accrediting agency standards, and recognized prudent infection control practices~~
~~i. Prepare for a mass influx of highly contagious patients, especially those requiring airborne precautions~~
~~j. Provide a system for evaluating the effectiveness of program performance and implementation~~

~~B. STATEMENT OF AUTHORITY:~~
~~1. Responsibility [TJC IC.01.01.01, CMS §482.42 (a), GACHRLS HSC §1288.95]~~
~~a. The Medical Executive Committee (MEC) by Authorization of the Board of Directors, delegates to the Infection Prevention Committee (IPC), through Tri-City Medical Center's Medical Director of Infection Prevention and the Infection Preventionist the responsibility and authority for ensuring that infectious disease precaution policies are adhered to and correct procedures are maintained by all departments and all levels of personnel. The program design is based on requirements and guidelines from governmental agencies such as the Centers for Disease Control and Prevention (CDC), The Joint Commission~~

(TJC), the California Occupational Health and Safety Administration (CALOSHA), the California Administrative Code, the California Department of Public Health (CDPH).

b. Individuals responsible for the Infection Prevention Program.
   i. The IP Program requires management by an individual with knowledge that is appropriate to the risks identified by the hospital, as well as knowledge of the analysis of infection risks, principles of infection prevention, and data analysis.
   ii. The Medical Director of Infection Prevention is an infectious disease physician.
   iii. Management responsibilities for the IP program at TCMC has been assigned to the Infection Preventionist.
   iv. The IP Department has been given authority to develop, implement and enforce the IP Program policies, effectiveness of prevention and/or control activities and interventions.
   v. The IP Department has the authority to order patient isolation or patient testing as requested by the local public health authorities.
   vi. The Infection Preventionist will report to the Director of Clinical Quality Resources.
   vii. Hours of operation are M-F 8:00-4:030, and on call after hours and weekends.
c. Maintenance of qualifications for Infection Prevention Leadership [TJC IC.01.01.01]
   i. There will be no less than 1 certified Infection Preventionist, who will be certified (CIC) through the national certification board of Infection Control and Epidemiology (CBIC).
   ii. The IP staff will maintain competency in all essential elements of the job through professional organizations and through educational offerings relevant to the position. These educational offerings may include webinars, self-learning modules, or hospital programs.
   iii. The Infection Prevention Department Head will maintain membership in infection control associations (National APIC, San Diego County Chapter of APIC)
   iv. The Infection Prevention Committee Chairperson designated hospital epidemiologist will participate in a continuing medical education (CME) training program offered by the CDC and Society for Healthcare Epidemiologists of America (SHEA), or other recognized professional organization. Documentation of attendance will be placed in the physician's credentialing file.
d. Allocation of resources for the Infection Prevention Program
   i. Hospital leaders will allocate needed resources for the Infection Prevention Program and provide systems to support infection prevention activities. In determining the number of Infection Preventionists and support staff, the organization considers patient census, characteristics of the patient population, and the complexity of the healthcare services to assure that resources are adequate to accomplish the task required for the infection prevention program.
   ii. Hospital leadership will review, on an ongoing basis (but no less frequently than annually), the resources and the effectiveness of the hospital's infection prevention activities.
   iii. Systems to access information will be provided to support infection prevention activities, such as CernerWorks.
   iv. Laboratory support will be provided to support infection prevention activities. Reference laboratory services may be utilized for assistance in specialty areas such as strain typing.
   v. Equipment, supplies, and resource materials will be provided to support infection prevention activities; the Infection Prevention department has the necessary computer hardware and software to support surveillance and analysis, a designated printer/copier, and confidential fax.
   vi. Infection Prevention personnel will have appropriate access to medical or other relevant records and to staff members who can provide information on the adequacy of the institution's compliance with regard to regulations, standards,

and guidelines.

vii. The support of the Information Technology Department will be provided to assist in compliance with required reporting of infection surveillance information to external organizations.

e. Shared responsibilities for the Infection Prevention Program

i. The prevention of infections is a shared responsibility among all clinical and non-clinical staff in the hospital.

ii. Medical Staff Responsibilities: The Medical Directors and Medical Staff provide expertise from their respective areas and disciplines in conjunction with the members of the Infection Prevention Committee to assist with preventing infections.

iii. Department Specific Responsibilities: The Managers/Directors or their designee are responsible for monitoring employees and assuring compliance with infection prevention policies and procedures. Responsibilities include, but are not limited to:

1) Monitor cleanliness of their departments or units.
2) Monitor compliance with use and documentation related to high-level disinfection, as appropriate for their job functions.
3) Assure that healthcare workers use safe and effective practices for all cleaning, disinfection, and sterilization, as appropriate for their job functions and in accordance with policy.
4) Monitor compliance with hand hygiene policies.
5) Coordinate with Infection Prevention to plan and implement educational or in service programs on the prevention of infections.
6) Orient existing and new staff on infection prevention issues and risks specific to their job duties, i.e. sharps safety, medical waste handling, infection prevention policies and National Patient Safety Goals.
7) Ensure proper documentation for invasive devices (central lines, ventilators, and urinary catheters) and monitor use for medical necessity.
8) Ensuring proper patient care practices and product safety are maintained in the unit.
9) Revising and updating departmental policies relating to infection prevention in collaboration with the Infection Prevention personnel

iv. Healthcare Worker Responsibilities: All healthcare workers of the organization have responsibilities in preventing the spread of infection and will:

1) Not report to work with signs and symptoms of illness e.g., diarrhea, conjunctivitis, or fever.
2) Notify Infection Prevention Department of infection related issues.
3) Comply with required immunizations.
4) Participate fully in the Caregiver Health Program.
5) Complete orientation and annual education review and test.
6) Participate in the review of infection prevention data within own departments.
7) Use safety sharps and safe handling of sharps to avoid blood borne pathogen exposure.
8) Avoid food and drink in areas of patient care
9) Adhere to Infection Prevention policies for prevention of healthcare associated infections (Infection Prevention Manual in **Policy Manager**Lucidoc)
10) Adhere to hand hygiene guidelines

C. **INFECTION PREVENTION COMMITTEE [TJC IC.01.05.01, GACHRLS HSC §70739:**

1. The purpose of the Infection Prevention Committee is to provide a planned, systematic, system-wide approach to designing, measuring, assessing and improving performance related to the

infection prevention program thereby providing a safe environment for patients, employees, physicians, visitors, and others.

2. **Function**
   a. Review, analyze and evaluate patient infection rates and trends in employee exposures, injuries and resulting illnesses.
   b. Define and approve the type and scope of surveillance, prevention and control activities annually.
   c. Promote continuing education related to infection prevention and control for medical staff and hospital personnel.
   d. Establish protocols for special studies or focused reviews.
   e. Review and approve major changes made to any hospital-wide and/or individual department infection prevention and control policies and procedures. The Infection Prevention Department Head has the authority to approve minor changes and will conduct a review of the above mentioned policies/procedures every three years or as needed per changes in practices, regulations and standards.
3. **Reporting**
   a. The Committee reports activities and surveillance data through the TCMC's Quality Assurance Performance Improvement (QAPI) Committee on a regularly scheduled basis with quarterly review of established scorecards. The Committee minutes are routed to the TCMC Medical Staff Executive Committee. Reports may be presented to other individuals/groups/departments that need to be aware of the information presented or problems identified so they may be involved in corrective actions, resolutions and evaluations. Copies of all reports are kept on file in the Infection Prevention department office.
4. **Membership**
   a. The Infection Prevention Committee is a medical staff committee chaired by the TCMC Chair of Infection Prevention with interdisciplinary representation of at least the following:
      i. Medical staff which may include: hospitalist; surgeon; administration; quality improvement; risk management; microbiology; nursing; perioperative/surgical services; pharmacy; employee health.
   b. TCMC's Infection Prevention Department Head is an active member who oversees the agenda as it relates to infection prevention issues.
   c. Upon request from the IP medical director, other departments/service (e.g. environmental services, facilities, respiratory care, sterile processing, etc.) will send a representative on an ad hoc basis when issues arise requiring their input or expertise.
5. **Meetings**
   a. The TCMC Infection Prevention Committee will meet at a minimum **four times**quarterly per year. Regular agenda items related to infection prevention, employee health, and performance improvement will be discussed and all conclusions, recommendations and actions will be documented in the minutes.
6. **Statement of Authority**
   a. The Infection Prevention Committee, or its designee, has the responsibility and authority to ensure compliance with Infection Prevention policies and procedures, to make decisions regarding their implementation, and to institute any specific surveillance, isolation, prevention and/or control measures deemed necessary when there is reason to believe that any patient, healthcare worker or other person may be in danger of contracting or transmitting an infectious disease or an epidemiologically significant microorganism.

D. **SCOPE OF PROGRAM:**

1. The infection prevention program is multidisciplinary/interdisciplinary and works in conjunction with all facilities, clinics, departments and services associated with TCMC to assess and integrate quality care practices and infection prevention and control principles.
2. **Management Processes [TJC IC.01.03.01 – IC.01.05.01]**

a. **Policy Development**
   i. Decisions concerning the design, construction, and appropriateness of Infection Prevention policies are based on published criteria and guidelines from recognized technical sources such as the Centers for Disease Control and Prevention (CDC), the Healthcare Infection Control Practices Advisory Committee (HICPAC), the American Society for Microbiology (ASM), the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Hospital Epidemiologists of America (SHEA), The Joint Commission (TJC), the California Department of Public Health (CDPH) and other relevant professional societies, accrediting organizations, and government agencies.

b. **Risk Assessment**
   i. Risk assessments are conducted annually and as needed, to proactively evaluate the impact patient care services, infection prevention and control practices, and surveillance methodologies have on controlling and/or reducing healthcare-associated infection (HAI) transmission and the prevalence of epidemiologically significant organisms. These assessments follow standard guidelines and are supported by scientific evidence.

c. **Performance Improvement**
   i. The methodologies employed for performance improvement encompass goal-setting, monitoring performance indicators, and assessing sentinel/unusual events, using retrospective root cause analysis (incident review). Incidents in which a healthcare-associated infection is related to serious temporary harm are treated as sentinel events. Performance indicators are defined for organism surveillance, healthcare-associated infection surveillance, and infection prevention surveillance.

d. **Data Management and Dissemination**
   i. Data Collection and management is fully described in the *Infection Prevention Program Information Management Pathway* graphic **in Related Documents** which delineates case finding and database sources, evaluation and analytical techniques, and information dissemination.n (see Section VI). Data and information derived from these various input sources are then used to compile Quarterly and Annual Reports for dissemination to the Infection Prevention Committee, selected management team members, the QAPI Committee and the Medical Staff Executive Committee.

e. **Educational Programs [NPSG.07.013.01; NPSG.07.04.01; NPSG 07.05.01, GACHRLS HSC §1288.95]**
   i. **Healthcare Worker**
      1) A variety of educational programs are provided for healthcare worker orientation, in-service, and continuing education. Standard educational methodologies are employed in curriculum design and development and include the use of educational objectives to assess the effectiveness of the instruction. Formal standardized instruction is given to all new employees and physicians during their orientation. Patient care personnel receive additional instruction relevant to the patient care environment. Additionally, healthcare personnel receive annual infection prevention instruction via computer learning modules. Further educational modalities include Infection Prevention rounds. Lastly, EVS are trained by the hospital and observed for compliance with sanitation measures via high touch audits. Training is given at the start of employment, when new prevention measures have been adopted, and annually thereafter.
   ii. **Patient and/or Family [TJC IC 0.02.01.01 EP 7, NPSG 07.03.01 EP 3]**

1) The patient and/or family is provided various infection prevention related educational materials during their hospital stay. During their hospital stay if the patient is placed in isolation precautions, has specific organisms (i.e., MRSA, VRE, *Clostridium difficile*) and/or has a healthcare-associated infection (i.e., surgical site infection (SSI), device-associated infection) the patient and/or family is given information which addresses frequently asked questions.

3. **Surveillance [TJC IC.02.01.01, IC.01.05.01, CMS §482.13, 482.42, 482.51, GACHRLS HSC §1288.8**
   a. **Healthcare-Associated Infection Criteria**
      i. All infections identified by surveillance are classified as either healthcare-associated (HA) or community-acquired (CA). The criteria is defined by the Centers for Disease Control and Prevention (CDC) and the National Healthcare Safety Network (NHSN), approved by the Infection Prevention Committee and is used by Infection Prevention to determine whether an infection is healthcare-associated or community-acquired.
   b. **Infection Surveillance Methods**
      i. A variety of surveillance methods are employed to routinely collect standardized information which is analyzed and used to describe and define the occurrence and distribution of infection rates or sentinel/unusual occurrences of infections.
         1) *Focused surveillance* is conducted on certain high-risk procedures, patient populations or specific infections/organisms that are determined annually by the Infection Prevention Program Plan with input from the Infection Prevention Committee or as mandated by state or federal requirements.
         2) *Periodic priority-directed targeted surveillance* is conducted for specific units or departments, specific patient populations or specific procedures or clinical indicators as a method for identifying problems. This determined by the Infection Prevention program director with input from various departments such as Employee Health, Quality and Risk Management, OR Committee and/or other Medical Committees. Examples include; employee exposures, compliance with isolation precautions or other infection control protocols, etc.
         3) *Cluster or outbreak investigation [GACHRLS HSC §70737]* becomes the immediate top priority at any time an unexpected occurrence or frequency of infections becomes evident, such as:
            a) Clustering of infections above expected levels
            b) Cases of unusual or epidemiologically significant organism infections, surgical procedures or specific areas with an increased number or an unusually high incidence of infections (i.e. bacteremias, wound infections, respiratory infections). Indicators of such increased incidence may include microbiology reports, or notification from physicians, staff members, or the Health Department.
            c) Immediate notification will be made to the IP Medical Director as it relates to the cluster/outbreaks.
         4) *Communicable/Infectious disease exposure investigation and follow-up [GACHRLS HSC §70737]* becomes an immediate priority whenever a patient and/or employee is involved in an exposure to a communicable disease. Infection Prevention and Employee Health collaborate with the TCMC Infection Prevention Medical Chairperson to implement post exposure follow up:
            a) Notification of patient/employee exposures from staff or the

Quality Reporting Event system (RL Solutions)
b) Determining the nature of exposure and level of infectiousness
c) Placing involved persons in appropriate precautions or work restrictions
d) Conducting the appropriate follow-up and record keeping

5) *Notifiable conditions [GACHRLS HSC §70737]* monitoring and reporting is conducted on an ongoing basis throughout the year in accordance with the Title 17 provisions of the California Administrative Code as well as to San Diego County Public Health Services (SDCPH) requirements.

6) *Notification of surgical site infections performed at outside facilities.* When a surgical site infection is identified that was not performed at TCMC, the Infection Prevention department notifies that hospital's infection prevention department that a surgical site infection has occurred.

7) *Surgical Site Infection Investigations:* Surgical site infections will be identified according to NHSN definitions. When a surgical site infection is identified, a notification is provided to the surgeon's office and surgeon, and the IP Medical Director. If trends in SSI are identified by IP staff, it is reported to the appropriate committee and the IP Medical Director. Identification of infections will be conducted through:
a) Monitoring daily census for readmissions for wounds/cellulitis.
b) Reviewing wound cultures for possible surgical site infections.
c) MD self reports via phone or email
d) Notification by staff nurses for possible healthcare-associated infections
e) Community networking with other Infection Preventionists: Infection Preventionists from other hospitals notify **the** our Infection Prevention Department**t**. of admissions related to procedures performed at TCMC.

8) *MRSA Screening:* Per Senate Bill 1058, a process is in place to screen select patients for MRSA within 24 hours of admission if the following criteria is met:
a) Admit or transfer to Intensive Care Unit (ICU) or Neonatal Intensive Care Unit (NICU) unless tested positive during this admission.
b) Receiving inpatient dialysis.
c) Previously discharged from a general acute care hospital; within the last 30 days.
d) The patient is transferred from a skilled nursing facility.
e) Pre-op screening for MRSA may be deemed appropriate for other procedures and ordered at the discretion of the surgeon/admitting MD.
f) Discharge criteria includes patients who were screened on admit and had a negative result but may be at risk for invasive MRSA **to be determined by the physician/Allied health Professional.**

4. **Inter-departmental Oversight [TJC IC.02.02.01 – IC.02.04.01]**
a. **Sterilization and Disinfection**
i. Sterilization and disinfection practices are based on a technical understanding of the physical, chemical, and microbiological factors which influence these methodologies.
ii. Standardized protocols are developed and monitored in compliance with CDC and Association for the Advancement of Medical Instrumentation

(AAMI) guidelines.

b. **Environment of Care**
   i. Infection Prevention is a member of the Environment of Care (EOC) Rounds team and conducts quarterly rounds with follow-up required by the surveyed department.
   ii. Air-handling system monitoring to ensure that there is proper air exchange, positive and negative air pressure differentials, HEPA filter integrity, and preventive cleaning where appropriate.
   iii. Infection Prevention oversees renovation and repair activities which includes delineating engineering controls and infection control practices necessary to limit the dispersal of infectious organisms. This management process includes performing a risk assessment and issuing Infection Prevention Permits describing approved containment procedures.
   iv. Water systems are managed in accordance with Environment of Care standards EC.02.05.01 and EP 1-13, and the ANSI/ASHRAE standard 188 for the purpose of preventing the growth and survival of *Legionella* and other waterborne bacteria in the utility water systems. The details of this are described in the TCMC Waterborne Illness.
   v. Infection Prevention consults on renovation and construction activities which includes delineating engineering controls and infection prevention practices necessary to limit the dispersal of infectious organisms. This management process includes performing an infection control risk assessment (ICRA) delineating approved containment procedures.
   vi. Infection Prevention oversees procedures for remediation after environmental emergencies such as air handling system failures, water leaks, mold growth, and loss of structural integrity.
   vii. Environmental microbiological culturing is not routinely performed except in a few specific situations, i.e. targeted ambient bioaerosol sampling and water used for dialysis procedures. Otherwise, environmental cultures are obtained only when inanimate surfaces, ambient air, equipment, instruments, solutions, drugs, etc. appear to be associated with disease transmission or outbreak investigation.

c. **Emergency Management [TJC IC 01.06.01]**
   i. The Infection Prevention department collaborates with the Emergency Management team in the development and implementation of the mitigation, preparedness, and response and recovery phases of the Emergency Management Plan for TCMC. IP provides input and consultation regarding surge capacity, their role in the incident command system, environmental concerns in the physical plant, occupational health during disasters, and prioritizing limited resources that may affect infection transmission. Policies have been developed to prepare TCMC to deliver vital care, treatment and services in the event of an emergency incident or disaster.
   ii. The Infection Prevention department receives current information about the emergence of epidemics or new infections through California Health Alert Network (CAHAN), San Diego County Public Health alerts, CDC, APIC Alerts, EPI newsletters, and email and fax alerts from the Local Health Officer. In addition, the organization participates in State and Local emergency preparedness drills.

d. **Product and Program/ Product Line Evaluation**
   i. Proposed new hospital programs/product lines, or those undergoing substantive alteration, are appropriately subject to review by Infection Prevention while in the planning stage regarding the potential for increased Healthcare- Associated Infection occurrence and the capability of any proposed perioperative protocol to limit such risk.

e. **Patient Care Practices**

i. Patient care practice policies are developed so that procedures shown to be effective in preventing or controlling infection are adopted as part of routine patient care practice. These practices include explanations of the infection process, methods to reduce the risk of infection, including bundled care practices, and surveillance methods for assessing infection prevention measures.

f. **Employee Health [TJC IC.02.03.01]**

i. The TCMC Employee Health Program is designed to provide occupational health services and systems for preventing, monitoring, and managing potentially harmful exposures and outbreaks of infectious disease among hospital personnel. This is accomplished through pre-employment physical examination assessment, annual health assessments, immunization programs, tuberculosis surveillance, prophylaxis for exposure to infectious disease, and the management of work restrictions for employees with transmissible etiologic agents. IP serves as a consultant to TCMC Employee Health.

g. **Antibiotic Stewardship Program (ASP) [GACHRLS HSC §1288.85, 1288.8]**

i. The TCMC Antibiotic Stewardship Committee meets quarterly and reports to the Infection Prevention and Pharmacy and Therapeutic Committees. Patterns of antimicrobial resistance are routinely monitored and compiled by Pharmacy into an annual antibiogram. Antibiotic stewardship guidelines are used to promote the prudent use of antibiotics in order to prevent or delay the emergence of multidrug-resistant organisms and to minimize the risk of antibiotic-associated side effects including *C. difficile* infection (CDI). Membership includes representation from TCMC leadership and infectious disease physician.

5. **Annual Reports and Evaluations [TJC IC.03.01.01]**

a. **Infection Prevention Plan and Risk Analysis**

i. Each year an Infection Prevention Plan is compiled to succinctly describe and document the review and analytical processes which establishes programmatic priorities based upon identified risks for transmitting and/or acquiring infectious agents within the healthcare setting. The methodologies used for establishing priorities and setting goals includes:

1) Updating the Infection Prevention Plan which describes scope, objectives, and program components.

2) Analyzing surveillance data to determine if data trends indicate that corrective action is required, and /or if changes in surveillance methodologies, frequencies, or supportive educational programs are required.

3) Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program.

b. **Goals and Strategies**

i. The following are priority areas to limit exposure to infections by implementing specific prevention measures as defined in related policies and procedures:

1) The first goal is to provide an effective, ongoing program that prevents or reduces the risk of infection for patients, employees, healthcare providers and visitors through continuous improvement of the functions and processes involved in the prevention of infection that includes:

a) Identifying and preventing the occurrences of HAIs by pursuing sound IP practices such as hand hygiene, aseptic technique, environmental sanitation, isolation precautions including standard precautions, proper use of personal protective equipment (PPE), proper cleaning and disinfection of medical

equipment and supplies, and monitoring the appropriate use of antibiotics and other antimicrobials.

ii. The second goal is to promote actions that are designed to limit the spread and/or prevent the occurrence of HAIs by:
   1) Identifying and reducing risks of acquiring and transmitting infections among patients, healthcare providers, contract workers, students, volunteers and visitors.
   2) Preventing the spread of infections from patients to employees and healthcare providers by enforcing sound IP practices, providing immunization services and reducing potential exposures to blood and body fluids and other potentially infectious material by minimizing unprotected sharps and splash.
   3) Supporting the efforts of the Antibiotic Stewardship Program (ASP) to retard the evolution of multidrug-resistant pathogens and minimize antibiotic-associated complications such as CDI.

iii. In addition, TCMC has identified the following Performance Improvement (PI) goals and strategies for FY2021:
   1) Goal #1: FY21 CLABSI Goal (baseline FY20 SIR=0.88):
      a) Target SIR Goal = 0.61*
      b) Strategies: Ensure compliance with prevention bundle elements through regular compliance audits performed by nursing and/or Infection Prevention staff. Implement PICC appropriateness guidelines.
   2) Goal #2: FY21 CAUTI Goal (baseline FY20 SIR = 1.16)
      a) Target SIR Goal = 0.67*
      b) Threshold SIR Goal = 1.01*
      c) Strategies: Reduce urinary catheter utilization through implementation of a nurse driven removal protocol and ensuring compliance with prevention bundle elements through regular audits by nursing and/or Infection Prevention staff.
   3) Goal #3: FY21 CDIFF Goal (baseline FY20 SIR = 1.35)
      a) Target SIR Goal = 0.51
      b) Threshold SIR Goal = 0.75
      c) Strategies: Implement 2-step testing (PCR + Toxin/antigen)
   4) Goal #4: FY21 SSI Goal (baseline FY20 Deep/Organ Space SIR = 1.71)
      a) Target SIR Goal = 0.84*
      b) Threshold SIR = 1.26*
      c) Strategy: Establish SSI prevention committee and develop charter

   *Target SIR equates to NHSN national SIR 50th percentile (Median); Threshold SIR equates to NHSN national SIR 75th percentile

E. **RELATED DOCUMENTS:**
   1. Infection Control Policy: Infection Prevention Risk Assessment
   2. Infection Prevention Annual Goals and Evaluation (Operation Plan Summary)

~~F. **REFERENCES:**~~

~~1. APIC Text of Infection Control and Epidemiology, 2021.~~
~~2.1. Joint Commission, Hospital Accreditation Standards, Chapter: Infection Prevention and Control, www.jointcommission.org~~
~~3.1. CMS Conditions of Participation: IC~~
~~4.1. Title 22, Calif. Code of Regulations~~

Tri-City Medical Center
Oceanside, California

INFECTION CONTROL

ISSUE DATE: 11/99

SUBJECT: Standard and Transmission-Based Precautions

REVISION DATE~~(S)~~: 10/05, 01/11, 09/15, 01/17, 08/17 07/18, 08/19

Infection Control Department Approval:	**~~06/19~~11/22**
Infection Control Committee Approval:	**~~07/19~~11/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~07/19~~01/23**
Administration Approval:	**~~08/19~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**08/19**

A. **PURPOSE:**

1. The Center for Disease Control and Prevention (CDC) and the Hospital Infection Control Advisory Council (HICPAC) published the Guidelines for Isolation Precautions in Hospitals in 2007. Changes were made to include respiratory hygiene/cough etiquette practices. Masking for spinal procedures and application of **Personal Protective Equipment** (PPE) prior to entering the room of a patient in Droplet or Contact Precautions
2. The current guidelines continue to support two levels of precautions, Standard Precautions and Transmission-based Precautions. Standard Precautions are the primary strategies to be used in the care of all patients to protect both healthcare workers and patients. Transmission-based Precautions are designed only for the care of specified patients, or patients known or suspected to be infected or colonized with epidemiologically important pathogens transmitted via airborne, droplet, or contact with dry skin or contaminated objects.

B. **POLICY:**

1. For immunocompromised patients see Patient Care Services: Neutropenic Precautions Policy.
   a. Use Standard Precautions, with emphasis on hand hygiene.
   b. Private room preferred. If semi-private room is used, select a roommate with no identified infection, including respiratory tract, urinary tract, or skin/wound infection.
   c. A patient is not required to wear a standard surgical mask when out of the room.
2. Physicians' role
   a. If a patient is known or suspected to be infected with a highly transmissible disease, or if a patient is infected or colonized with an epidemiologically important microorganism, appropriate isolation precautions should be ordered for the patient.
   b. In addition to hand washing before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance, physicians need to evaluate their interaction with patients, and use barriers such as masks, eyewear and gown based upon anticipated contact with infectious materials.
   c. Physicians should be aware of their current vaccination status regarding (rubella, measles, varicella, hepatitis B) and participate in the Medical Center's annual tuberculosis screening program. All physicians who have frequent contact with blood and body fluids should be immunized against hepatitis B.
3. The role of nurses and other direct care providers is to:
   a. Assure that isolation orders are entered and proper isolation signage is posted outside of the patients' room.

b. Perform hand hygiene before and after patient contact, wearing gloves before and discarding gloves and washing hands after touching any body substance. Direct care providers need to evaluate their interaction with the patient and use barriers such as masks, eyewear, and gown based upon possible and anticipated contact with infectious aerosols, splashes, vomitus, etc. that may result during the contact.
c. If a patient has a disease that requires Transmission-based precautions, the nurse is responsible to triage persons wishing to enter the patient's room.
d. Any direct care provider who uses reusable equipment for a patient in contact precautions is responsible to disinfect that item before it is used for another patient.
e. The nurse and or caregiver is responsible to communicate to receiving departments the isolation status of a patient. This is accomplished by completing the Off Unit Transfer/Assessment: Type of Isolation/Precautions in the Electronic Medical Record (EMR)

4. All direct care providers need to know their own hepatitis B, chicken pox, rubella and measles status and participate in the Medical Center's annual TB skin testing program. This participation is required by the hospital.
5. All direct care providers who have frequent contact with blood or body fluids should be immunized against hepatitis B. Free hepatitis vaccination is a benefit of employment at Tri-City Medical Center **(TCMC)**.
6. Specimen Labeling
7. Standard Precautions tell us to consider all bodily fluids as potentially infectious regardless of the patients' diagnosis. Standard precautions need to be utilized while handling all specimens. (Handling of soiled linen from patients' rooms
   a. All linen must be handled in a consistent and identical manner because there are no "infectious linen" designations under Standard Precautions. All linen leaves the Medical Center in unmarked plastic bags. The contract laundry, also regulated by OSHA and the state, requires workers to wear protective barriers when handling soiled linen at all times. Linen should be handled minimally.
8. Dishware and eating utensils
   a. The combination of hot water and detergents used in dishwashers is sufficient to decontaminate dishware and eating utensils. Therefore, no special precautions are needed for dishware (e.g., dishes, glasses, cups) or eating utensils; reusable dishware and utensils may be used for patients requiring Transmission-Based Precautions.
9. Disposal of waste from patients' rooms
   a. All trash generated from individual patient rooms follow general hospital waste guidelines. If waste is saturated and/or dripping with blood place in the red "Biohazard" trash. See Infection Control Policy: Blood borne Pathogen Exposure Control Plan.
10. All closed system fluid filled containers (e.g., Pleur-evac, auto transfusion, etc.) are to be disposed of as follows:
    a. Obtain a red "biohazardous" plastic bag from the soiled utility room.
    b. Place the container into the bag and tie it securely by gathering the circumference and using a single knot to close the bag. Be sure to reinforce the bag if there is a leak or if leaking is anticipated.
    c. If a patient's room does not have a "biohazard" waste receptacle, carry the red bag to the soiled utility room and place it into the labeled biohazard barrel.
    d. All suction canister liners and tubing should be changed every 24 hours or when ¾ full, whichever comes first. Suction canisters liners may be emptied in the hopper or treated with a Liquid Treatment System (LTS). Once the contents solidify, the LTS, the canister liner and its contents are discarded in the regular trash.
11. Wound Dressings
    a. All wound dressings are to be disposed of in a manner as to confine and contain any body fluids that may be present. Wound dressings dripping with blood or bloody body fluids should be discarded in a red biohazard bag and placed into the biohazard barrel. Dressings with small amount of blood can be disposed of in the regular trash. Examples

of these are IV dressings, trach site dressings, bandaids, gauze or cotton balls used in fingerstick glucose testing,

b. Small dressings can be enclosed in a disposable glove used to remove the dressing. Pull the glove off inside out containing the dressing inside of it. The dressing and gloves can be discarded into the regular trash container in the patient's room.

C. **STANDARD PRECAUTIONS:**

1. Standard Precautions are designed to reduce risk of transmission of blood-borne pathogens transmission of pathogens to and from mucus membranes and non-intact skin.
   a. All blood, body fluids, secretions, excretions (except sweat) are handled as if potentially carrying bloodborne pathogens. Clean gloves are required when touching non-intact skin and mucus membranes.
2. Elements of Standard Precautions
   a. All personnel should implement Standard Precautions at all times regardless of the patient's diagnosis
   b. Hand Hygiene: See Infection Control Policy: Hand Hygiene
      i. Respiratory Hygiene/Cough Etiquette education of healthcare facility staff, patients, and visitors is accomplished through New Employee and Physician Orientation, the patient hand book and signage posted at cough etiquette stations provided throughout the hospital. Tissues are provided along with hand hygiene solution and adult and child sized masks in patient waiting areas throughout the hospital.
   c. Gloves
      i. Wear gloves when touching blood, body fluids, secretions, excretions, contaminated objects, mucous membranes and non-intact skin.
      ii. Change gloves between tasks and procedures on the same patient when moving from one body site to another.
      iii. Remove gloves after use, before touching uncontaminated items and environmental surfaces, and before going to another patient.
      iv. Perform hand hygiene- immediately after removing gloves.
   d. Masks, Eye/Face Shields
      i. Wear a mask, eye protection or a face shield to protect mucous membranes of the eyes, nose, and mouth during procedures and activities that are likely to create splashes or sprays of blood, body fluids, secretions and excretions. (See Infection Control Policy: Blood borne Pathogen Exposure Control Plan, Appendix: Standard Precautions: Personal Precautions Equipment Table)
      ii. Wear a mask for insertion of catheters or injection of material into spinal or epidural spaces via lumbar puncture procedures (e.g., myelogram, spinal or epidural anesthesia).
   e. Gown
      i. Wear gown or plastic apron to protect the skin and prevent soiling of clothing during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions or excretions or cause soiling of clothing.
3. Flowers and Potted Plants
      i. Designate care and maintenance of flowers and potted plants to staff not directly involved with patient care
      ii. If plant or flower care by patient-care staff is unavoidable, instruct the staff to wear gloves when handling the plants and flowers and perform hand hygiene after glove removal
4. Patient Care Equipment
   a. Handle used patient care equipment contaminated with blood, body fluids, secretions and excretions in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and transfer of microorganisms to other patients and the

environment.

b. Ensure that reusable equipment is properly cleaned and disinfected before it is used for the care of another patient.

c. Single use items should be discarded.

5. Environmental Control
   a. Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment, and other frequently touched surfaces per protocol.
6. Safe injection practices – see Patient Care Services: Medication Administration policy. The following practices apply to the use of needles, cannulas that replace needles, and, where applicable intravenous delivery systems:
   a. Use aseptic technique to avoid contamination of sterile injection equipment.
   b. Do not administer medications from single-dose vials or ampules to multiple patients or combine leftover contents for later use.
   c. Multi-dose vials should be dedicated to a single patient whenever possible. If multidose vials must be used both the needle or cannula and syringe used to access the multidose vial must be sterile.
7. Do not keep multidose vials in the immediate patient treatment area and store in accordance with the manufacturer's recommendations; discard if sterility is compromised or questionable.

D. **TRANSMISSION-BASED PRECAUTIONS:**

1. Transmission-based Precautions are used in addition to Standard Precautions for diseases that require extra barriers to prevent transmission.
   a. Types of Transmission-based Precautions:
      i. Airborne Precautions
      ii. Droplet Precautions
      iii. Contact Precautions
   b. See Type and Duration of Precautions - Disease Specific (FKA Short Sheet - https://tcmc.ellucid.com/documents/view/4323).
   c. Communicate and notify receiving department/services if patient requires Transmission-based Precautions (i.e. Airborne, Contact or Droplet Precautions).
2. Airborne Precautions
   a. In addition to Standard Precautions, use Airborne Precautions for patients known or suspected to be infected with microorganisms transmitted by airborne droplet nuclei.
   b. Place patient in an Airborne Infection Isolation room AIIR with at least 6-12 air exchanges per hour, HEPA filtration and negative pressure. If the AIIR rooms are not available Engineering can assist with a temporary set-up. Every effort must be made to place a patient in an AIIR within 5 hours of identification.
   c. Wear respiratory protection (N95 respirator or Powered Air Purifying Respirator) when entering the room. See the Infection Control Policy: ATD: Tuberculosis Control Plan for more information.
   d. Minimize patient dispersal of microorganisms by placing a surgical mask (not an N95 respirator) on the patient during transport.
3. Droplet Precautions
   a. In addition to Standard Precautions, use Droplet Precautions for a patient known or suspected to be infected with organisms that are transmitted by droplets
   b. Place the patient in a private room or cohort patients who have the same infection with the same microorganism.
   c. Wear masks when entering the patient room.
   d. Mask patients during transport.
4. Contact Precautions
   a. In addition to Standard Precautions, use Contact Precautions for specified patients known or infected or colonized with epidemiologically important microorganism that can be transmitted via direct contact with the patient or equipment in the patients' environment such as MRSA and VRE. (See Infection Control Policy: Management of

Patients with MDRO's)

b. Place patient in a private room or cohort patients who are carrying the same microorganisms. When a private room is not available and cohorting is not achievable, consider the epidemiology of the microorganism and the patient population when determining patient placement. First try to select someone with no invasive lines (IV, central line, foley, trach, etc.) or open wound. If this is not possible, then select someone with an invasive line that carries a low risk of infection, such as a peripheral IV or NG tube. Consultation with Infection Prevention staff is advised when there are questions about patient placement.

c. Gloves
   i. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g. medical equipment, bed rails) Don gloves upon entry into the room or cubicle and continue to follow Standard Precautions.

d. Gowns
   i. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient. Don gown upon entry into the room or cubicle and continue to follow Standard Precautions.
   ii. Remove gown and gloves and perform hand hygiene before leaving the patient-care room or environment

e. Dedicate the use of non-critical equipment to a single patient, when possible

f. Clean and disinfect commonly used items before use of another patient with hospital approved disinfectant

g. Patient transport
   i. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport destination.

E. PREGNANT HEALTH CARE WORKERS:

1. Pregnant healthcare workers are not more likely to contract infections from patients.
2. Unless a pregnant healthcare worker is susceptible to a patient's infection, the HCW will provide the same care as provided by non-pregnant worker.
3. Restricting pregnant HCW from caring for patients with potentially transmissible infections is considered only for patients with parvovirus B19 and for patients with respiratory syncytial virus infections who are receiving ribavirin aerosol.

F. RELATED DOCUMENT(S):

1. Infection Control Policy: ATD: Tuberculosis Control Plan
2. Infection Control Policy: Blood borne Pathogen Exposure Control Plan
3. Infection Control Policy: Ebola Plan
4. Patient Care Services Policy: Medication Administration
5. Patient Care Services Policy: Neutropenic Precautions
6. Type and Duration of Precautions - Disease Specific (AKA Short Sheet)

G. REFERENCE(S):

1. Centers for Disease Control and Prevention (2007). CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Setting. Retrieved from https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/index.html Accessed 5-14-19
2. Grota, P. (Ed.). (2014) APIC Text of Infection Control and Epidemiology (4th ed). Washington DC: Association for Professionals in Infection control and Epidemiology, Inc.
3. Sehulster LM, Chinn RYW, Arduino MJ, Carpenter J, Donlan R, Ashford D, Besser R, Fields B, McNeil MM, Whitney C, Wong S, Juranek D, Cleveland J. Guidelines for environmental infection control in health-care facilities. Recommendations from CDC and the Healthcare Infection Control Practices Advisory Committee (HICPAC). Chicago IL; American Society for Healthcare

Engineering/American Hospital Association; 2004. https://www.cdc.gov/infectioncontrol/pdf/guidelines/environmental-guidelines.pdf Accessed 5-14-19

4. Siegel JD, Rhinehart E, Jackson M, Chiarello L, and the Healthcare Infection Control Practices Advisory Committee, 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, June 2007 https://www.cdc.gov/infectioncontrol/pdf/guidelines/isolation-guidelines-H.pdf Accessed 5-14-19

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**11/99**	**SUBJECT:**	**Communication of Results – Women's Center**
REVISION DATE:	**08/11, 02/19**		

Mammography Department Approval:	**~~10/17~~09/21**
Department of Radiology Approval:	**~~10/18~~12/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~11/18~~01/23**
Administration Approval:	**~~01/19~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**02/19**

A. **AUTHORIZED TO PERFORM:**
1. Radiologists and Records Techs

B. **PURPOSE:**
1. To meet Mammography Quality Standard Act (MQSA) standards to ensure that reports/results are sent to patients and referring physicians in a timely way.

C. **POLICY:**
1. The Mammography Center will provide patients with written results within thirty (30) days. Self-referring patients will receive the written report as well as the summary.
2. Results that are "suspicious" or "highly suggestive of malignancy" will be communicated directly by the interpreting Radiologist or designee ASAP to the referring MD or, if self-referred, to the patient. Self referred patients will be given the Breast Help Line phone number, 940-5100, for a list of physicians for follow-up.
3. Patients that are called back to the facility for additional views will be scheduled within ten (10) working days. The department's scheduler will make several attempts to contact the patient. If the patient cannot be reached, a letter will be sent to the referring physician reporting our request for follow-up. If the mammography department receives no response within five (5) working days, a certified letter will be sent to the patient's residence signifying the importance of breast imaging follow-up. A copy of receipt of letter will be filed with the patient's records.

D. **EXTERNAL LINK(S):**
1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf
2. Mammography Clinical Experience Requirements (2017) https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4

E. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 10/97

SUBJECT: Completion of Diagnostic Report

REVISION DATE: 08/11, 02/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	10/18
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **RESPONSIBILITY:**
1. Transcriptionists, Radiology Records Techs

B. **PURPOSE:**
1. To expedite the finalization of the diagnostic report.

C. **POLICY:**
1. The diagnostic report will be dictated, transcribed, printed, and distributed to the referring physicians in a timely manner.

D. **PROCEDURE:**
1. The transcription department will transcribe the diagnostic report in a timely manner.
2. The Radiologist will review the report and make corrections.
3. The Radiologist will finalize the report.
4. Periodically, throughout the day, the signed reports are printed for distribution.

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**08/11**	**SUBJECT:**	**Diagnostic Mammography**
REVISION DATE:	**04/19**		

Mammography Department Approval:	**~~03/18~~06/19**
Department of Radiology Approval:	**~~02/19~~02/20**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~02/19~~01/23**
Administration Approval:	**~~03/19~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **AUTHORIZED TO PERFORM:**
1. Licensed Mammography Technologist possessing certification from the American Registry of Radiology Technologists (ARRT) and California Certified Radiologic Technologist (CRT) in Mammography. Must have performed 200 mammograms in a 24-month period as per Mammography Quality Standard Act (MQSA) regulations.

B. **PURPOSE:**
1. To provide consistent guidelines for diagnostic mammograms on patients who have signs and/or symptoms of breast disease, or radiographic finding of abnormalities.

C. **POLICY:**
1. To be done on persons with a palpable lump previous breast cancer (within 5 years if benign) or any abnormality in the breasts or per physician's request.
   a. Specific focus of clinical concerns including, but not limited to, mass, induration, axillary lymphadenopathy, some types of nipple discharge, skin changes, or persistent or focal areas of pain or tenderness.
   b. Possible radiographic abnormalities detected on Screening Mammography.
   c. Short, interval follow-up (e.g., less than one year) for clinical or radiographic concerns.
   d. Patients whose examination requires direct involvement of the Radiologist for special views, breast physical examination, or consultation.
   e. Women who have implants with complications as requested by referring physician.
   f. Women who have been treated for breast cancer (either with breast conservation or mastectomy), one year post-surgery.

D. **PROCEDURE:**
1. Views to be done are:
   a. Craniocaudal views (cc)
   b. Mediolateral Oblique views (mlo)
   c. Mediolateral views (ml)
   d. Medial/lateral exaggerated views
2. Identify on patient history sheet, any information regarding the problem patient is having and draw any surgical scars seen on the breast.
3. Show films to Radiologist prior to patient departure when at all possible.

E. **EXTERNAL LINK(S):**
1. Mammography Quality Standards Act (MQSA) of 1998

https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf

F. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 05/12

SUBJECT: Distribution of Mammography Reports

REVISION DATE: 01/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	~~10/18~~10/21
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **AUTHORIZED TO PERFORM:**
   1. Radiologists and Radiology records techs

B. **PURPOSE:**
   1. To expedite the finalization and timely distribution of the of the mammography reports to the Requesting physicians.

C. **POLICY FOR MAMMOGRAPHY EXAMS**
   1. Requiring no prior films from outside facilities
      a. Scheduled returning patients will have their images loaded from the PAC's system and available at their appointment time.
      b. Radiologist will interpret mammogram and compare with previous images.
      c. Report will be transcribed and Radiologist will finalize the report.
      d. Reports will be automatically faxed to the referring physician within 24 hours of Transcription.
      e. Normal result letters will be mailed to patients within 30 days.
      f. Self-referred patients, if a health provider (or a responsible designee) is not named or is unavailable, then the report must be provided to the patient.
      g. Communications to the patient, if there is no health care provider, must include: 1) the complete report of findings referenced above and 2) the summary written in lay terms that is required for all patients.
   2. Needing comparison films from outside facilities
      a. The patient's current mammogram study will be flagged in the "hold-pending prior films" box for no longer than 10 working days
      b. If outside images have not arrived within a 10-day period, images will be dictated and results faxed to referring physician within 24 hours
      c. When and if images arrive from outside facilities, the mammography study will be flagged for the radiologist and an addendum comparison report will be dictated, transcribed and finalized by the radiologist. The final result will be faxed to the referring physician through the automated fax server application
   3. Mammograms with "suspicious or highly suggestive malignancy" assessment
      a. The interpreting Radiologist will dictate and finalize the report and fax to the referring physician with their findings within 24 hours of mammography study.
         i. A letter will be mailed to the patient indicating the need to follow-up with their physician any abnormality seen on their mammogram within 5 working days.
         ii. If a biopsy or surgical intervention is attained, then the pathology report is

collected from the lab and these findings are entered into the mammography tracking program for statistical computation.

iii. The interpreting Radiologist will add an addendum to the report documenting the pathology findings. The addended report is refaxed to the referring physician with the addended results.

D. **PROCEDURE:**

1. Twice daily Remote Installation Service (RIS) will automatically transmit a facsimile to the requesting physician after the Radiologist approves the diagnostic report.

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 06/93

SUBJECT: Mammography Image/Data Retention, Check-Out and Copying

REVISION DATE: 08/11, 01/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	~~10/18~~10/21
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **AUTHORIZED TO PERFORM:**
1. Radiology records technician, radiologic technologist.

B. **PURPOSE:**
1. To ensure that all original films and reports are retained in accordance with Joint Commission (JC) and hospital policies; to ensure that all appropriate requests for films and/or reports are handled in the proper manner to maintain patient confidentiality and legal requirements.

C. **POLICY:**
1. All employees are responsible to maintain the files, films, and reports in good order.

D. **PROCEDURE:**
1. Retention:
   a. Images and reports are filed by the Imaging Services Department using the patient's medical record number and a terminal digit and most recent year of visit.
   b. All images/data and reports are retained for ten (5) years by the Imaging Department.
      i. Films on all minors (under age 18) are retained until 25 years of age.
      ii. Mammographs are retained 10 years or 5 years if a new set of images are performed at the facility

E. **REQUEST COPY OF REPORTS/MAMMOGRAMS/ULTRASOUND:**
1. Requests for copies of report/images on a disc should be directed to the Film Library.
2. Requests by patients:
   a. Patients may check out their original reports/mammograms only if they complete the authorization form for disclosure of individually identifiable health information, as set forth and consistent with California and Federal law concerning the privacy of such information.
   b. Patients need to fill out the Authorization for Use or Disclosure from and sign the form by presenting their identification documents.
3. Requests by Mammography from outside facilities:
   a. Women's Diagnostic Center may request a copy of reports/mammograms/ultrasounds through Medical Record Department Fax Transmittal Sheet.
   b. Patient needs to sign and fill out the authorization form to authorize the release of medical records, mammograms and reports to Tri-City Medical Center Women's

Diagnostic Center.

c. Mammographer needs to send the release of authorization request by finding the fax number from Mammography Centers Directory.

F. **FACSIMILE TRANSMISSION (FAX):**

1. In accordance with Administrative Compliance Policy: Faxing Protected Health Information 522, confidentiality of all patient records must be maintained at all times, and is not to be discussed with any person not directly associated with the case.
2. Facsimile machines may be used to transmit confidential information (e.g., reports), but reasonable care must be taken to assure the information reaches its destination (e.g., confirmation form) and is kept confidential.
3. Per Administrative Information Technology Policy: Fax Transmissions 616 a FAX transmittal sheet must accompany any records that are sent via facsimile machine and maintained as a permanent part of the patient's file.

G. **DISCIPLINARY ACTION:**

1. Failure to follow these guidelines for film retention and release will result in disciplinary action.

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

1. Administrative Compliance Policy: Faxing Protected Health Information 8610-522
2. Administrative Compliance Policy: Patient Access to Protected Health Information in the Designated Record Set 8610-516
3. Administrative Information Technology Policy: Fax Transmissions 8610-616

I. **REFERENCE(S):**

1. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	**12/99**	**SUBJECT:**	**Mammography Quality Assurance (QA) Plan**
REVISION DATE:	**08/11, 01/19**		
Mammography Department Approval:		~~10/17~~09/21	
Department of Radiology Approval:		~~10/18~~10/21	
Pharmacy & Therapeutics Committee Approval:		n/a	
Medical Executive Committee Approval:		~~11/18~~01/23	
Administration Approval:		~~01/19~~02/23	
Professional Affairs Committee Approval:		n/a	
Board of Directors Approval:		01/19	

A. **PURPOSE:**

1. To ensure the safety, reliability, clarity and accuracy of mammography services performed at Tri-City Medical Center (TCMC).

B. **POLICY:**

1. The Edgar and JoAnne Jones Mammography Quality Assurance Program will meet the Mammography Quality Standard Act (MQSA) standards and those of other appropriate regulatory bodies. The program will be reviewed bi-annually by the responsible mammography interpreting physician as mandated by California Code of Regulations, Title 17, Section 30317.20. The program will consist of multiple parts and be supported by a system that incorporates the following:
   a. Audit of Results
      i. Whereby positive results are entered into the system
      ii. System in place to obtain all pathology results
      iii. System in place to compare pathology results with physician interpretations
      iv. Analysis data kept for at least 24 months following the analysis
   b. Reporting of Results - communication of results to patients and physicians.
   c. Appropriate procedures to ensure consistency and safety in performance and procedures.
   d. Defined processes/responsibilities to support the service
   e. Monitoring of important aspects of care
   f. Patient satisfaction data
   g. Competent staff - orientation, training, and continuing education
   h. Equipment - Quality Control testing and corrective actions followed up when results not acceptable
   i. Annual Medical Physicians Survey performed in a timely and complete manner, with results and recommendation reviewed by the facility
   j. Performance improvement

C. **RESPONSIBILITIES :**

1. Responsible individuals shall:
   a. Be qualified for assignments.
   b. Know the specifics of their assigned tasks.
   c. Have adequate time to perform duties.

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

1. Mammography Quality Standards Act (MQSA) of 1998
   https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf

E. **REFERENCE(S):**

1. California Code of Regulations, Title 17, Section 30317.20
2. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 01/00

SUBJECT: Scheduling of Self-Referring Mammography Patients

REVISION DATE: 08/11, 01/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	~~10/18~~10/21
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **DEFINITION(S):**
1. Self-Referred: comes for a mammogram but has no personal health care provider or the provider declines responsibility.
2. Self-Requesting: has taken the initiative to come for a mammogram, can name health care provider, but does not have a referral.

B. **PURPOSE:**
1. To clarify the Women's' Center self-referral process for screening versus diagnostic exams.
2. To clarify follow up for the self-requesting and self-referring patients.

C. **POLICY:**
1. The Women's Center will perform self-referral exams for screening only. Self-referring patients with breast symptoms must have a physical exam by a physician prior to mammogram scheduling.
2. The Women's Center will ensure that follow up for self-referring and self-requesting patients meet MQSA standards.

D. **PROCEDURE:**
1. Scheduling:
   a. The scheduler will confirm whether the exam is for screening or diagnostic purposes.
   b. The scheduler will ask for referring physician for all patients.
   c. The scheduler will inform the self-referring patient with breast symptoms of this Policy (Diagnostic Exam) and provide the Breast Help Line number, 940-5100 for physician referral information.
2. Interpretation:
   a. Self-referred: The interpreting physician will assume responsibility for women's breast care; including education and physical exam, communication of results (see Mammography Policy: Communication of Results).
   b. Self-requesting: The Women's Center will document that the designated provider accepts responsibility for follow up, or the interpreting physician will assume responsibility for women's breast care, if physician declines.

E. **RELATED DOCUMENT(S):**
1. Mammography Policy: Communication of Results

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 08/11 **SUBJECT: Screening Mammography**

REVISION DATE: 01/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	~~10/18~~10/21
Pharmacy &Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **AUTHORIZED TO PERFORM:**

1. Licensed Radiologic Technologist processing certification from the American Registry of Radiology Technologists (ARRT) and the California Certified Radiologic Technologist (CRT) in Mammography. Must have performed 200 mammograms in a 24-month period.

B. **PURPOSE:**

1. To provide consistent guidelines for screening mammograms to detect unsuspected breast cancer in symptomatic women and meet all Mammography Quality Standard Act (MQSA) and American College of Radiology (ACR) accreditation requirements

C. **POLICY:**

1. Screening Mammography is indicated in symptomatic (including patients with a family history of breast cancer) women at least 40 years of age, with or without referring physician order.
   a. Exception: Screening mammography will not be done on pregnant or lactating women unless ordered by physician.

D. **PROCEDURE:**

1. Standard views to be done:
   a. Craniocaudal (cc)
   b. Mediolateral (mlo)
2. If the patient is a symptomatic and/or something abnormal is seen on mammogram, show films to Radiologist for recommendations for additional imaging studies. The Radiologist will complete an "Additional Evaluation Required" form, which constitutes a diagnostic order from physician.
3. If a breast abnormality is identified on the same date of service prior to the patient leaving, and additional films are performed, the patient's screening mammogram will be edited by the technologist to a diagnostic mammogram as per Radiologist's orders.
4. If this breast abnormality is identified after the patient has left our facility, the patient will be billed for the screening mammogram on the original date of service and will be billed for a diagnostic mammogram on the return visit.
5. One copy of this order will be given to the registrar in the Women's Diagnostic Center and a second copy to the Billing Department.

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

1. Mammography Clinical Experience Requirements (2017) https://www.arrt.org/docs/default-source/discipline-documents/mammography/mammography-clinical-experience-requirements-2017.pdf?sfvrsn=4

F. **REFERENCE(S):**

1. AART (2017, July 1) Updated Mammography Content Specifications, Clinical Experience Requirements, and Task Inventory. Retrieved from https://www.arrt.org/news/2017/03/22/updated-mammography-content-specifications-clinical-experience-requirements-and-task-inventory-effective-july-1-2017

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE: 11/99

SUBJECT: Staff & Personnel Listing Women's Center

REVISION DATE: 08/11, 02/19

Mammography Department Approval:	~~10/17~~09/21
Department of Radiology Approval:	~~10/18~~12/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~01/23
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	02/19

A. **PURPOSE:**

1. In addition to Quality Control (QC) test records, a Quality Assurance (QA) program includes clearly assigned personnel responsibilities. The QA program should identify the person responsible for overall quality assurance and compliance with the quality standards at the facility. It should also identify the QC technologist and the medical/ physicist and describe their responsibilities within the QA/QC program

B. **PERSONNEL:**

1. The Edgar and JoAnne Women's Center has an actively involved lead interpreting radiologist to oversee the program. The program also includes a physicist and a Mammography Diagnostic Specialist who serves as the facility's Quality Control technologist. Other technologists and personnel help with testing. The Diagnostic Specialist ensures that the program is run according to MQSA standards. All personnel associated with mammography services must meet the MQSA qualifications, training and continuing education requirements.
2. See the Mammography Staff and Responsibilities List

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

1. Mammography Staff and Responsibilities List

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

1. Mammography Quality Standards Act (MQSA) of 1998 https://www.fda.gov/downloads/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/Regulations/UCM110849.pdf
2. The Mammography Quality Standards Act Final Regulations: Preparing for MQSA Inspections; Final Guidance for Industry and FDA (2001) https://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/ucm094441.pdf

E. **REFERENCE(S):**

1. Mammography Quality Standards Reauthorization Act, Pub. L., Title XLII § 263b. (1998).
2. U.S. Food & Drug Administration (2017, November 16) Mammography Quality Standards Act and Program. Retrieved from https://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 03/06

SUBJECT: Appropriate Use of Commercial Support and Exhibits

REVISION DATE~~(S)~~: 05/08, 11/12, 12/15, 06/18, 03/19 03/20, 04/21

POLICY NUMBER: 8710-603

Medical Staff Department Approval:	~~10/20~~04/22
CME Committee Approval:	~~01/21~~10/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/21~~01/23
Administration Approval:	~~04/21~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. **PURPOSE:**

1. To describe appropriate behavior in planning, designing, implementing, and evaluating Continuing Medical Education (CME) activities, for which commercial support is received.

B. **DEFINITION(S):**

1. **Commercial Support: Accredited providers that choose to accept *commercial support* (defined as financial or in-kind support from ineligible companies) are responsible for ensuring that the education remains independent of the ineligible company and that the support does not result in commercial bias or commercial influence in the education. The support does not establish a financial relationship between the ineligible company and planners, faculty, and others in control of content of the education.** ~~Commercial Support: Financial and other support provided by commercial organizations to enhance the quality of CME activities.~~

C. **POLICY:**

1. Tri-City Healthcare District (TCHD) adheres to the Accreditation Council for Continuing Medical Education (ACCME) Standards~~4~~ for **Managing** Commercial Support **Appropriately: This** Standards **applies to** ~~to Ensure the Independence of CME Activities. In operational issues, the CME Program is guided by what is in the best interest of the public, and decisions are made with the principles of independence from commercial interests, transparency, and keeping CME separate from product promotion.~~ **accredited providers that choose to accept commercial support are responsible for ensuring that the education remains independent of the ineligible company and that the support does not result in commercial bias or commercial influence in the education. The support does not establish a financial relationship between the ineligible company and planners, faculty, and others in control of content of the education.**
2. **Decision-making and disbursement: The accredited provider must make all decisions regarding the receipt and disbursement of the commercial support.**
   a. **Ineligible companies must not pay directly for any of the expenses related to the education or the learners.**
   b. **The accredited provider may use commercial support to fund honoraria or travel expenses of planners, faculty, and others in control of content for those roles only.**

c. **The accredited provider must not use commercial support to pay for travel, lodging, honoraria, or personal expenses for individual learners or groups of learners in accredited education.**

d. **The accredited provider may use commercial support to defray or eliminate the cost of the education for *all* learners.**

3. **Agreement: The terms, conditions, and purposes of the commercial support must be documented in an agreement between the ineligible company and the accredited provider. The agreement must be executed prior to the start of the accredited education. An accredited provider can sign onto an existing agreement between an accredited provider and a commercial supporter by indicating its acceptance of the terms, conditions, and amount of commercial support it will receive.**

4. **Accountability: The accredited provider must keep a record of the amount or kind of commercial support received and how it was used, and must produce that accounting, upon request, by the accrediting body or by the ineligible company that provided the commercial support.**

5. **Disclosure to learners: The accredited provider must disclose to the learners the name(s) of the ineligible company(ies) that gave the commercial support, and the nature of the support if it was in-kind, prior to the learners engaging in the education. Disclosure must not include the ineligible companies' corporate or product logos, trade names, or product group messages.**

~~6. Standard 1: Independence~~

~~a. TCHD CME Committee ensures that CME activity content is free of control of a "commercial interest" including the identification of CME needs; determination of objectives; selection and presentation of content; selection of all persons and organizations that will be in the position to control the content of the CME; selection of educational methods; and evaluation of the activity.~~

~~b. TCHD does not jointly sponsor CME activities with a commercial interest.~~

~~7. Standard 2: Resolution of Personal Conflicts of Interest~~

~~a. Relevant financial relationships with commercial interests of everyone who is in the position to control the activity content must be disclosed. Relationships in any amount and occurring within the past 12 months that create a conflict of interest are to be disclosed.~~

~~b. Individuals who refuse to disclose relevant financial relationships will be disqualified from being a planning committee member, and cannot have responsibility for the development, management, presentation, or evaluation of the CME activity.~~

~~c. TCHD CME Committee will identify and resolve all conflicts of interest prior to the CME activity taking place, using the Medical Staff Policy: Conflict of Interest Resolution 8710-605.~~

~~8. Standard 3: Appropriate Use of Commercial Support~~

~~a. All commercial support for TCHD CME activities shall be obtained as unrestricted grants and dispensed by the CME Committee/designee in accordance with the Accredited Council for Continuing Medical Education (ACCME) Commercial Support Standards.~~

~~b. TCHD CME Committee makes all decisions regarding the disposition and disbursement of commercial support and all funding must be received by Tri-City Medical Center to support the expenses associated with Tri-City Medical Center sponsored activities.~~

~~c. TCHD is not required to accept advice or services from the commercial interest regarding presenters or content as conditions of contributing funds or services. Content development must remain beyond the control of the commercial supporter. Content validation by the provider should be established.~~

~~d. TCHD must be aware of all commercial support associated with the CME activity, and must approve all such support. Tri-City Medical Center and its agents (joint sponsors) must decide what commercial support will be accepted and how it will be utilized, not the commercial interest.~~

~~i. Written Agreement documenting terms of support~~

1) TCHD and the commercial supporter will have a written agreement indicating the terms, conditions, and purposes of the commercial support for all directly and jointly sponsored activities.
2) The Letter of Agreement specifies the commercial interest at the source of the commercial support.
3) The Letter of Agreement must be signed by TCHD (accredited provider) and commercial supporter.

ii. Expenditures for an individual providing CME
1) TCHD adheres to its policy 8710-604, "CME Speaker & Honoraria Reimbursement" which governs honoraria and reimbursement of out-of-pocket expenses for planners, presenters, and authors of CME activities. Honorarium amount is set by the CME Committee.
2) TCHD CME Committee/designee is responsible for payment of honoraria and expense reimbursement in compliance with policy governing such.
3) No additional payment may be given to the planning committee members, presenters or authors, joint sponsor, or any others involved with the supported activity.
4) When presenters or authors also participate as a learner, their expenses can be paid for their presenter or author role only.

iii. Expenditures for learners
1) Social events or meals at CME activities will not take precedence over the educational events, and will be planned by the CME Coordinator or designee.
2) Commercial support funds are used to underwrite the expenses for developing and presenting the activity, including expenses of presenters, and staff working on the activity.

iv. Accountability
1) Tri-City Medical Center maintains all income and expense documentation related to its directly and jointly sponsored activities. This will detail the receipt and expenditure of the commercial support.

9. Standard 4: Appropriate Management of Associated Commercial Promotion
a. Commercial exhibits or advertisements cannot interfere with the presentation, nor be a condition of the provision of commercial support.
b. Product promotion material or product specific advertisement of any type is prohibited during CME activities. Staffed exhibits and/or presentations, or enduring printed or electronic ads must be kept separate from CME. Adherence to the Standards for Commercial Support Standard 4.2 is required.
c. Educational materials such as slides, abstracts, and handouts cannot contain any advertising, trade name, or product message.
d. The program book which contains non-CME elements that are not directly related to the transfer of education may include product promotion material or product specific advertisement.
e. Commercial interests cannot provide a CME activity to learners either by distribution of self-study activities, or arranging for electronic access to CME activities. The commercial supporter may distribute promotional materials developed by the provider.
f. CME Exhibits are not considered "Commercial Support;" however, the ACCME Standards of Commercial Support apply with regard to the location of the exhibits.
i. Exhibitors may not display exhibits in the same room as the CME activity or in the direct path of the activity.
ii. Exhibitors may not promote products or services directly prior to, during, or immediately following the CME activity in the same lecture hall.

~~iii. Exhibitors/vendors are required to complete a "CME Exhibit Request Form." Prior approval from the CME Committee/designee is required for vendors to exhibit during a TCHD sponsored CME activity.~~

~~iv. Reasonable exhibit fees shall be assessed to exhibitors in an amount to be determined by the CME Committee, but shall not be less than $500, and are due and payable to "TCHD Medical Staff Treasury" prior to the activity.~~

~~10. Standard 5: Content and Format Without Commercial Bias~~

~~a. TCHD CME activities and related materials promote improvements or quality in healthcare, and not a specific proprietary business interest of a commercial interest.~~

~~b. Presentations must give a balanced view of therapeutic options and use generic names when possible; or use multiple trade names, not the trade name from a single company. CME must be free of commercial bias and not promote products or services, but promote improvements in healthcare.~~

~~11. Standard 6: Disclosures Relevant to Potential Commercial Bias~~

~~a. Relevant financial relationships of those with control over CME content~~

~~i. Individuals must disclose to the learners all relevant financial relationships, including the name of the individual, the name of the commercial interest, and the nature of the relationship. Disclosure is preferred to be written and available to all learners. Verbal disclosure may be used to supplement written disclosure when the event is televised.~~

~~ii. Disclosure must also be made when the individual has indicated no relevant financial relationships.~~

~~b. Commercial support for the CME activity~~

~~i. The source of commercial support must be disclosed to learners, and the "in-kind" support must include specific information about the actual support, e.g. equipment loan.~~

~~ii. Trade names or product group message must never be included in such disclosure.~~

~~c. Timing of disclosure~~

~~i. Disclosure of relationships and support by a commercial interest must be provided to the learners prior to the beginning of the educational activity.~~

D. **PROCEDURE:**

1. **Standard 5: Accredited providers are responsible for ensuring that education is separate from marketing by ineligible companies—including advertising, sales, exhibits, and promotion—and from nonaccredited education offered in conjunction with accredited continuing education**
   a. **Arrangements to allow ineligible companies to market or exhibit in association with accredited education must not:**
      i. **~~a.~~ Influence any decisions related to the planning, delivery, and evaluation of the education.**
      ii. **~~b.~~ Interfere with the presentation of the education.**
      iii. **~~c.~~ Be a condition of the provision of financial or in-kind support from ineligible companies for the education.**
   b. **The accredited provider must ensure that learners can easily distinguish between accredited education and other activities.**
      i. **~~a.~~ Live continuing education activities: Marketing, exhibits, and nonaccredited education developed by or with influence from an ineligible company or with planners or faculty with unmitigated financial relationships must not occur in the educational space within 30 minutes before or after an accredited education activity. Activities that are part of the event but are not accredited for continuing education must be clearly labeled and communicated as such.**
      ii. **~~b.~~ Print, online, or digital continuing education activities: Learners must not be presented with marketing while engaged in the accredited**

education activity. Learners must be able to engage with the accredited education without having to click through, watch, listen to, or be presented with product promotion or product-specific advertisement.

iii. **~~c.~~ Educational materials that are part of accredited education (such as slides, abstracts, handouts, evaluation mechanisms, or disclosure information) must not contain any marketing produced by or for an ineligible company, including corporate or product logos, trade names, or product group messages.**

iv. **~~d.~~ Information distributed about accredited education that does not include educational content, such as schedules and logistical information, may include marketing by or for an ineligible company.**

c. Ineligible companies may not provide access to, or distribute, accredited education to learners.

E. RELATED DOCUMENT(S):

~~2.~~**1.** ~~Medical Staff Policy: CME Speaker & Honoraria Reimbursement 8710-604~~**ACCME Planning guide for independence in Accredited Continuing Education (ACCME Toolkit)**

~~3.~~**2.** Medical Staff Policy: ~~Conflict of Interest Resolution~~ **Prevent Commercial Bias and Marketing** 8710-605

~~4. Written Agreement for Commercial Support~~

~~5. CME Exhibit Request Form~~

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

~~1.~~ Accreditation Council for Continuing Medical Education (ACCME) Standard~~s~~**4 and 5** for Commercial Support.

~~2. *Institute for Medical Quality (IMQ)/California Medical Association (CMA) 2017 CME Accreditation Standards Manual/ Essential areas and their Elements/ Accreditation Criteria*~~

~~a.~~**1.** ~~Element 3.3: The provider must present CME activities in compliance with the ACCME's policies for disclosure and commercial support.~~

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 09/09

SUBJECT: Conflict of Interest Policy for Medical Staff

REVISION DATE~~(S)~~: 09/09, 04/17, 03/20

POLICY NUMBER: 8710-555

Medical Staff Department Approval:	~~09/09~~03/~~17~~02/20
Medical Staff Committee Approval:	~~n/a~~11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~02/~~20~~01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	~~04/17~~03/~~20~~ n/a
Board of Directors Approval:	~~04/17~~03/20

A. **PURPOSE:**
1. To safeguard the integrity and reputation of Tri-City Healthcare District (TCHD), and their medical staffs by fostering the proper and unbiased conduct of all medical staff activities.
2. To encourage unbiased, responsible management and decision-making.

B. **DEFINITION(S):**
1. Conflict of Interest: A divergence between an individual's private interests and his/her professional obligations to the medical staff, hospital, patients, and employees, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by considerations of personal gain, financial or otherwise.
2. Immediate family: Spouse, children, parents, siblings, or equivalents by marriage, or others residing in the physician's household.
3. This policy serves to:
   a. Describe situations that are prohibited.
   b. Educate medical staff members about situations that generate conflicts of interest.
   c. Provide means for the medical staff and the Hospital to disclose and manage conflicts of interest.
   d. Promote the best interests of patients, their families, employees, and other practitioners.

C. **POLICY:**
1. Medical Staff members shall conduct their affairs so as to avoid or minimize conflicts of interest, and must respond appropriately when conflicts of interest arise. The following are representative, but not inclusive, of conflict of interest situations:
   a. Influence on purchases of equipment, instruments, materials, or services for TCHD from the private firms in which the medical staff member, or an immediate family member, has a financial interest.
   b. Unauthorized disclosures of patient or Hospital's information for personal gain.
   c. Provide, offer, or promise anything of value, as a representative of TCHD to any government official to enhance relations with that official or the government.
   d. Transmit to a private firm or other use for personal gain of TCHD supported work, products, results, materials, record, or information that are not generally made available.
   e. Influence upon the negotiation of contracts between TCHD and private organizations with which the medical staff member, or immediate family member, has consulting or

other significant relationships, or will receive favorable treatment as a result of such influence.

f. Improper use of institutional resources for personal financial gain.

g. Accept compensation or free services from a vendor, service provider, or contractor of TCHD, when the medical staff is in a position to determine or influence TCHD's purchases from those persons.

2. All members of the Medical Staff shall complete a general disclosure statement upon appointment and reappointment.
3. Candidates for Medical Staff elected offices must submit a Conflict of Interest statement.
4. Whenever a medical staff member is in a situation where he/she may have a potential conflict of interest, he/she shall make a full disclosure in writing to the Chief of Staff with details of the situation to request an exception.
   a. For any conflict of interest disclosed, the Chief of Staff shall evaluate and determine how the conflict of interest may be managed or avoided.
   b. Confirmed conflict of interest may be disclosed to the Medical Executive Committee by the Chief of Staff.
5. Suspected violations of this policy shall be reported to and evaluated by the Chief of Staff. Reports are confidential and shall remain anonymous.
6. Disciplinary action, if indicated, shall be taken in accordance with the Medical Staff Bylaws.
7. A confirmed conflict of interest shall result in one or more of the following:
   a. Disclosure of the conflict of interest to the Medical Executive Committee;
   b. Abstention from voting on the matter to which the conflict relates;
   c. Recusal from the decision-making process and participation in, including the receipt of information related to the matter to which the conflict relates.

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

1. Conflict of Interest Form – Sample.

E. **REFERENCE(S):**

1. Joint Commission Standards 202~~17~~.
2. Conflict of Interest Guidelines for Organized Medical Staffs. American Medical Association.

Tri-City Medical Center

Conflict of Interest Form - Sample

Practitioner Name:_____ **Date:**_____
Print

Do you have any relationships that may be considered as potential conflict of interest which may include, but may not be limited to, other care providers, educational institutions, manufacturers, and payers? (See Medical Staff Policy, *Conflict of Interest Policy for Medical Staff, 8710-555*).

Yes _____ **No**_____

If you answered "YES," please disclose them in the space provided below.

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Practitioner Signature

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF
CONTINUING MEDICAL EDUCATION (CME)

ISSUE DATE: 05/08	**SUBJECT:** ~~Conflict of Interest Resolution~~Prevent Commercial Bias and Marketing
REVISION DATE~~(S)~~: 05/08, 11/12, 08/14, 06/18, 03/19 03/20, 04/21	**POLICY NUMBER:** 8710-605

Medical Staff Department Approval:	~~10/20~~11/22
CME Committee Approval:	~~01/21~~10/22
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~03/21~~01/23
Administration Approval:	~~04/21~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/21

A. **PURPOSE:**

1. **Standard 2:** To outline a process that will ensure **the following** ~~all stated potential conflict of interest of anyone in control of content~~ for AMA PRA Category 1 Credit(s)™
   - a. **The accredited provider must ensure that all decisions related to the planning, faculty selection, delivery, and evaluation of accredited education are made without any influence or involvement from the owners and employees of an ineligible company.**
   - b. **Accredited education must be free of marketing or sales of products or services. Faculty must not actively promote or sell products or services that serve their professional or financial interests during accredited education.**

   The accredited provider must not share the names or contact information of learners with any ineligible company or its agents without the explicit consent of the individual learner.

   ~~2.~~c. ~~is resolved.~~

B. **DEFINITION(S):**

~~1.~~ **Ineligible Company: Any entity whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.** ~~Conflict of Interest: A relationship with a commercial interest that benefits the individual in any financial amount and that has occurred within the past twelve (12) months; and has the opportunity to affect continuing medical education (CME) activity content with respect to the commercial interest's products or services.~~

1. **Relevant Financial Relationships: Financial relationships are relevant if the following three conditions are met for the individual who will control content of the education;**
   - a. **A financial relationship, in any amount, exists between the person in control of content and an ineligible company.**
   - ~~a.~~b. **Financial relationship existed during the past 24 months.**
   - c. **The content of the education is related to the products of an ineligible company with who the person has a financial relationship.** ~~Resolution of Conflict of Interest: To alter the financial relationship with the commercial interest; and/or alter the individual's control over the CME activity content with respect to the commercial interest's products or services.~~

C. **POLICY:**

~~**Scope of Practice – Allied Health Professionals**~~

1. All ~~conflict of interest~~**l relevant financial relationships** -for individuals who are in the position to control content for Category I Continuing Medical Education (CME) activities shall be disclosed and ~~resolved~~ **mitigated.**
2. **If the relevant financial relationship** ~~conflict of interest status~~ cannot be identified or resolved, the individual(s) shall not have any content control for Category I activities.
3. **If any of the following statements apply to the education, you do not need to identify, mitigate, or disclose relevant financial relationships for this accredited continuing education;**
   a. **It will only address a non-clinical topic (e.g. leadership or communication skills training)**
   b. **It is for a learner group that is in control of the content entirely (e.g. spontaneous case conversation among peers).**
   ~~a.~~**c. It is a self-directed educational activity where the learner will control their educational goals and report on changes that resulted (e.g. learning from teaching, remediation, or a personal development plan). When accredited providers serve as a source of information for the self-directed learner, they should direct learners only to resources and methods for learning that are not controlled by ineligible companies.**

D. **PROCEDURE:**

1. **Standard 3: These relationships must not be allowed to influence accredited continuing education. The accredited provider is responsible for identifying relevant financial relationships between individuals in control of educational content and ineligible companies and managing these to ensure they do not introduce commercial bias into the education. Financial relationships of any dollar amount are defined as relevant if the educational content is related to the business lines or products of the ineligible company.** Document all ~~conflict of interest resolved~~**relevant financial relationship** ~~or unresolved~~ in CME Committee minutes.
   a. **Collect information: Collect information from all planners, faculty and others in control of educational content about all their financial relationships, regardless of the amount, with ineligible companies within the prior 24 months. There is no minimum financial threshold; individuals must disclose all financial relationships, regardless of the amount, with ineligible companies. Individual must disclose regardless of their view of the relevance of the relationship to the education.** ~~If a conflict of interest is identified for a CME activity planning member (to include significant other), he/she shall recuse themselves from contributing to the discussion of content planning.~~
   b. **Exclude owners or employees of ineligible companies: Review the information about financial relationship to identify individuals who are owners or employees of ineligible companies. These individuals must be excluded from controlling content or participating as planners or faculty in accredited education (see C.3. for three exceptions).** ~~If a conflict of interest is identified for a speaker/author with the ability to control content, the CME Committee or designee shall ensure that the conflict is addressed by one of the following methods:~~
      ~~i. Replace the speaker/author.~~
      ~~ii. Review the speaker/author's presentation materials prior to the CME activity to ensure they are free of commercial bias.~~
      ~~iii. Notify the speaker/author that he/she is not to discuss any therapeutic options.~~
      ~~iv. Choose the materials from which the therapeutic recommendations will be made.~~
   c. **Identify relevant financial relationships: Review the information about financial relationships to determine which relationships are relevant. Financial relationships are relevant if the educational content an individual can control is related to the business lines or products of the ineligible company**

~~**Scope of Practice – Allied Health Professionals**~~

~~d. .If it is determined that the chosen speaker/author with a conflict of interest is the best candidate to deliver the presentation, the speaker/author shall read, complete, and sign the following documents:~~

~~i. Faculty Disclosure & Resolution Declaration Form.~~

~~Content Validation Form.~~

~~e.~~**d. Mitigate relevant financial relationships: Take steps to prevent all those with relevant financial relationships from inserting commercial bias into content.**

- **i. Mitigate relationships prior to the individuals assuming their roles. Take steps appropriate to the role of the individual. For example, steps for planners will likely be different than for faculty and would occur before planning begins.**
- **ii. Document the steps taken to mitigate relevant financial relationships**

~~f.~~**e. Disclose all relevant financial relationships to learners: Disclosure to learners must include each of the following:**

- **i. The names of the individuals with relevant financial relationships.**
- **ii. The names of the ineligible companies with which they have relationships.**
- **iii. The nature of the relationships**
- **iv. A statement that all relevant financial relationships have been mitigated.**

~~g.~~**2. Identify ineligible companies by their name only. Disclosure to learners must not include ineligible companies' corporate or product logos, trade names, or product group messages.**

~~h.~~**3. Disclose absence of relevant financial relationships. Inform learners about planners, faculty, and others in control of content (either individually or as a group) with no relevant financial relationships with ineligible companies.**

~~i.~~**4. Learners must receive disclosure information, in a format that can be verified at the time of accreditation, before engaging with the accredited education.**

~~2. Ask participants if commercial bias was observed in the speaker/author's presentation. If commercial bias is determined, appropriate action shall be taken by the CME Committee/designee to rectify future CME activities, and reduce the potential for commercial bias in these activities.~~

E. **FORM(S)**:

1. ~~Faculty~~ **CME** Disclosure Form ~~& Resolution Declaration~~
2. **Learners Disclosure Form.**
3. ~~Content Validation Form.~~

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

1. **Toolkit for the Standards for Integrity and Independence in Accredited Continuing Education**

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

1. ACCME Standards **2: Prevent Commercial Bias and Marketing in Accredited Continuing Education.**
2. **ACCME Standard 3: Identify Mitigate and Disclose Relevant Financial Relationships ~~of Commercial Support.~~**
3. **Key Steps for the ~~indentificationk~~Identification Mitigation, and Disclosures of relevant Financial Relationships (ToolKit).**

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 11/10	**SUBJECT:** Conflict Resolution Medical Staff
REVISION DATE~~(S)~~: 11/10, 4/17, 03/20	**POLICY NUMBER:** 8710 – 562
Medical Staff Department Approval:	~~03/17~~02/20
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~02/~~20~~01/23
Administration Approval:	~~03/20~~03/23
Professional Affairs Committee Approval:	~~04/17~~n/a
Board of Directors Approval:	~~04/17~~03/20

A. **PURPOSE:**

1. The Medical Staff, Healthcare District (TCHD) hospital management, and the District Board, will each use their best efforts to address, and resolve all conflicts between the Board, Medical Center, and the Medical Staff in the best interests of patients, the Medical Staff, TCHD, and the District Board.

B. **POLICY:**

1. Prior to the District Board taking any action contrary to a recommendation made by the Medical Executive Committee (MEC) relating to patient safety or quality, the Chair of District Board, or a designee, and management shall meet with representatives of the MEC, including the Chief of the Medical Staff, and seek to resolve the conflict through informal discussions.
2. If these informal discussions fail to resolve the conflict, the Chief of Staff or the Chairperson of the District Board may request the issue be addressed by the Joint Conference Committee. If a resolution is agreed upon in the Joint Conference Committee, the resolution will be forwarded to the MEC for approval.
3. If after consideration at the Joint Conference Committee the conflict is still unresolvable, then the Chief of Staff and the Chairman of the District Board or the Chief Executive Officer may request a formal conflict resolution process.

C. **PROCEDURE:**

1. The formal conflict resolution process will begin with a meeting of an Ad Hoc Committee within 30 days of the initiation of the formal conflict resolution process. The Ad Hoc Committee will be composed of:
   a. The Chief of Staff, past Chief of Staff, and at the discretion of the Chief of Staff either the Medical Staff Professional Behavioral Chair or the Chair for Quality Assurance/Performance improvement/Patient Safety.
   b. The Chair, Secretary, and Vice Chair of the District Board.
   c. The Chief Executive Officer or his/her designee.
2. If the Committee cannot produce a resolution to the conflict that is acceptable to the MEC and the Board within 30 days of the initial meeting, the MEC and the District Board shall enter into Mediation as that term is defined by California Evidence Code Section 1115. The MEC and the District Board shall together select the third-party mediator. The MEC and the District Board shall use their best efforts to collaborate with the third-party mediator to resolve the conflict. The District Board Chair and the MEC shall each designate at least three people to participate in the mediation. Any resolution arrived at during such a meeting shall be subject to the approval of the MEC and the District Board. The Mediation proceedings shall be confidential pursuant to Evidence Code Section 1119.

a. If, after 90 days from the date of the initial request for Mediation the MEC and the District Board cannot resolve the conflict in a manner agreeable to all parties, the District board shall have the authority to act on the issue that gave rise to the conflict in a manner consistent with the Medical Staff Bylaws and California law.

b. With respect to membership, privileges and peer review matters governed by Articles IV, V, VI and VII of the Medical Staff By-laws, this Conflict Resolution Policy shall not be utilized until the procedures set out in the By-laws have been exhausted. This Policy shall also be used for the meet and confer requirements of California Business & Professions Code Section 2282.5.

c. If the Board determines, in its reasonable discretion, that action must be taken related to a conflict in a shorter time period than that allowed through this conflict resolution process in an attempt to address an issue of quality, patient safety, liability, regulatory compliance, legal compliance, or other critical obligations of TCHD, the District Board may take action subject to subsequent review, and any necessary revision, through the conflict resolution process described above.

D. **REFERENCE(S):**

1. Joint Commission Standards 202~~217~~

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**02/90**	**SUBJECT:**	**Credentialing of Emergency Medicine Practitioners for Emergency Ultrasounds**
REVISION DATE~~(S)~~:	**01/03, 03/09, 11/10, 01/11, 07/17, 04/19**	**POLICY NUMBER:**	**8710 – 522**

Medical Staff Department Approval:	**~~02/19~~04/21**
Department of Emergency Medicine Approval:	**~~02/19~~04/22**
Credentials Committee Approval:	**~~02/19~~07/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Interdisciplinary Committee Approval:	**10/22**
Medical Executive Committee Approval:	**~~03/19~~01/23**
Administration Approval:	**~~04/19~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/19**

A. **PURPOSE:**

~~1. The purpose of this credentialing process is:~~

~~a.~~1. To define the **various~~core~~** privileges for ultrasound in Emergency Medicine.

~~b.~~2. To outline the two pathways by which Emergency Physicians and **Allied Health Professionals (AHP)** ~~Physician Assistants~~ may demonstrate competency **and be granted privileges** in ~~basic~~ **E**emergency **U**ultrasonography **(EUS)**.

B. **CORE PRIVILEGES IN EMERGENCY ULTRASONOGRAPHY:**

1. **Trauma**
2. **Pregnancy**
3. **Cardiac/Hemodynamic Assessment**
4. **Abdominal Aorta**
5. **Airway/Thoracic**
6. **Biliary**
7. **Urinary Tract**
8. **Deep Vein Thrombosis (DVT)**
9. **Soft-tissue/Musculoskeletal (MSK)**
10. **Ocular**
11. **Bowel**
12. **Procedural Guidance**

~~1. Limited obstetrical ultrasonography, both transabdominal and endovaginal, to verify intra-uterine pregnancy.~~

~~2. Limited abdominal ultrasonography including limited renal, evaluation for abdominal aortic aneurysms, and Focused Abdominal Sonography for Trauma (eFAST) to evaluate for evidence of free intraperitoneal fluid, pericardial fluid, and pneumothorax.~~

~~3. Procedural guidance for procedures Emergency Physicians and Physician Assistants are credentialed to perform in a blinded manner, including but not limited to central line placement, paracentesis, thoracentesis, pericardiocentesis, and drainage of soft tissue fluid collections.~~

C. **ADVANCED PRIVILEGES:**

1. **Ultrasound guided deep nerve blocks**

~~C.~~D. **CREDENTIALING PATHWAYS:**

1. In accordance with the 200137 Model of Clinical Practice of Emergency Medicine as defined by the Accreditation Council for Graduate Medical Education (ACGME) and the American College of Emergency Physicians (ACEP) policy statement for emergency ultrasound guidelines, ~~two~~**following** pathways are recognized to demonstrate proficiency in emergency ultrasound.
   - **a. Physician** Residency-~~B~~**b**ased Pathway ~~which~~**for Core Privileges in EUS:**
     - **i.** ~~R~~**r**equires demonstration of completion of an ACGME- approved Emergency Medicine residency program **on or after July 1, 2010**
     - **ii. OR a letter from a residency program** ~~that includes~~**confirming formal** training in **EUS**~~emergency ultrasonography.~~
     - **iii. OR proof of competency vi a Residency Case Log to include a minimum of 150 EUS cases**
     - ~~a.~~**iv. For Advanced Procedures, the letter from Residency Program must also confirm formal training in the Advanced Procedures listed above, and/or a case log including a minimum of 20 cases in that category**
   - **b. Physician and Allied Health Professional** Practice-based Pathway **for Core Privileges in EUS**~~which~~**:**
     - ~~b.~~**i. This** requires **BOTH** of the following:
       - ~~i.~~**1) Demonstration of** ~~C~~**c**ompletion of a formal course in ~~basic~~ **EUS**~~emergency medicine ultrasound~~ covering the core applications with both didactics and practical hands-on sessions.
       - ~~ii.~~**2)** Experiential training period during which the practitioner must perform a minimum of **20**~~5~~ cases in **any combination**~~each~~ of the **C**~~c~~**ore P**~~p~~**rivileges** ~~#1 and #2 above~~.
         - ~~1)~~**a)** During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.
         - ~~2)~~**b)** The **review**~~proctoring~~ shall be conducted by emergency physicians already credentialed in **EUS**~~basic emergency medicine ultrasonography~~.
     - **ii.** ~~Core privilege number 3, procedural guidance privileges, has no proctoring requirement if the practitioner is already credentialed to do the procedure in a blinded fashion.~~
   - **c. Physician and Allied Health Professional Practice-based Pathway for Procedural Emergency Ultrasonography:**
     - **i. Physicians who are already credentialed to perform a procedure without ultrasound do not require additional credentialing to perform that procedure under ultrasound guidance.**
     - **ii. Allied Health Professionals (and physicians who are not already credentialed to perform these procedures) must demonstrate competency by completion of a formal course in basic Emergency Utrasonography (as above) AND by performing a minimum of 5 supervised ultrasound guided procedures in any combination of central lines, paracentesis, or thoracentesis**
       - **1) During this period, ultrasound examinations shall be reviewed for technique**~~, image~~**, image acquisition, organ definition, and diagnostic/procedural accuracy.**
       - **2) The proctoring shall be conducted by emergency physicians already credentialed in Emergency Ultrasonography.**
   - **d. Physician and Allied Health Professional Practice Based Pathway for Advanced Procedures:**
     - **i. This requires BOTH of the following:**
       - **1) Demonstration of completion of a formal course in Emergency**

Ultrasonography covering the Special Procedures listed above

2) Experiential training period during which the practitioner must perform a minimum of 5 supervised cases in any combination of the Special Privileges.

a) During this period, ultrasound examinations shall be reviewed for technique, image acquisition, organ definition, and diagnostic accuracy.

b) The review shall be conducted by emergency physicians already credentialed in ultrasound guided nerve blocks.

E. PROCTORING:

1. Proctoring is not required for physicians:

i. Who meet the Residency trained pathway requirements

ii. Who use ultrasound guidance to perform procedures for which that physician is credentialed to perform in a "blinded" manner.

2. For all physicians and AHP who are not excluded from proctoring by the criteria above, the following proctoring will be required:

a. Core Privileges: 20 cases in any combination of the Core Privileges

b. Procedural Ultrasonography~~:~~ Proctoring Criteria:

i. Three (3) cases of central line, and three (3) cases of either parcentesis or thoracentesis

~~iii.~~c. Advanced Procedures: 5 cases in any combination of the advanced procedure category

F. REFERENCE(S):

~~D.~~1. Ultrasound Guidelines: Emergency, Point-of-care, and Clinical Ultrasound Guidelines in Medicine, ACEP Policy Statement, June 2016

~~1. American College of Emergency Physicians 2008 Ultrasound Credentialing Guidelines~~

2. Core Privileges for Physicians, Fourth Edition, 188-195.
3. ACGME 201~~307~~ Model of Clinical Practice of Emergency Medicine
4. American Medical Association House of Delegates Resolution 802 and policy 230.989.

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**05/08**	**SUBJECT:**	**Influenza Vaccination of Physicians and Allied Health Professionals (AHP)**
REVISION DATE:	**05/08, 08/12, 06/17, 05/20**	**POLICY NUMBER:**	**8710 – 547**

Medical Staff Department Approval:	**~~02/20~~11/22**
Infection Control Committee Approval:	**~~03/20~~12/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**~~04/20~~01/23**
Administration Approval:	**~~05/20~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**

1. To increase influenza vaccination rates of healthcare workers to provide a healthier work environment and reduce adverse patient outcomes The Centers for Disease Control recommends that all health care workers receive an annual influenza vaccination to prevent transmission to patients. Influenza immunization rates among health care workers remain low, with only 36%-40% of health care workers reporting influenza vaccination each year. Influenza vaccination is an important patient safety issue because unvaccinated staff can spread influenza to patients, coworkers, and family members, leading to influenza-related illness and death. When health care workers become ill with influenza, absenteeism and disruption of care may result. When health care workers transmit influenza to patients, some of them may experience serious, even life-threatening complications or secondary pneumonias. California SB739 states the following: "Each general acute care hospital shall require its employees to be vaccinated, or if the employee elects not to be vaccinated, to declare in writing that he or she has declined the vaccination." This requirement applies to all health care workers, including physicians.

B. **POLICY:**

1. All active physicians and Allied Health Professionals (AHP) at Tri-City Healthcare District (TCHD) will participate in the Annual Influenza Vaccination or Declination program.

C. **PROCEDURE:**

1. The program requires physicians and AHP to either sign the Influenza Vaccine Declination Statement or be vaccinated by November 30 each year, unless the vaccine is unavailable.
2. Physicians and AHP who begin work at TCHD after November 30 and before April 1 will have 14 days after they begin to sign the Influenza Vaccine Declination Statement or be vaccinated.
3. If the physicians and AHP fails to be vaccinated at TCHD, or submit a signed declination pursuant to 4.6-5, the practitioner's reappointment application will be considered incomplete and the practitioner shall be deemed to have resigned membership in the medical staff within 30 days past the due date.

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

1. Employee Health & Wellness: Immunization Policy
2. Infection Control: Aerosol Transmissible Diseases and Tuberculosis Control Plan IC 11

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 06/04	**SUBJECT:** Medical Staff Governance Documents Development and Review and Approval Mechanism
REVISION DATE(~~S~~): 09/11, 04/17, 03/20	**POLICY NUMBER:** 8710 – 500
Medical Staff Department Approval:	~~03/17~~02/20
Medical Staff Committee Approval:	n/a11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~02/~~20~~01/23
Administration Approval:	~~03/20~~02/23
Professional Affairs Committee Approval:	~~04/17~~n/a
Board of Directors Approval:	~~04/17~~03/20

A. **PURPOSE:**
1. To provide guidelines for development, review, revision, and approval of Medical Staff self-governance documents.

B. **DEFINITION(S):**
1. For purposes of this policy, Medical Staff governance documents are the Medical Staff Bylaws and documents that supplement them, including but not limited to, rules and regulations, policies, protocols, and standardized procedures.
2. Standardized Procedures are as defined by Title 22 and Title 16 for the performance of medical procedures outside the normal scope of practice for a Registered Nurse.
3. Protocols are developed when the supervising physician adopts standards to govern the performance of a physician assistant for some or all tasks.
4. Process is a series of steps taken to accomplish a goal.
5. Policy describes a deliberate plan of action to guide decisions and achieve rational outcome(s).
6. Procedure describes how each step in the process is to be carried out.
7. Rules and Regulations refer to the rules and regulations that describe the privileges, competency, and other requirements of each Medical Staff Department, and/or Division. The General Medical Staff Rules and Regulations apply to all Medical Staff Members regardless of Medical Staff status.
8. Medical Staff Bylaws define the Medical Staff as a self-governing body.
   a. Issues that must be addressed in the Medical Staff Bylaws are as required by:
      i. The Medicare Conditions of Participation.
      ii. The Joint Commission Standards pertaining to the Medical Staff.
      iii. California Code of Regulations, Title 22 pertaining to the Medical Staff.
   b. The Criteria used to identify the issues that must be addressed in the Medical Staff Bylaws are as required by the:
      i. Medicare Conditions of Participation.
      ii. Joint Commission Standards pertaining to the Medical Staff.
      iii. California Code of Regulations, Title 22, pertaining to the Medical Staff.
      iv. Specific issues reviewed and determined to be appropriate by the Medical Staff Bylaws Committee.
      v. Specific issues as presented by Medical Staff members.

C. **GUIDELINE(S):**

1. Medical Staff governance documents are developed as needs are identified. They may relate to regular operations or functions of the Medical Staff, and are used to assure consistency for Medical Staff processes. Medical Staff governance documents are approved by the Medical Executive Committee and the Board of Directors. Medical Staff governance documents that are related to specific departments, divisions, or committees will also be reviewed and approved by that respective group.
2. Standardized Procedures are developed when the physician is authorizing nurses to assist in certain patient care activities under the general supervision of physicians. Standardized Procedures are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Standardized Procedures are reviewed as provided in the standardized procedure, and updated as necessary.
3. Department and Division Rules and Regulations are subject to the approval process outlined in the Medical Staff Bylaws (Section 9.4(l) and 9.5).
4. The General Medical Staff Rules and Regulations are subject to the approval process outlined in Section 13.1 of the Medical Staff Bylaws.
5. Medical Staff Bylaws are reviewed and approved per Medical Staff Bylaws (Article 14).
6. The minimum content of protocols shall be as provided in California Business & Professions Code Section 3502. Protocols must be authenticated and dated by the supervising physician and the physician assistant, with a copy provided to the Medical Staff. The supervising physician shall review, counter-authenticate, and date a minimum of 10% sample of medical records of patients treated pursuant to protocols within thirty (30) days of the date of treatment. Protocols are approved by the Division and/or Department level, the Pharmacy and Therapeutics Committee (if necessary), the Interdisciplinary Practice Committee, the Credentials Committee, the Medical Executive Committee and the Board of Directors of the hospital. Protocols are reviewed and updated as necessary.

D. **REFERENCE(S):**

1. The Joint Commission 2022~~17~~ Medical Staff Standards.

Tri-City Medical Center
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 10/01	**SUBJECT:** Name Tags for Health Care Practitioners
REVISION DATE~~(S)~~: 09/11, 11/14, 04/17, 03/20	**POLICY NUMBER:** 8710 – 521

Medical Staff Department Approval:	~~03/17~~02/20
Medical Staff Committee Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17 02/20~~01/23
Administration Approval:	~~03/20~~02/23
Professional Affairs Committee Approval:	~~04/17~~n/a
Board of Directors Approval:	~~04/17~~03/20

A. **PURPOSE:**

1. To outline the requirements for name badges for Medical Staff members and Allied Health Professionals (AHP), in accordance with the provisions of California Business & Professions Code Section 680.

B. **REQUIREMENT(S):**

1. All health care practitioners who have been granted membership and/or clinical privileges must wear name badges.
2. The name badge must disclose his/her name per license/credential, licensure status as granted by the State, and photo.
3. This name badge must be in at least 18-point type font.
4. The name badge must be worn and visible while providing care in the hospital.

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 11/03	**SUBJECT:** Physician Orders/Family Members
REVISION DATE~~(S)~~: 09/11. 12/14, 04/17, 03/20	**POLICY NUMBER:** 8710 – 529

Medical Staff Department Approval:	~~03/17~~02/~~20~~11/22
Medical Staff Committee Approval:	n/a11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~02/~~20~~01/23
Administration Approval:	~~03/20~~02/23
Professional Affairs Committee Approval:	~~04/17~~n/a
Board of Directors Approval:	~~04/17~~03/20

A. **PURPOSE:**

1. To outline the ethical and compliance issues for a physician who wants to order tests or therapies on themselves or their family members.

B. **POLICY:**

1. It is the policy of the Medical Staff of Tri-City Healthcare District (TCHD) that it is inappropriate for physicians to evaluate, and treat themselves or immediate family members except in emergency settings, isolated settings where there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. The American Medical Association (AMA) issued a statement, E-8.19 regarding physicians treating themselves or members of their immediate families, and the Medical Staff supports that statement. (See attached AMA Statement).
3. The Code of Federal Regulations states that Medicare will not cover charges for services provided to a patient who is an immediate family member of the physician or a member of the physician's household.
4. TCHD follows Medicare rules with regard to compliance issues.

C. **DEFINITIONS OF TERMS:**

1. Immediate family members are defined as follows:
   a. Husband or wife.
   b. Natural or adoptive parent, child or sibling.
   c. Stepparent, stepchild, stepbrother, stepsister.
   d. Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law.
   e. Grandparent or grandchild.
   f. Spouse of grandparent or grandchild.
2. Member of the household means:
   a. Any person sharing a common abode as part of a single-family unit.
   b. Domestic employees and others who live together as part of a family unit, not a roomer or boarder.
3. Physician:
   a. Immediate family member.
   b. Member of household.
   c. MD, DO, DDS with membership to TCHD Medical Staff.
4. Patient means whoever of the following is receiving the tests or therapies:
   a. Physician
   b. Immediate family member.
   c. Member of household.

D. **PROCESS:**

1. Medical Staff members can only order tests and prescribe treatment for themselves, their immediate family members, and members of their household in an emergency, if there is no other qualified physician available, or in situations in which routine care is acceptable for short-term, minor problems.
2. Per Code of Federal Regulations and other TCHD contractual agreements, the patient may be responsible for charges incurred.

E. **GUIDELINE(S):**

1. AMA Ethical Opinion E-8.19 - Sample
2. 42 C.F.R. § 411.12.

AMA STATEMENT

E-8.19 Self-Treatment or Treatment of Immediate Family Members.

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE: 06/04

SUBJECT: Physicians' Well-Being Committee Policy

REVISION DATE~~(S)~~: 09/07, 03/12, 04/17, 03/20

POLICY NUMBER: 8710 – 511

Medical Staff Department Approval:	~~03/1 02/20~~11/22
Medical Staff Committee Approval:	~~n/a~~11/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17 02/20~~01/23
Administration Approval:	~~03/20~~02/23
Professional Affairs Committee Approval:	~~04/17~~n/a
Board of Directors Approval:	~~04/17~~03/20

A. **POLICY:**

1. It is the policy of Tri-City Healthcare District (TCHD) Medical Staff to offer assistance to those physicians who are physically or emotionally impaired or under the influence of alcohol or drugs, and who may benefit from rehabilitation or hospitalization. Furthermore, TCHD's policy is to enhance the safety and security of patients, physicians, and employees, and to prevent impaired physicians who may harm patients from practicing medicine.
2. In this regard, this process provides education about physician health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.

B. **PURPOSE:**

1. The Physicians' Well-Being Committee is established to provide a process for assistance and rehabilitation, rather than discipline, to aid a physician in retaining or regaining optimal professional functioning, consistent with protection of patients, staff and physicians. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a physician is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

C. **PROCESS:**

1. The process design includes but is not limited to the mechanisms for the following:
   a. Evaluate the credibility of a complaint, allegation, or concern; communicate with the referred physician.
   b. Provide annual education to the medical staff and other TCHD staff about illnesses and impairment recognition issues specific to physicians, (at-risk criteria), and to take steps to promote wellness.
   c. Establish a self-referral process by a physician or other TCHD staff:
      i. Self-referrals shall be made directly to the Chairman of the Physicians' Well-Being Committee when possible.
      ii. Issues identified through the hospital's Quality Review Reporting process should be routed directly to the Medical Staff Office, and forwarded to the Chairman of the Physicians' Well-Being Committee.
   d. Referral of the affected physician to the appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

e. Assure and maintain the confidentiality of the physician who is seeking referral or being referred for assistance, and/or the informant if applicable, except as limited by applicable law, ethical obligation, or when the health and safety of a patient, staff, or other physician is threatened:
   i. Any retaliation against the informant will not be tolerated, and will be referred to the Professional Behavior Committee for appropriate action.

f. Monitor the affected physician and the safety of patients until rehabilitation is complete and if applicable periodically thereafter.

g. Report to the Medical Staff leadership instances in which a physician is providing unsafe treatment or engaging in behavior that undermines the culture of safety.

D. **SPECIAL CONSIDERATION:**

1. It is the physician's responsibility to comply with the Physicians' Well-Being Committee's assistance and recommendations.
2. Noncompliance with completion of the required rehabilitation program will be reported to the Medical Executive Committee for appropriate action.
3. Unsafe treatment provided by an impaired physician will be reported to the Medical Executive Committee for appropriate action or referral.

E. **REPORTING:**

1. A report will be provided to the Medical Executive Committee and to the Board on a quarterly basis.

F. **DOCUMENTATION:**

1. While the Physicians' Well-Being Committee records are ultimately the property of TCHD Medical Staff, active records will be retained by the Chair of the Physician Well Being Committee.
2. Information, as applicable, will be maintained in a locked file in the Medical Staff Office with access only to the Chief of Staff, and the Chair of the Physicians' Well-Being Committee.

G. **REFERENCE(S):**

1. The Joint Commission Medical Staff Standards 2021~~17~~.
2. Medical Staff Bylaws.

Tri-City Healthcare District
Oceanside, California

MEDICAL STAFF

ISSUE DATE:	**06/02**	**SUBJECT:**	**Supervision of Residents in Emergency Medicine**
REVISION DATE:	**06/02, 02/06, 04/08, 10/13, 05/16 07/17, 04/20**	**POLICY NUMBER:**	**8710 – 571**

Medical Staff Department Approval:	**~~02/20~~11/22**
Emergency Medicine Approval:	**~~03/20~~12/22**
Pharmacy & Therapeutics Committee Approval:	**n/a**
Medical Executive Committee Approval:	**~~03/20~~01/23**
Administration Approval:	**~~04/20~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**04/20**

A. **POLICY:**

1. All medical care provided by Emergency Medicine (EM) Residents is under the supervision of the Director of the Emergency Residency Rotation or a designated Medical Staff member(s) who are member (s) of Tri-City Healthcare District (TCHD) Medical Staff. Each emergency medicine resident is at least a 3rd or 4th year emergency medicine resident who is doing a clinical rotation at TCHD to round out their community hospital education. Every patient seen by an emergency medicine resident, on either required or elective clinical rotation, will have a designated emergency medicine physician medical staff member (s) who will be responsible for and will supervise all medical care provided by the residents, and will be directly involved in the treatment of every patient. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements, and potential participation in departmental grand rounds before starting his/her month long rotation. The residency rotation director gives individual verbal feedback of the residents' performance during the course of the rotation, in addition to submitting a formal written evaluation to the Emergency Medicine Residency Program Director at the completion of each resident's rotation (see sample Resident evaluation form). Finally, the progress of the program is reviewed at the GME committee annually, and on an ad hoc basis in the Emergency Department meeting.

B. **PROCEDURE:**

1. Orientation:
   a. Each emergency resident is orientated to his/her responsibilities, job description (function in the department), documentation requirements (P&P 8710-513), and potential participation in departmental grand rounds before starting his/her month long rotation.
2. Orders:
   a. Emergency medicine residents may write orders on the chart, or type in orders utilizing the computer ordering system, under supervision and review by an attending emergency department physician - a member of the TCHD medical staff and the department of Emergency Medicine.
   b. Verbal orders are permitted during codes and extreme emergency situations with instantaneous review from the supervising emergency physicians present with the resident and patient.
      i. If a nurse or other hospital employee has any question about any order given by the emergency medicine resident they may immediately question the resident and the supervising emergency department physician.

c. The supervising emergency department physician will review all orders.

3. Documentation:
   a. Documentation on each patient will be dictated by the emergency medicine resident (complete dictation), or entered into the computerized documentation system. The attending emergency department physician will also document an attending summary either via dictation or using the computerized documentation system. (See P&P 8710-513).
4. Direct versus Indirect Supervision of Residents in the Emergency Department In accordance with the Common Program Requirements established by the Accreditation Council for Graduate Medical Education (ACGME), this section defines the levels of supervision provided to residents rotating through the emergency department at TCHD for different stages of their training and for various labels of knowledge and skills.
   a. Levels of Supervision
      i. Direct Supervision: The supervising physician is physically present with the resident and the patient.
      ii. Indirect Supervision with Direct Supervision immediately available: The supervising physician is physically within the hospital and usually, within the department, and is immediately available to provide direct supervision.
   b. Permissible Level of supervision by graduate year of training
      i. Emergency medicine residents in Post Graduate Year 1 and 2 must be directly supervised at all times.
      ii. Emergency medicine residents in Post Graduate Year 3 and 4 may be indirectly supervised with direct supervision immediately available.
   c. While it is expected that the sequential levels of supervision allow for progressive independence and autonomy, residents rotating through TCHD emergency department may not supervise less experience residents but instead must be supervised only by an attending physician who is board certified (or board eligible) in emergency medicine.
5. Emergency Resident Position Description (job description) during TCHD rotation:
   a. Goals and objectives of the EM residency training program are set forth in the EM residency curriculum document. Overall, the goal of the EM training program is to provide EM residents with an extensive experience in the art and science of emergency medicine in order to achieve excellence in the diagnosis, care and treatment of emergency patients-Additionally, this experience will help to establish the trainee's eligibility to participate in the American Board of Emergency Medicine's board examination. In accordance with this curriculum, the EM resident trainee agrees to do the following while at TCHD, other institutions and the parent organization:
      i. Develop and participate in a personal program of self-study and professional growth with guidance from the EM faculty teaching staff.
      ii. Under the supervision of the EM faculty, participate in safe, effective, and compassionate patient care, consistent with the trainee's level of education and experience and in accordance with the Residency's description of graduated responsibility.
      iii. Participate fully in the educational activities of the residency program and assume responsibility for participation in the teaching of more junior physicians, of medical students and students in allied health professions.
   b. The required educational activities of the EM residency are summarized as follows:
      i. A minimum attendance level at all mandatory EM conferences either offsite or onsite.
      ii. Record and update procedure logs, ultrasound logs, and patient follow up logs. Participate in procedure labs and follow up conference. Participate in institutional programs and activities involving the medical staff and adhere to established practices, procedures, and policies of the institution.
      iii. Develop an understanding of ethical, socioeconomic, and medical/legal issues that affect graduate medical education and the practice of emergency medicine.

Learn cost containment measures in the provision of patient care.

iv. Perform all duties in accordance with the established practices, procedures and policies of the institution, the emergency medicine program, and other institutions to which the resident is assigned.

v. Formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed.

vi. The EM-3 resident will have developed skills as a clinical teacher and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.

vii. Adhere to the emergency department schedule of assigned shifts, as well as the call schedule and assignments of off service rotations, in a prompt and timely fashion.

c. Document patient care in the medical record in a timely fashion as per medical staff policy.

i. Adhere to the ACGME institutional requirements and the ACGME-RRC program requirements for emergency medicine.

ii. Participate in the evaluation of the EM training program.

iii. Comply with the licensure requirements of the State of California and/or State of California requirements if in Active Duty, and the laws of the State and Federal Governments.

iv. Adhere to the policies of the Emergency Medicine Residency- parent and rotation and adhere document entitled; Guidelines for Managing Impaired Residents.

v. Adhere to the principles of the SAEM and CORD Statement on Professionalism in Emergency Medicine summarized as follows:

1) The specialty of emergency medicine recognizes the importance of defining its professional responsibilities, values, and commitments. Trainees must be taught and emergency physicians must practice the following:

a) To make clinical decisions according to the best interests of the patient.

b) To behave in a manner that enhances patient trust.

c) To deliver high quality emergency medical care, maintaining the highest level of knowledge and skills.

d) To listen attentively, maintain confidentiality, and communicate truthfully, respectfully, openly, and honestly.

e) To be an advocate for the health care needs of emergency patients and the community.

f) To place the interest and well-being of the patient above self-interest.

g) To serve as a role model for health care professionals in training.

h) To work collegially with others, helping to create a productive and effective work environment.

d. Summary:

i. Professionalism is defined as behaviors that enhance the trust of patients and of society. This is accomplished by putting the needs of patients ahead of the physician's self-interest. Professionalism must be demonstrated by all emergency medicine professionals, integrated into residency training programs,

and continually reinforced. At this time of tumultuous change, professionalism serves as a point of reference, at the core of the identity of the emergency medicine specialist.

C. **GRADUATED RESPONSIBILITY FOR EMERGENCY MEDICINE RESIDENTS:**

1. The emergency medicine (EM) residency provides a graduated level of responsibility for EM trainees. Residents enter into the EM residency after successful completion of a PG-I (general internship) and in the case of the Navy residents some in the field practice. These residents are assumed to have developed the basic skills of history-taking and physical examination, as well as general medical and surgical patient work-up and management
2. Before the emergency medicine resident arrives at TCHD, he/she will be expected to have mastered basic skills in initial stabilization, essential diagnostic work-up, emergency core procedures, and emergency department management of individual acutely ill and injured patients in the unique environment of the ED.
3. By completion of the EM-2 (PGY-III) year, EM residents will have acquired expertise in multi-tasking and managing both patient care and administrative responsibilities simultaneously. The EM-2 resident will be comfortable in managing, and prioritizing the patient care of multiple patients. Furthermore, EM-2 residents will be able to take on the additional responsibilities of the stabilization and work-up of emergency department patients, emergency core procedures, and coordinating further inpatient or outpatient evaluation and care with representatives of other specialties. Furthermore, EM-2 residents will actively participate as base hospital physicians directing paramedic pre-hospital providers.
4. Upon completion of the EM-3 (PGY-IV) year of residency, EM trainees will have mastered all the above skills and in addition be capable of supervising all operational issues regarding patient flow and prioritization in the ED, as well as the pre-hospital setting. An EM faculty member is continuously present in the ED, but the EM-3 resident is expected to formulate diagnostic, therapeutic and disposition decisions independently. The EM-3 resident will be able to competently perform all the major critical procedures for the stabilization and treatment of emergency patients. Administrative skills of appropriate transfer of ED patients in accordance with applicable state and federal regulations and interfacing with representatives of HMOs and other third party payers will be stressed. The EM-3 resident will have developed skills as a clinical teacher, and mastered presentation skills in case conference and lecture formats. Original research has been conducted, and the resident has developed skills in literature review and critical appraisal. The basic skills to provide evidence-based healthcare have been acquired. Significant teaching and academic responsibilities are included in the EM-3 experience.
5. Residency progress will be reviewed; problems with communication, suggestions for improvement, and other questions of a general nature will be addressed. Any specific medical problem with the resident's management will be discussed in the monthly Department QA meetings as necessary.

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

1. Resident Evaluation Form – Sample

Resident Evaluation Form – Sample

Tri-City Medical Center
Medical Staff Office
4002 Vista Way
Oceanside, CA 92056
(760) 940-3071 (phone) * (760) 940-3486 (fax) plantsm@tcmc.com (e-mail) *

ANNUAL ASSESSMENT "EFFECTIVENESS OF GENERAL MEDICAL EDUCATION PROGRAM"

The Medical Executive Committee is interested in your comments regarding the GME program held at TCMC. Your feedback is vital to the continued success of the program.

ANNUAL ASSESSMENT "Effectiveness of GME Program"	Yes	No
1. Do you feel that the GME Program meets your needs? **Comments:**		
2. Have the medical students/residents/fellows been well received by the patients and staff? **Comments:**		
3. Are the medical students/resident's/fellows rotations sufficient to enable them to experience all acuity levels of the patients? **Comments:**		
4. Has the supervision of the medical students/residents/fellows been consistent with the standards? **Comments:**		
5. Was this program successful in meeting the needs of the hospital, patients and participants, and should the program be continued? **Comments:**		
6. During peer review, have there been any identified outliers that have not been consistent with the standard of care within the department? **Comments:**		
7. Has the clinical decision making process been appropriate and dependable? **Comments:**		
8. Were all safety precautions/protocols identified/followed? **Comments:**		
9. **Any additional comments/suggestions:**		
10. **Future Goals and Actions for 2017:**		

Thank-you for participating in the evaluation of TCMC's GME Program.

Signature *Date*

Please return completed form to the Medical Staff Office: Attn: Sarah Plant

Tri-City Medical Center
Oceanside, California

ULTRASOUND AND VASCULAR IMAGING

ISSUE DATE: 05/11 **SUBJECT:** How to Report a Critical/Stat Read

REVISION DATE~~(S)~~: 01/18

Ultrasound Department Approval:	~~08/17~~09/21
Department of Radiology Approval:	~~10/17~~12/22
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~11/17~~01/23
Administration Approval:	
Professional Affairs Committee Approval:	01/18
Board of Directors Approval:	01/18

A. **DEFINITION(S):**

1. A critical result is identified as a result that changes the management of patient care. Some examples are deep vein thrombosis, ectopic, or pseudo-aneurysm.

B. **POLICY:**

1. After scanning a patient and speaking with a radiologist to confirm that it is a critical read the sonographer must contact the referring physician for further instruction.
2. A phone call will be placed to the referring physician office explaining the results and requesting further instructions for the patient.
3. The sonographer must document the phone call. Make sure the date, time and person the sonographer spoke to are documented on the requisition under the "critical results" area.
4. The sonographer will complete the exam in Cerner and McKesson and scan in the documented critical results requisition.
5. The sonographer will speak with the patient regarding the instructions from the referring physician.
6. The Sonographer will scan the paperwork into Mckesson and then shred the paperwork

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES

ISSUE DATE: 10/94

SUBJECT: Partners ~~I~~in Care for Women and Newborn Services

REVISION DATE~~(S)~~: 01/00, 06/03, 08/09, 07/10, 06/14, 01/19

Women and Newborn Services Department Approval:	~~11/18~~04/20
Department of OB/GYN Approval:	~~n/a~~11/22
Perinatal Collaborative Approval:	n/a
Department of Pediatrics Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~01/19~~02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. **PURPOSE:**

1. The healthcare team supports the presence of family and friends as "Partners in Care" and encourages their ongoing participation during their stay at Tri-City Medical Center (TCMC) to enjoy full and equal visitation privileges consistent with the wishes of the patient. ~~The staff of Tri-City Medical Center (TCMC) for Women and Newborn Services (WNS) are committed to supporting the strength and integrity of families as they adapt to the physical and psycho/social changes brought about by childbirth. We promote a patient and family centered care philosophy that is a mutually beneficial partnership between healthcare providers, patients, and their families.~~ In order to address special circumstances, exceptions may be made by the Charge Nurse (RN), ~~and/or~~ the ~~Assistant Nurse~~ Manager on duty, or ~~delegeee~~signee. ~~The healthcare team supports the presence of family and friends as "Partners in Care" and encourages their ongoing participation during their stay at TCMC to enjoy full and equal visitation privileges consistent with the wishes of the patient. Visitation rights will not be denied on the basis of race, color, national origin, religion, sex, sexual orientation, gender identity or disability.~~

B. **PROCEDURE:**

1. All Partners ~~I~~in Care:
   - a. Will be issued a visitation sticker for safety and security purposes that must remain visible ~~while in the hospital and when entering into the WNS area~~at all times while in the hospital.
     - i. The "~~patient will determine the~~ support person" (determined by the patient) ~~that~~ will receive the 2nd adult baby band in place of the visitation ~~stickerwhich~~sticker. ~~which will and then the band will permit that person to enter the WNS area.~~
     - ii. ~~The 2nd adult baby band for the support person is not transferable~~Once the support person has been banded, the band is non-transferable.
     - iii. The support person must be over the age of 18, unless the father is a minor.
     - iv. The support person is welcome at the bedside 24/7.
   - ~~a.~~b. Are welcome to visit between the hours of 8am and 8pm, except in labor and delivery.

b. Will need to perform thorough hand hygiene prior to entering and exiting the patient room.

c. Will have a restriction of visitation for those children 14 and below during the influenza or Respiratory syncytial virus (RSV) season or as restricted throughout the community.

d. Children must be over the age of 1 one and need to be accompanied by an adult other than the patient when they are visiting.

i. They cannot be accommodated overnight.

ii. Strollers must be occupied.

c. Car seats are not allowed on the unit for safety reasons.

iii. Will need to wait in the waiting room if **visitation is restricted due to the need for privacy, clinical condition of the patient and/or baby, concerns for the patient(s) wellbeing, safety/security of other patients, and/or unusual activity in the department that temporarily is contrary to visitation.** an emergency occurs or if there is need for patient privacy.

e.d. In order to provide a confidential environment for patients and a safe environment for everyone, waiting in the hallways is not permitted.**Will wait in the designated waiting area not be permitted to linger in and not in the hallways in order to provide to ensure a confidential and safe environment for all.**

e. **Will be encouraged to take S**still photography of the **labor process,** baby, and/or mother, and family **(at the discretion of the staff and physicians),** **, per their request,** but not of the**Wwill not take videos or pictures during the** delivery or procedures. In some situations, it may be requested that no photography is performed.

f. **Children over the age of 1 may visit but must be accompanied by an adult other than the patient when they are visiting.**

2. Exceptions to "Family Presence or Visitors**Partners in Care" presence at the bedside**:

a. **The patient may request restrictions to the support person's or** Except when the patient, staff or provider chooses to restrict family and other "Partners in Care**"'s presence at the bedside at any time.**

a.b. **I**Limitations on the presence**to the support person or Partners in Care** of these individuals may be appropriate in exceptional circumstances**may be enforced in certain circumstances**, such as when:

i. A legal reason (e.g., a restraining order, the patient is in legal custody, or a court order) this will prohibit all visitors). **prohibiting visitors.**

i.1) **The patient will be registered as a "No Information" patient and staff will not be able to identify the patient's presence either via the phone or to an in-person visitor(s).**

ii. **When B**behavior is disruptive to maintaining a therapeutic environment on the patient care unit.

iii. **When A**a family member or visitor who is actively coughing, sneezing or has had a fever in the last 24 hours

iii.**iv.** **At the discretion of the health care team based on the patient's condition or unit activity.** is requested to not visit. This may jeopardize the patient's and baby's health.

3. Labor and Delivery **(LD)**:

a. "Partners in Care" are welcome in the patient's room, 24 hours/day., at the discretion of the patient. Visiting may be limited by the healthcare team if the patient's medical condition warrants. Waiting lounges are available during those occasions. The patient's spouse/significant other who is over the age of 18, unless the significant other is a minor, is encouraged to stay overnight while on the Labor and Delivery unit.

b. To ensure their comfort and safety, cChildren 14 and below **under** must be accompanied by an adult who is not the patient's primary support person while **the mother is in**in labor.

b.c. **For the first hour after delivery, it is recommended that the mother, significant others support person and baby are left alone to initiate skin to skin contact and**

promote bonding . During this time, it is recommended that the other Partners of Care stay in the waiting area unless the patient requests that theyall Partners in Care remain in the room.

c.4. Antenatal testing area-/-triage:

i.a. The antenatal testing/triage is a semi-private area for testing and evaluating expecting mothers.

ii. In order to respect the privacy of our patients only one the support person is recommended allowed in the Triage room. during this short term observation. They may be asked to step out of the Triage room for privacy per the patient or healthcare provider request.

Antepartum:

b. Partners in Care are welcome to visit between 8:00 a.m. to 8:00 p.m.

The spouse/significant other is encouraged to stay overnight. The support person must be over the age of 18, unless the father of the baby is a minor.

The number of visitors may be limited at the discretion of the healthcare team due to the medical condition of the patient.

d.5. Operating Room/PACU:

i.a. One The designated support person is welcome to attend a cesarean birth except in the event of an emergency. Observation may be denied in the event of an emergency.

ii.b. For Cesarean births, one visitorThe support person (usually the banded person) will be invited to the Recovery Room after initial stabilization of the patientescort the infant to the recovery room.

1) Other friends and family may wait comfortably in the waiting lounge.

4.6. PostpartumMother Baby Unit (MBU):

a. When transferring patients from LD to MBU Partners in Care will be left in the waiting room and only the support person will accompany the mother to the room. When the transfer from Labor and Delivery to Mother Baby occurs, we ask that only the banded person come to the room, while the other Partners in Care wait in the waiting room. This will give staff time to check the Mother and Baby prior to visitors entering.

a. "Partners in Care" are welcome to visit between 98 a.m. and 98 p.m. The number of guests may be limited in semiprivate rooms.per the discretion of the patient/significant other and possibly the healthcare team should a medical or safety issue arise.

b. As long as the patient doesn't have a "suitemate", tThe support person spouse/significant other is encouraged to stay overnight so they can participate in providing care and support to their new family.

i. The support person must be over the age of 18, unless the father of the baby is a minor.

ii.i. Chairs and recliners are provided for the support person.; the second bed is reserved for possible admission.

If the patient does have a "suitemate" then aAll guests, children and significant others willould need to say goodbye go home by 98 p.m., when visiting hours for the unit are over, to ensure privacy and rest for all involved.

b. If the Mother remains inpatient following the baby's discharge, the Baby needs to remain as a patient for additional medical treatment, and Baby is discharged, per protocol, Baby will then be considered a "Visitor" and require care by another adult over the age of 18 (not including the mother of the baby) unless the Father/Support person of the Baby is a minormust be accompanied by the support person at all times. The Baby cannot be left unattended at any time.alone with the mother. The parent(s)/patient/support peopleperson and the baby must keep their baby bands on the entire time that the mother is in the hospital in order to allow for visitation.

c. If the Baby ~~needs to remain as a patient for additional medical treatment, and the Mother is discharged, per protocol,~~remains inpatient following the mother's discharge, the baby will remain in MBU if the unit is able to accommodate the arrangement. One banded individual must remain with the infant at all times. ~~the Mother may be able to stay as a Visitor in a patient room with her Baby if the unit is able to accommodate the arrangement per the Charge Nurse discretion. If the unit~~MBU is unable to accommodate this, the baby will be transferred to the Neonatal Intensive Care Unit (NICU) for ~~care and that unit visitation policy will be utilized.~~ care. Refer to the NICU Visitation Policy for specifics. In either case the ~~parent(s)/significant other(s)~~banded individuals must keep their baby bands on the entire time the baby is in the hospital in order to visit the baby.

~~c.~~

~~5. Transition Nursery:~~

~~At the discretion of the healthcare team the "banded" primary support person is welcome in the Transition Nursery during the short term observation, if needed.~~

~~Together Time:~~

~~The unit will have a time for the Mother, significant other, and baby to bond that is considered a quiet time, if the patient wishes to observe this.~~

~~a. Neonatal Intensive Care Unit (NICU) see the unit specific policy for details.~~

C. RELATED DOCUMENT(S):

1. WNS Visitation Letter (English)
2. WNS Visitation Letter (Spanish)
3. Extended Stay Mother (English)
4. Extended Stay Mother (Spanish)
5. Extended Stay Baby (English)
6. Extended Stay Baby (Spanish)
7. Neonatal Intensive Care Unit Visitation Policy

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE: 06/14

SUBJECT: Standards of Care: Antepartum

REVISION DATE~~(S)~~: 05/17

Department Approval ~~Date(s~~:	~~12/16~~10/22
Department of OB/GYN Approval:	~~02/17~~11/22
Department of Pediatrics Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	~~04/17~~ n/a
Board of Directors Approval:	05/17

~~A. **PREAMBLE:**~~

~~1. Nursing practice in the care of women and newborns is delivered in an environment that respects the goals, preferences, and patient rights of the family from admission, through the episode of care, to discharge. The Women's and Newborn Services (WNS) nursing staff shall use established Tri City Medical Center (TCMC) and unit specific policies and procedures, and 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).~~

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

~~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) 2016, p.2)".~~

~~2. Scope of Nursing Practice: "Describes the who, what, where, when, why and how of nursing practice. Each of these questions must be answered to provide a complete picture of the dynamic and complex practice of nursing and its evolving boundaries and membership (ANA, 2016)".~~

~~3. Standards: "Authoritative statements defined and promoted by the profession by which the quality of practice, service or education can be evaluated" (ANA, 2016, p. 67).~~

~~a. "Standards of care are Standards of Professional Nursing Practice."~~

~~4. Nursing Process: "The essential core of practice for the Registered Nurse (RN) to deliver holistic, patient focused care. The practice as outlined by the ANA (2016) includes the following:~~

~~a. Assessment: A systematic, dynamic way to collect and analyze data about a patient i.e., patient. Assessment includes not only physiological data, but also psychological, sociocultural, spiritual, economic and life style factors". An assessment includes subjective and objective data~~

~~i. Subjective what the patient says.~~

~~ii. Objective observation based on assessment findings.~~

~~iii. Focused Assessment/Reassessment: A more specific generalized assessment that focuses on the main items need to be reassessed. This may be documented as no change since last assessment. The items that may be assessed are not all inclusive, but not limited to: orientation assessment, level of consciousness, affect/behavior, respiratory symptoms, respirations, respiratory pattern, and skin color and skin temperature.~~

~~b. Diagnosis: A nurse's clinical judgment about the patient'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 effectiveness of nursing care. It is a process that involves continuous evaluation of the patient and the modifications to the Plan of Care.
5. Patient: Recipient of nursing care.
6. Health Care Providers: Individuals with special expertise who provide health care services or assistance to patients
7. Significant Others: Family members and/or those significant to the patient
8. Reasonable and a timely manner: Defined as within 4 hours after completion of assessments or care provided.
9. Registered nurses use the nursing process to plan and provide individualized care to their patients. Nurses use the theoretical and evidence-based knowledge of human experiences and responses to collaborate with the 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, 2016)".

C. **WNSWNS STANDARDS OF PRACTICE:**
1. The results of care provided to the patient shall be continuously evaluated by the health care team, while looking for opportunities to improve delivery and quality of care given.
2. A comprehensive and dynamic data base shall be maintained on all patients admitted to the hospital.
3. The patient can expect to have appropriate confidentiality maintained at all times.
4. The patient can expect that the RN shall ensure the optimal desired level of privacy.
5. The patient can expect that the RN shall collect initial objective data within established time frames that reflect the gravity of his/her condition.
6. The patient can expect that the RN shall facilitate the availability of pertinent data and collaborate with other members of the health care team to establish an integrated plan of care.
7. The identification and prioritization of the patient's problems/needs shall be based on collected data obtained from assessments, patient/parent interviews, patient medical records, and from other members of the health care team.
8. The patient can expect that the RN shall utilize collected data to individualize the plan of care.
9. The patient can expect that the RN shall establish the priority of problems/needs on an ongoing basis according to the gravity of the patient's condition.
10. An appropriate plan of care shall be formulated for each patient.
11. The plan of care will be implemented according to the priority of identified problems or needs.
12. The plan of care shall be developed with an understanding of the psychosocial needs of the patient.
13. The patient can expect that there will be documentation of interventions related to the plan of care and that this documentation will be part of the patient's permanent medical record.

D. **NURSING PROCESS:**
1. Standards Of Care: Assessment
a. RN shall ensure all maternal and infant patients have a general system review in all systems completed. Detailed system assessments shall be completed as indicated by the patient's condition.
2. Standards Of Care: Diagnosis
a. RN shall review the data obtained from each patient's assessment, history, and information documented by the interdisciplinary team to identify outcomes to develop the patient's plan of care (POC) every shift and PRN.
3. Standards Of Care: Outcome Identification
a. RN shall use the information obtained from Standards of Care: Assessment and Standards of Care: Diagnosis to identify appropriate patient outcomes every shift and PRN.
4. Standards Of Care: Planning

~~a. RN shall use the outcomes identified in Standards of Care: Outcome Identification and the provider orders to develop an individualized patient POC. The POC shall prescribe interventions, which may be implemented to attain expected outcomes.~~
~~5. Standards Of Care: Implementation~~
~~a. RN shall implement the interventions identified in the POC and/or ensure unlicensed assistant personnel are assigned tasks appropriately.~~
~~6. Standards Of Care: Evaluation~~
~~a. RN shall evaluate the patient's progress toward obtaining their outcomes in the POC per TCMC policy.~~
~~b. Emergent and urgent changes in the patient's assessment shall be communicated to providers as soon as possible per TCMC policy.~~
~~c. Non-emergent and/or not urgent changes in patient's assessment shall be communicated during provider rounds, or as soon as possible within the shift the changes were identified~~
~~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 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.~~

I. **ADMISSION HISTORY:**
- A. Patient History
  1. All inpatients shall have the admission history completed and documented within 24 hours of admission to the unit.
- B. Medication History
  1. All patients shall have a medication history documented upon admission to the unit per the Medication Reconciliation Policy.
- C. Height and Weight/Other Measurements
  1. Height and weight can be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation allows, it is preferred that the patient be weighed upon admission.
     a. Weights shall be documented in kilograms (kg) and height in centimeters (cm).
- D. Allergies
  1. Any known medication or food allergies will be documented on admission as follows:
     a. On the patient allergy band
     b. On the allergy sticker placed on the front of the chart
     c. In the patient's Electronic Health Record (EHR)
- E. Social History
  1. The following will be documented upon admission:
     a. History of tobacco use
     b. History of depression, suicide and domestic violence
     c. Substance use/abuse
        i. Toxicology urine specimen will be obtained if the patient has had a positive toxicology screen during the current pregnancy, a history of substance use in the last 5 years, has had less than or equal to three prenatal visits, suspicion of placental abruption, or per Obstetrical (OB) Provider request.
  2. Social Service Needs
     a. Initiate a social service referral for the following (including, but not limited to)
        i. Adoptions

ii. Infants going into foster care
iii. Patients with no prenatal care
iv. Teen moms
v. Positive toxicology results
vi. Mothers of newborns in the Neonatal Intensive Care Unit (NICU) or in another facility
vii. All mothers and families experiencing Perinatal loss
viii. High risk mother or newborn, as defined by their provider

F. Immunizations
1. Patients will be screened for the Influenza vaccine during the designated hospital flu season.
a. If the patient meets requirements, the registered nurse (RN) will administer the vaccine or document refusal of the vaccine prior to discharge.
2. Patients will be screened for the Tetanus Diphtheria Pertussis (Tdap) upon admission
a. If the patient meets the requirements, the RN will administer the vaccine or document refusal of the vaccine prior to discharge.

II. GENERAL OB NURSING ASSESSMENT:
A. Vital Signs
1. Maternal Vital Signs (VS) include: Temperature, Heart Rate (HR), Blood Pressure (BP), Respiratory Rate (RR), Pain and Oxygenation level (when clinically indicated).
2. VS will be obtained on admission to the hospital, upon transfer to a new unit, within 1 hour prior to discharge and/or per provider orders.
3. Antepartum VS will be recorded every 6 hours minimum or per procedure (i.e., Magnesium Sulfate, Administration in Obstetric Patients Procedure)
a. If febrile (>100.4°F or 38°C), temperature every 2 hours until afebrile, then return to every 6 hours.
4. Notify the provider if:
a. Temperature is greater than 38°C or 100.4°F
b. HR is greater than 110 beats per minute
c. SBP is greater than 140 mmHg and/or DBP is greater than 90 mmHg
i. If known hypertension notify provider for SBP greater than 155 mmHg and/or DBP greater than 105 mmHg
d. RR is greater than 25 breaths per minute or less than 12 breaths per minute

B. Pain Assessment
1. Refer to Patient Care Services: Pain Management, for the full standards of care
2. Patients will be assessed for pain upon admission to the unit, with routine VS and with each report of a new or different pain.
a. A pain assessment will include the following
i. Acceptable/target pain level
ii. Current pain level
1) Mild: pain level 1-3
2) Moderate: pain level 4-7
3) Severe: pain level 8-10
iii. Pain scale used
iv. Symptoms of pain which may include but are not limited to:
1) Intensity, location, quality, curation, alleviating factors and/or aggravating factors
3. All patients will be assessed for sedation prior to the administration of opiates
4. A pain assessment will be documented with each patient report of a new or different pain

5. Assessment of pain level shall be performed with routine vital signs and as needed
6. Reassessment of pain level and relief shall be performed per the following:
   a. 30 minutes for intravenous medications
   b. 60 minutes for oral or intramuscular medications
7. 15-60 minutes for non-pharmacological treatments

C. Intake and Output (I&O)
1. I&O will be monitored as follows:
   a. Intake: Each meal will be documented for percent of food/oral fluids consumed
   b. Output: Every 8 hours, with 24-hour totals
   c. Patients with a Magnesium Sulfate infusion refer to the procedure: Magnesium Sulfate, Administration in Obstetric Patients.
   d. Notify the provider for any of the following:
      i. Patient is not voiding within 6 hours of foley catheter removal
      ii. Measured output is less than or equal to 30mL per hour, or less than or equal to 120mL in 4hours.
   e. Blood loss: refer to WNS procedure Obstetrical Hemorrhage

D. Postpartum Hemorrhage Risk
1. The Postpartum Hemorrhage (PPH) Risk Assessment will be performed on admission
2. For patients with vaginal bleeding or pre-term labor the PPH Risk Assessment will be documented each shift and prior to delivery (within 1 hour).

E. Infusion Therapy
1. Central venous lines, including PICC lines, shall be assessed per PCS Central Venous Access Devices Procedure
2. Peripheral IV site shall be assessed per the Standards of Care Adult policy.

G. Aspiration Assessment
1. Maintain aspiration precautions for maternal patients identified at risk.
   a. Maintain head of bead (HOB) at 30 degrees at all times.
   b. Maintain suction equipment at bedside at all times.

H. Patient Safety
1. The health care team shall provide measures to ensure patient safety. This includes having the bed in the lowest position, wheels locked, and room free of clutter.
3. 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.
4. A Fall Risk will be assessed and documented at minimum every shift.
5. Activities of Daily Living (ADL) will be assessed and documented at minimum every shift

F. Fetal and Uterine Monitoring
1. Continuous Antepartum Monitoring: A complete analysis of the FHR and uterine activity will be documented hourly at a minimum per the Association of Women's Health, Obstetric and Neonatal (AWHONN) guidelines in the patient's Electronic Health Record (EHR).
   a. May have continuous monitoring in the presence of risk factors, based on medical history and per provider order.
   b. In the absence of continuous monitoring, obtain fetal heart tones (FHT) at least once per shift or per provider order.
   c. Presence of fetal movement once a shift
2. Annotations: Complete annotations for any clinical, medical, and/or nursing interventions performed in response to labor progress and/or FHR assessment on the electronic strip or in the fetal monitoring evaluation section in the EHR. Items for consideration can include but are not limited to:

a. Ambulation of the patient; position changes
b. Oxygen administration
c. Artificial or Spontaneous rupture of membranes
d. Vaginal examinations
~~b.~~e. Interventions completed for Category II or Category III strips

III. SYSTEM ASSESSMENT:

A. All patients admitted to WNS shall be assessed by a RN per the following:
1. Admission/Initial Shift Assessment:
a. All patients admitted to the Labor and Delivery Unit will have a system assessment documented within 4 hours, dependent on the situation (stage of labor or urgency in which the patient is being seen)
b. Initial shift system assessment will be performed within 2 hours of the start of shift and documented within 4 hours of the start of shift.
2. Reassessment:
a. After the completion of an Admission/Initial shift assessment a focused assessment will be completed every 6 hours or sooner in response to treatment given or a change in the patient's condition.
b. If the patient refuses an assessment, document the refusal in the EHR.

B. Systems:
1. Neurological
a. Assess the following on admission and on the initial shift assessment, unless otherwise indicated more frequently (i.e. WNS procedure Magnesium Sulfate):
i. Level of consciousness
ii. Orientation
iii. Presence of:
1) Headache
2) Visual disturbances, e.g. blurred vision or scotoma
iv. Deep Tendon Reflexes
1) Patellar or brachial
v. Clonus
2. Cardiovascular
a. Assess heart sounds, note regular or irregular rhythm.
b. Check capillary refill
c. Check edema location and grade
d. Assess peripheral perfusion; skin warm and dry
e. Assess calves bilaterally for the presence of tenderness and swelling
3. Pulmonary
a. Check oxygen delivery devices if applicable
b. Check amount oxygen flow if applicable
c. Assess pulse oximetry as indicated
i. Per orders or per PCS procedure: Magnesium Sulfate Administration in Obstetric Patients
d. Assess for respiratory symptoms, pattern, and rate of respirations
e. Auscultate breath sounds all lobes
f. Assess sputum amount, color, and consistency if applicable
g. Assess for presence of cough
h. Assess chest expansion for symmetry
4. Gastrointestinal
a. Assess gravid abdomen:
i. Round or asymmetrical
ii. Soft, firm, distended, non-distended.
iii. Pain upon palpation

b. Assess for nausea and/or vomiting.
c. Auscultate for presence of bowel sounds in all four quadrants.
d. Assess bowel function including passing flatus and last stool.

5. Genitoutinary
   a. Assess urine color and clarity, frequency and dysuria.
   b. Assess for bladder distension.
      i. Assess external anatomy/perineum as applicable
      ii. Assess for leaking of amniotic fluid:
         1) Color, amount, and/or odor.
      iii. Assess vaginal discharge:
         1) Color, amount, and/or odor.
6. Musculoskeletal
   a. Presence of assistive devices.
   b. Presence of joint or musculoskeletal abnormalities.
   c. Full range of motion
   d. Mobility appropriate for age.
7. Integumentary (Refer to skin and wound care policy for further information)
   a. Assess mucous membranes and skin color
   b. Palpate skin for temperature and moisture.
   c. Assess skin turgor.
   d. Assess skin integrity
   e. Complete Braden Scale Predicting bed sore risk.
8. Psychosocial
   a. Coping
      i. Support/Coping Interventions
   b. Affect/Behavior
   c. Distress
   ~~a.~~d. Stressors

VII. RELATED DOCUMENT(S):
- A. Adult Standards of Care
- B. Magnesium Sulfate, Administration in Obstetric Patients
- C. Obstetrical Hemorrhage
- D. Fetal Heart Rate (FHR) Surveillance/Monitoring
- E. Patient Care Services (PCS): Critical Results and Critical Test/Diagnostics
- F. PCS: Identification, Patient
- G. PCS: Physician/Allied Health Professionals (AHP) Inpatient Orders
- H. PCS: Central Venous Access Devices
- I. PCS: Specimen Handling
- J. PCS: Medical Equipment Brought into the Facility
- K. PCS: Fall Risk
- L. PCS: Hand-off Communication
- M. PCS: Medication Reconciliation
- ~~B.~~N. PCS: Pain Management

VIII. REFERENCE(S):

- A. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2017. *Guidelines for Perinatal Care 8th Edition.* Washington, DC
- B. Mattson, S., & Smith, J.E. (Eds.) (2016) *Core Curriculum for Maternal-Newborn Nursing (5th Ed.)* Philadelphia, PA: Saunders
- C. Rice Simpson, K., Creehan, P.A., O'Brien-Abel, N., Roth, C.K., Rohan, A.J. (2021) Perinatal Nursing (5th Ed.) Philadelphia, PA: Wolters Kluwer

E. **GENERAL OB NURSING ASSESSMENT:**
1. Standards Of Care: Vital Signs:
2. Maternal vital signs shall include:
a. Temperature, documented in Celsius (preferred)
b. Blood Pressure (BP)
c. Heart Rate (HR)
d. Respiratory Rate (RR)
e. SpO2 prn
f. Pain Level
3. Vital signs shall be obtained on admission, transfer to a unit, at discharge per Patient Care Services (PCS) procedure: Discharge of Patients, per provider's orders, and as follows:
a. Antepartum:
i. Approximately every 6 hours, as ordered by provider, as clinically indicated, or per procedure, i.e., PCS procedure: Magnesium Sulfate Administration for Obstetric Patient.
ii. If premature rupture of membranes (PROM) or prolonged PROM, temperature every 4 hrs. if afebrile or per provider orders. Notify provider if:
1) Temperature greater than or equal to 100.4° F or 38° C
2) BP greater than or equal to 140 Systolic and/or d greater than or equal to 90 diastolic.
a) If patient has hypertension or preeclampsia history, a BP; greater than or equal to a 160 systolic and/or 110 diastolic is known as a hypertensive emergency and may require IV anti-hypertensive medications per provider order.
3) Pulse greater than or equal to 120 bpm
4) Respirations greater than 28 or less than 12
b. Fetal Monitoring (per Fetal Heart Surveillance procedure):
i. The antepartum patient:
1) Document the fetal heart rate (FHR) tracing and uterine activity every hour or as ordered by provider.
2) Palpate the uterus (goal soft without a contraction and if felt during a contraction document if palpates mild, moderate or firm)
3) Assess uterine tenderness
4) Assess for fetal movement once a shift
4. Standards Of Care: Pain Assessment:
a. Assessment: Pain per Pain Management Policy
i. Acceptable level of intensity
ii. Pain scale
iii. Current pain intensity
iv. If patient complains of pain, assess the following:
1) Location, intensity, and duration/onset
2) Quality/type
3) Aggravating factors
4) Alleviating factors
b. Assess for presence of pain/discomfort with vital signs and PRN
c. Perform a pain assessment with each patient report of new or different pain.
d. Perform a pain reassessment as follows:
i. Thirty (30) minutes after intravenous medications, intramuscular, or subcutaneous intervention
ii. One (1) hour after oral medication intervention
5. Standards Of Care: Intake And Output:
a. Intake and output shall be monitored as ordered and as follows:
i. Antepartum:
1) I&O totals every shift with 24 hour totals when patient has Intravenous (IV) Fluids ordered
2) Assess bladder every 4-6 hours, or as ordered by provider.
3) Notify provider if patient is not voiding and/or measured output is less than or equal to 30 mL per hour or less than or equal to 120 mL in 4 hours.
4) Bleeding

a) Patients shall be screened for risk of obstetrical hemorrhage upon admission, and as part of the ongoing reassessment throughout antepartum and/or intrapartum admission.
b) Patients will be screened who present to labor and delivery with placenta previa accreta and its variants, possible placental abruption with or without vaginal bleeding.
i) Assess and document quantity (# of pads/chux, degree of saturation and/or weigh as needed), color, associated symptoms and frequency of bleeding.
ii) Notify provider for active bleeding, and report above findings.
iii) Refer to WNSWNS procedure: Obstetrical Hemorrhage.
6. Standards Of Care: Height And Weight/Other Measurements:
a. Height and weight will be self-reported and/or transcribed from prenatal record with information from last office visit prior to admission. If the situation permits, it is preferred that the patient be weighed upon admission.
i. Weights shall be documented in kilograms (kg) and height in centimeters (cm)
b. Medications shall be calculated using the patient's admission weight unless ordered otherwise by a provider.
7. Standards Of Care: Aspiration Assessment:
a. Maintain aspiration precautions for maternal patients identified at risk.
i. Maintain head of bead (HOB) at 30 degrees at all times.
1) If eclamptic seizure, lower head of bed, open airway, roll patient to side and suction secretions as necessary.
2) Avoid attempts to insert suctioning device when patient's teeth are clenched.
ii. Maintain suction equipment at bedside at all times.
8. Standards Of Care: Patient Safety:
a. The health care team shall provide measures to ensure patient safety for the unique maternal-fetal dyad and/or mother baby couplet. This includes the bed in the lowest position, wheels locked, and room free of clutter.
b. Patient safety shall be assessed per the following:
i. The RN shall observe the patient's physical condition on admission and/or transfer to their unit, prior to and after epidural placement and/or other procedures, and as needed.
ii. Patients shall be identified per Patient Care Services (PCS): Identification, Patient Policy.
iii. Allergies will be monitored and documented upon admission
1) Any known medication or food allergy shall be documented as follows:
a) The patient allergy band
b) Allergy sticker placed on the front of the chart
c) In the patient's Electronic Medical Record (EMR)
iv. Orders shall be obtained, reviewed, and implemented per PCS: Physician Orders Policy.
v. Critical test values shall be reported per PCS Procedure: Critical Results and Critical Test/Diagnostic Procedures.
vi. Patient's specimens shall be handled per PCS: Specimen Handling Procedure, or by selecting the appropriate Mosby's Online Specimen Collection Procedure.
vii. Electronic or medical equipment brought to TCMC shall be evaluated, used, and stored per PCS: Medical Equipment Brought into the Facility Policy.
viii. Patients shall be assessed for falls per PCS: Falls Risk Procedure.
ix. Hand-off Communication shall be provided per PCS: Hand-off Communication Policy and unit-specific hand-off policies.
x. Medication shall be reconciled per PCS: Medication Reconciliation Policy.
xi. 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.

F. **SYSTEM REVIEW:**
1. All maternal, fetal/or newborn patients will have a general system review of all systems completed and documented at least once a shift. A focused assessment, or any reassessment, shall be completed and documented as indicated by the patient's condition.
2. Standard Of Care I: Assessment:

a. All patients admitted to WNS nursing units shall be assessed by a Registered Nurse(RN) per the following:
b. Admission and/or Transfer: Assessment
i. All patients admitted or transferred to a higher level of care shall have a head to toe assessment initiated as soon as possible upon arrival to unit, a detailed or disease specific assessment shall be documented as needed.
ii. The assessment shall be completed in a timely manner.
c. Admission Assessment- Patient History:
i. All inpatients shall have the Admission Assessment-Patient History completed and documented within 24 hours of admission to the unit.
1) This assessment patient history shall include an assessment for obstetric hemorrhage
d. Medication Patient History Form
i. All patients shall have a Medication Patient History completed upon arrival to the unit per the Medication Reconciliation Policy.
e. Initial Shift Assessment
i. RN shall initiate an ongoing head to toe assessment at the beginning of each shift.
f. Reassessment/Focused Assessment may be documented as no change since last assessment.
i. After completion of an Admission or an initial shift assessment, patients shall have a focused reassessment performed and documented during the shift, when clinically indicated:
1) If the patient refuses a reassessment, document her refusal in the medical record.
ii. System-Specific Assessment (Focus assessment) shall be completed as follows:
1) Change in patient's condition from the initial shift assessment or reassessment.
2) Response to treatment provided to a patient.
3. Standards Of Care I.1: Assessment Neurological System Review:
a. Neurological: System Review
i. Assess the following: Level of consciousness
ii. Orientation
iii. Presence of:
1) Headache
2) Visual disturbances, e.g. blurred vision or scotoma
iv. Deep Tendon Reflexes
1) Patellar or brachial
2) Clonus
4. Standards Of Care I.2: Assessment Cardiovascular System Review:
a. Cardiovascular System Review
i. Assess heart sounds ; note regular or irregular
ii. Check capillary refill
iii. Check edema location and grade
iv. Assess peripheral perfusion; skin warm and dry
5. Standards Of Care I.3: Assessment Pulmonary System Review:
a. Pulmonary: System Review
i. Check oxygen delivery devices if applicable
ii. Check amount of oxygen flow if applicable
iii. Assess pulse oximetry prn
iv. PCS procedure: "Magnesium Sulfate Administration in Obstetric Patients"
v. Assess respiratory effort (pattern, symptoms)
vi. Auscultate breath sounds in all lobes
vii. Assess sputum amount, color, and consistency if applicable
viii. Assess for presence of cough
ix. Assess for presence of artificial airway, tubes, and drains if applicable
x. Assess chest expansion for symmetry
6. Standards Of Care1.4: Assessment Gastrointestinal (GI) System Review:
a. GI: System Review
i. Assess abdomen

1) Round, gravid, distention
2) Soft, firm, distended, non-distended
3) Pain in upper right quadrant
ii. Assess for nausea and/or vomiting
iii. Auscultate for presence of bowel sounds in all four quadrants
iv. Assess bowel function including passing flatus or last stool
7. Standards Of Care 1.5: Assessment Genitoutinary System Review:
a. Genitourinary (GU) System Review
i. Assess urine color and clarity, frequency and dysuria.
ii. Assess for bladder distension.
iii. Assess external anatomy/perineum as applicable.
iv. Assess for leaking of amniotic fluid.
1) Color, amount, and/or odor
v. Assess vaginal discharge.
1) Color, amount, and/or odor
8. Standards Of Care 1.6: Assessment Musculoskeletal System Review:
a. Musculoskeletal System Review
i. Presence of assistive devices
ii. Presence of joint or musculoskeletal abnormalities
iii. Full range of motion against gravity, some to full resistance of all extremities
iv. Mobility appropriate for age
9. Standards Of Care 1.7: Assessment Integumentary System Review:
a. Integumentary System Review
i. Assess mucous membranes and skin color; consistent with person's ethnicity
ii. Palpate skin for temperature and moisture
iii. Assess skin turgor
iv. Assess skin integrity, temperature, and condition of any dressings
v. Complete Braden Scale
vi. Assess for the presence of skin abnormalities
vii. Assess for the presence of pressure ulcers
10. Standards Of Care 1.8: Assessment Psycho/Social:
a. Psychosocial assessment shall consist of the following:
i. Coping
ii. Affect/Behavior
iii. Social Service (SS) Referral Reason
1) Distress
iv. Stressors
v. Support/Coping Interventions
vi. Psycho/Social: Nursing Interventions
vii. In ordered to promote family centered care, the nurse shall:
1) Introduce bedside health care providers to the patient/family.
2) Review visitation and unit policies to patient/family on admission and as needed.
3) Assess and then verify with patient/family age appropriate needs.
4) Assess and then verify patient/family's ability to understand and participate in the plan of care.
5) Encourage the family to have periods of uninterrupted sleep when appropriate.
viii. Promote patient/family centered care
1) Discuss expectations and collaborate with patient/family
2) Encourage patient/family to ask questions
3) Promote patient independence in Activities of Daily Living (ADL)
ix. Promote comfort measures (if ordered or request order) by:
1) Music therapy
2) Therapeutic recreation
3) Spiritual comfort
a) Guided imagery

4) Reminiscence therapy
5) Encourage family/friend to visit
6) Arrange for a child's visitation
7) Arrange for pet therapy
8) Arrange for physical or occupational therapy
x. Assess for history of domestic violence/safety in home.
xi. Request social services as appropriate.
1) Initiate social services referrals for the following (including, but not limited to):
a) Adoptions
b) Infants going to foster care
c) Patients with no prenatal care
d) Teen moms
e) Positive toxicology results
f) Mothers of infants in Neonatal Intensive Care or in another facility
g) All mothers and families experiencing Perinatal loss.
h) High risk mother and/or newborn, as defined by their provider.
11. Standards Of Care: Infusion Therapy:
a. Central venous (i.e. PICC) lines shall be assessed per PCS Central Venous Access Devices Procedure
i. Note date and time of next central venous dressing change
b. Peripheral IV site shall be assessed on admission, ongoing and transfer from other nursing unit.
i. The following shall be assessed:
a) IV insertion date
b) IV access type
c) IV site and condition
2) Patency
a) Dressing type and condition
b) Date infusion changed
c. Saline lock insertion site(s) shall be assessed every shift, with flushes, prior to the administration of medications and PRN per provider order.
d. Maintenance or continuous infusion shall be assessed and documented every shift and PRN.
e. Infusion Therapy: Nursing Interventions
i. Peripheral IV sites shall be changed every 4 days unless otherwise ordered.
ii. Document initials and date IV started directly on the dressing.
iii. Pre-hospital IV starts shall be discontinued and restarted within 48 hours of admission.
iv. IV site shall be discontinued and restarted with complaint of persistent discomfort not relieved by comfort measures, the presence of an infiltration, inflammation, pallor, phlebitis, bleeding at insertion site, or leaking of IV solution at insertion site.
v. IV solutions and tubing shall be changed as follows:
1) Change every 4 days
a) All IV tubing
b) Add-on devices (neutral displacement connector MicroClave antireflux, extension set, etc) and with tubing change.
c) Rotate IV insertion sites.
d) Commercially prepared solutions, if the bag is spiked once with initial start.
e) Piggyback tubing (back flush with a minimum of 10 mL before and after each piggyback).
2) Change every 24 hours
a) All IV solutions mixed by pharmacy or nursing, unless manufacturer's expiration recommends less than 24 hours
b) Lipids or lipid containing products
c) Neutral displacement connector (MicroClave, anti-reflux, extension set, etc) and with tubing change
vi. Label IV tubing and/or neutral displacement connector (MicroClave) with *change date sticker* indicating date tubing is to be changed using numerical day and month.
vii. Label IV solutions with date and time IV solution hung.

viii. Dressings shall be changed when damp, loose, soiled, or whenever dressing prevents direct visualization of the site.
1) Infusion pumps shall be used per TCMC Infusion Pump-Infusion System with Guardrails.
ix. A separate site shall be used for research study drugs per TCMC Investigational Drugs Policy
x. Needleless components added to IV administration sets shall be changed every 4 days unless contaminated or a catheter related infection is suspected or documented.
xi. Swab Caps should be used:
1) When a Central Venous line injection port is not in use, place Swab Cap on the unused port(s)
2) When a peripheral line, if injection port is not in use, place a swab cap on the port closest to the IV insertion site..
3) When a saline lock is not in use
4) Apply a new Swab Cap
a) Every time the cap is removed.
b) Every 8 hours with routine IV flushing.
12. Standards Of Care: Immunizations/Other:
a. Rhogam will be administered if indicated
b. During flu season: all patients will be screened for influenza and vaccination will be administered if indicated per the Standardized Procedure Pneumococcal and Influenza Vaccine Screening Administration
c. All patients will be screened for Tetanus, Diphtheria, Pertussis (Tdap) and vaccination will be administered if indicated per the Standardized Procedure Tetanus, Diphtheria, Pertussis (Tdap) Vaccine Administration for Postpartum Patients

G. REFERENCES:

1. American Academy of Pediatrics and American College of Obstetricians and Gynecologists. 2014. *Guidelines for Perinatal Care Seventh Edition.* Washington, DC
2. American Nurses Association (ANA). (2016). *Nursing scope and standards of practice.* Silver Spring, MD: Nursesbooks.org.
3. American Nurses Association (ANA). (2016). The nursing process. Retrieved from http://www.nursingworld.org
4. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). *Standards for Professional Nursing Practice in the Care of Women and Newborns*, Sixth Edition.
5. Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN). Perinatal Nursing. (2014). 4th edition.
6. Besuner, P. AWHONN Templates for Protocols and Procedures for Maternity Services, 2nd Edition (2007). Washington, D.C.
7. Mattson, S., & Smith, J.E. (Eds.) (2011) *Core Curriculum for Maternal-Newborn Nursing (4th Ed.)* Philadelphia, PA: Saunders

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

REVISION DATE: 12/13

SUBJECT: Decontamination &and Sterilization of Instruments

Department Approval:	~~02/20~~01/23
Infection Control Committee Approval:	11/22
Pharmacy and Therapeutics Approval:	
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	12/13

RETIRE - follow Patient Care Services Policy: Point of Use Pre-Cleaning of Reusable Instruments

~~**ISSUE DATE:** 6/07~~ ~~**SUBJECT:** *DECONTAMINATION & STERILIZATION OF INSTRUMENTS*~~

~~**REVISION DATE:**~~
~~**REVIEW DATE:**~~
~~**STANDARD NUMBER:**~~
~~**CROSS REFERENCE:**~~
~~**APPROVAL:**~~

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

~~1. In compliance with infection principles, this document outlines the safe and effective method of cleaning, decontamination, and sterilization of surgical instruments used in clinic procedures.~~

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

~~1. The clinic will follow infection control principles when handling contaminated instruments.~~
~~2. Competent and qualified clinic staff will observe the principles of cleaning, decontamination and sterilization.~~

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

~~1. Fresh germicidal enzymatic solution will be used for each in-room covered container at the beginning of each day.~~
~~2. Instruments used in the clinic's procedures will be placed in the covered container immediately after each use.~~
~~3. Hinged instruments will be placed in an open position for effective soaking.~~
~~4. Disposable instruments will be discarded according to hospital policy.~~
~~5. Containers holding soiled instruments will be collected at the end of each day by clinic staff using appropriate personal protective equipment (PPE) and brought to the soiled utility area for cleaning.~~
~~6. A qualified person will clean the instruments of all debris using appropriate PPE, rinse, air-dry, and wrap in a covered container for transport to Central Service/Processing for proper decontamination and sterilization.~~
~~7. Central Service/Processing will be responsible for sterilization of the clinic's instruments and performing biological indicator testing and other testing to ensure proper functioning of sterilizers.~~
~~8. The clinic staff will pick up the sterilized instruments and store them properly in the designated clean area for future use.~~
~~9. The Center will follow the event-related procedures for sterile products/equipment per Infection Control Manual.~~

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

REVISION DATE: 12/10

SUBJECT: Infection Prevention & Control Activities

Wound Care Department Approval:	**~~07/22~~01/23**
Infection Control Committee Approval:	**11/22**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**~~04/20~~02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**12/10**

A. **PURPOSE:**

1. Comprehension of and compliance with infection control principles is an essential component of the quality of care provided in the **clinic**~~Center~~. The purpose of this document is to:
   a. Delineate the role in and scope of infection prevention and control activities.
   b. Define the infection control and prevention measures to be followed to prevent cross-infection among patients.
   c. Provide procedures to be adhered to by the staff of the clinic for protection from illnesses/conditions related to working with and caring for patients admitted to the program.

B. **POLICY:**

1. A qualified patient will not be denied access to the services offered by the ~~program~~ **clinic** *unless* the patient has an active infectious communicable airborne disease such as tuberculosis or has any other active communicable disease that cannot be safely managed by the clinic. This type of patient may be admitted to the ~~program~~**clinic** once he/she is medically cleared by a qualified physician.
2. All healthcare workers shall comply with the hospital's infection control policies and procedures.
3. The clinic shall follow infection control department policies and procedures related to compliance with State regulations for reporting of specified conditions.

C. **ACCOUNTABILITY:**

1. The clinical manager is responsible for implementing and monitoring compliance with all infection control policies and procedures.
2. The clinical manager is responsible for ensuring the appropriate infection control education/training is provided to all personnel.
3. The infection control policy is submitted to the Infection Control Committee as often as the hospital requires.

D. **PROCEDURE:**

1. Patient Considerations
   a. Patients with a known or suspected infectious communicable airborne disease/condition (or any other condition that cannot be safely managed in the clinic) shall *not* be admitted to the ~~program~~**clinic** until medically cleared by a qualified physician.
   b. Patients with known or suspected infection/condition that can be safely managed in the clinic shall be admitted to the ~~program~~**clinic**, and appropriate precautions shall be taken to prevent cross-infection. These include, but are not limited to, MRSA, VRE, and HIV.

c. Cultures are obtained from patients with open wounds/soft tissue infections or suspected bone infections for treatment purposes and to identify potential communicability.

2. Occupational/Employee Health
   a. All personnel shall comply with hospital policies related to the occupational health, safety, and well-being of healthcare workers as delineated in such policies as those found in the:
      i. Infection Control Manual and include those related to:
         1) Employee health
         2) Hepatitis B vaccine program
         3) Post-blood exposure management
      ii. Environment of Care (EOC) Manual:
         1) Blood-borne pathogens exposure control plan
         2) Tuberculosis management

3. Infection Transmission Reduction Methods: All staff members are expected to fully support the hospital's infection control efforts and to clearly understand the role they play in the infection control program. All clinic personnel shall comply with:
   a. Hospital transmission-based precautions such as Standard (with Universal) and Contact Precautions.
   b. The Blood-borne Pathogens Exposure Control Plan
   c. The hospital's hand hygiene policy
   d. The proper handling of biohazardous waste as defined in the Infection Control Manual.
   e. Aseptic sterile and clean technique
   f. Visitor and traffic control policies

4. Listed below are the minimum requirements recommended during controlled situations to protect the healthcare worker from potentially infectious agents. This list is not all-inclusive. If the situation indicates, increased infection control measures may be indicated, e.g., additional barrier protection in less-controlled situations.

CATEGORY	HANDWASHING	GLOVES	GOWN	MASK	EYE PROTECTION
Vital signs - TPR & BP	R				
~~Phlebotomy~~	~~R~~	~~R~~			
Handling specimens	R	R			
Routine dressing changes	R	R	S		
Dressing changes large amount draining	R	R	R	**	**
Handling medical waste	R	R	S		
Decontamination instruments	R	R	S	**	**
Cleaning equipment	R	R	S		
Applying pressure to control bleeding	R	R	S		
Assisting with procedures such as wound debridement	R	R	S	**	**
Wound irrigation	R	R	S	**	**
Suture/staple removal clean, dry wound	R	R			
Capillary blood glucose testing	R	R			
Cleaning work surfaces	R	R			

CATEGORY	HANDWASHING	GLOVES	GOWN	MASK	EYE PROTECTION
Cleaning up small blood spills	R	R			
Cleaning large blood spills	R	R	R	**	**

Legend
R = routinely
S = If soiling likely
**** = If splattering likely**

5. Decontamination and Sterilization
   a. Utilizing appropriate personal protective equipment (PPE), only trained personnel shall clean and decontaminate the clinic's surgical instruments and equipment.
   b. Decontaminated instruments shall be transported safely to Central Supply/Processing in a covered container.
   c. Central Supply shall decontaminate and sterilize all instruments used in the clinic.
   d. The hospital's "Event-Related Sterility" policy will be followed.
6. Housekeeping
   a. Routine environmental cleaning is performed by the designated housekeeping staff using hospital-approved germicidal products.
   b. Germicidal agents with "Hepatitis B" claim shall be used for cleaning blood or OPIM spills.
   c. Exam chairs are disinfected between patients by the clinical staff using approved germicidal wipes/solution. Linen may be placed on the chair for protection from large draining wounds.
   d. The clinical staff shall disinfect reusable items such as BP cuffs, stethoscopes, and electronic thermometers ~~daily, or more frequently as needed.~~**after every patient use.**
   e. Work surfaces are cleaned/disinfected ~~daily~~**after every patient use** and as needed by the clinic staff using the hospital-approved germicide.
   f. The cleaning/decontamination of medical equipment is the responsibility of the clinic staff.
   g. Biohazardous waste is handled according to policy in the Infection Control Manual.
7. Surveillance Activities
   a. The clinic shall participate in the surveillance activity of the Infection Control Department, as requested by the Infection Control Committee.
   b. Any unusual microbial patterns or isolated findings shall be reported to the Infection Control Department/practitioner.
8. Infection Control Education/Training
   a. All personnel shall attend the infection control orientation program upon hire.
   b. All personnel shall complete the annual infection control module.
   c. Additional infection control **in-service** presentations and consultation shall be provided as needed.

E. **REFERENCE(S)**:

1. Centers for Disease Control and Prevention (CDC), Guideline for Isolation Precautions in Hospitals, 1996
2. Centers for Disease Control and Prevention (CDC), Guideline for Infection Control in Health Care Personnel, 1998
3. OSHA Bloodborne Pathogens Standard, 1997
4. Title 17 California Code of Regulations, 2001

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Cardiac Arrest in the Chamber**

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure safe removal of a patient from the chamber during a cardiac emergency to initiate CPR.

B. **POLICY:**

1. When it is determined that a patient is experiencing a cardiac emergency, every effort will be made to safely remove the patient from the chamber to initiate CPR.
2. All HBOT staff will be current with BCLS certification
3. All HBOT staff will be trained in the safety procedures for safe removal of patients from the chamber.

C. **PROCEDURE:**

1. When it is determined that a patient is experiencing a cardiac emergency, the hospital's code procedure will be followed.
2. The supervising physician will be notified immediately
3. The emergency decompression procedure will be initiated
   a. Decompression rate will depend upon the condition of the patient
   b. Use emergency vent decompression with caution by intermittent decompression method **if needed**
   ~~b.~~**c.** Turn chamber off
   ~~c.~~**d.** ~~Use emergency vent decompression with caution by intermittent decompression method~~
4. The patient is removed from chamber once decompression is complete, and the gurney is moved away from the chamber immediately
5. The patient's gown and as much linen as possible is removed from the immediate area. NOTE: Oxygen remains trapped in linens.
6. CPR is initiated as indicated until the hospital's emergency team or paramedics arrive.
7. Defibrillation is done only when the following conditions have been met:
   a. The patient has been moved as far away fro the chamber as possible
   b. At least 60 seconds has elapsed since the chamber door has been opened
   c. Defibrillator pads are well lubricated (not dry) before defibrillator is discharged
   d. The defibrillator is charged only when absolutely necessary for defibrillation
   e. Defibrillator paddles are not to be discharged in the air.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Complications of HBOT

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the potential complications of hyperbaric oxygen therapy (HBOT).

B. **POLICY:**

1. HBOT staff will understand and will be trained to respond to complications that patients may experience during the treatment process.

C. **PROCEDURE:**

1. The following is a list of potential complications of HBOT and the associated signs and symptoms.
   a. Oxygen Toxicity is a state in which, due to prolonged oxygen exposure, the body's antioxidant defenses are overwhelmed, and toxic manifestations occur.
      i. Predisposing Factors: Certain factors, which hasten the onset or increase the severity of oxygen toxicity include:
         1) Adrenocorticotropic hormone
         2) CO_2 inhalation
         3) Seizures
         4) Dextroamphetamine
         5) Epinephrine
         6) Hyperthermia
         7) Acidosis
         8) Steroids
         9) Narcotics
         10) Insulin
         11) Norepinephrine
         12) Paraquat
         13) Thyroid hormones
         14) Vitamin E deficiency
         15) Irradiation

(1) The existence of one or more predisposing factors to oxygen toxicity should be an indication for caution, and consideration should be given to reducing the inspired oxygen pressure and decreasing the duration of oxygen exposure. This decision will be made by the supervising hyperbaric physician.

ii. Signs and Symptoms
1) Muscle twitching: Appears first in the lips or elsewhere in the face, but may affect any muscle
2) Nausea: May be intermittent
3) Spasmodic vomiting
4) Dizziness/abnormalities of vision and hearing:
   a) Tunnel vision (loss of the ability to see things to the sides) is one of the more frequent visual symptoms
   b) Tinnitus is the symptom that is described as a "ringing" within the ears
5) Difficulty in breathing: The patient may experience "air hunger", may sense an increase in breathing resistance for no apparent reason, or may have trouble taking a full breath of air into the lungs
6) Anxiety, confusion, irritability
7) Unusual fatigue
8) Incoordination and clumsiness
9) Convulsion: The most serious direct consequence of CNS oxygen toxicity – it may occur suddenly without preceded by any other symptom. Refer to the departmental guideline for "Management of Oxygen Toxicity Seizure", located in the departmental Policy and Procedure Manual, for proper handling of patient and situation.
   (1) The list of signs and symptoms may be present prior to an actual seizure. Should any of these be present, the patient should be taken off oxygen immediately, shifting to "emergency air" and/or decreasing the pressure within the chamber to decrease the actual partial pressure of oxygen encountered by the patient.

iii. Prevention: Susceptibility to development of oxygen toxicity varies widely among individuals. There are some factors that have been found to delay the onset or decrease the severity of oxygen toxicity. The use of these factors is to be evaluated by the hyperbaric medicine unit physician on a case-by-case basis. These factors include:
1) Acclimatization to hypoxia
2) Adrenergic blocking drugs
3) Anesthesia
4) Antioxidants
5) Chlorpromazine
6) Disulfiram (Antabuse)
7) Gamma-aminobutyric acid
8) Ganglionic-blocking agents
9) Guitathione
10) Hypothermia
11) Hypothyroidism
12) Immaturity
13) Intermittent exposure (air breaks)
14) Reserpine
15) Starvation
16) Succinate
17) Trisaminomethane
18) Correction of acidosis
19) Allaying anxiety with orientation and relaxation techniques

20) No strenuous physical exercise prior to HBOT

iv. Management: Should any of the signs and symptoms of oxygen toxicity develop, remove the source of oxygen from the patient and immediately contact HBO RN and HBO physician. The chamber operator and/or inside observer (multiplace) are required to note time, duration, and specifics of adverse symptoms reported or observed with the patient.

1) Should a patient develop a grand mal seizure:
   a) Switch the gas supply form oxygen to air (if applicable) or remove the patient's source of oxygen delivery
   b) Observe for cessation of seizure activity. When seizure stops, decompress at rate of tolerance. NOTE: The patient must not be decompressed during the tonic phase due to breath-holding, which occurs during this phase.
   c) Document the action taken and response
   d) Document time, duration, and type of seizure
   e) Follow the direction of the HBO physician in the administration of medications to the patient
   f) The HBO physician will assess and evaluate the patient as applicable
   g) Obtain patient's vital signs and place on cardiac monitor
   h) The HBO physician may order the continuation of treatment after conducting a patient evaluation and a minimum of 15 minutes has passed after the patient's symptoms have completely subsided.

b. Barotrauma is trauma to ears, sinuses, eyes, teeth or lungs due to the pressure applied during therapy.

i. Predisposing factors:
   1) Recent upper respiratory infection
   2) Sinusitis
   3) Earwax buildup
   4) Air trapping in decayed or filled teeth
   5) Anxiety and failure to understand measures to alleviate risk of barotrauma

c. Ear and Sinus Squeeze occurs when the patient is unable to equalize the pressure increase in these air-filled cavities. Initially this is felt as a fullness or pressure. As it progresses, it is felt as pain. The most severe effect could be rupture of the tympanic membrane or sinus bleeding.

i. Prevention and management:
   1) Assess the patient for a history of problems with ears, sinuses, or teeth with changes in pressure (i.e. flying or diving)
   2) Examine the patient's ears, with particular attention to the external auditory canal and the tympanic membrane
   3) Should excessive earwax be noted, the ears should be irrigated
   4) Tympanometry may be indicated for the patient with a history of ear disease or surgery
   5) Instruct the patient on the various Valsalva techniques for equalization of pressure built up within the ears and sinuses during descent
   6) Prophylactic medication may be ordered by the hyperbaric medicine physician (i.e., Afrin, Sudafed). Check to see that the medications were taken by the patient as directed in a timely manner prior to treatment.
   7) Patients having their initial treatment should be compressed slowly and coached on the various methods of Valsalva. If persistent problems in equalization occur, it may be necessary for the unit HBO physician to arrange for a consult for placement of equalization tubes by ENT.

8) If the patient should experience ear or sinus pain during descent, halt descent to allow the patient ample time to attempt various Valsalva techniques to find the one best suited for their problem. It may be necessary to decompress a few feet to decrease the pressure applied to the patient for ease of relief. Ensure the patient is not attempting Valsalva or breath-holding for decompression, as an over-inflation syndrome could possible occur.

d. Tooth Squeeze may occur when air is trapped inside a tooth or a filled cavity.
   i. Prevention and management:
      1) Screen the patient's dental history. Observe closely if the patient has had previous problems.
      2) Compress and decompress slowly during initial treatment
      3) If tooth pain develops, manage as described above for ear and sinus squeeze
      4) Notify HBO physician and obtain dental consultation

e. Barotrauma to the Lungs: Spontaneous pneumothorax or collapsed lung is a serious complication, which can occur due to rapid decompression of the chamber or breath-holding during ascent.
   i. Signs and symptoms:
      1) Sudden, stabbing chest pain or upper back to the affected side aggravated by deep breathing
         i) (i)To minimize pain, instruct patient to breathe in a shallow, rapid manner
         ii) (ii) The patient may become pale and exhibit a tendency to bend the chest toward the affected side
      2) Sudden shortness of breath with difficulty breathing
      3) Tracheal shift toward the unaffected side secondary to gas expansion
      4) Worsening of respiratory distress with increased anxiety

   ii. Management:
      1) Should tension pneumothorax be suspected during decompression, recompress the patient to depth of relief until the thoracic cavity can be properly vented
      2) Notify HBO physician immediately
      3) Obtain chest tray from ER and prepare for thoracentesis
      4) With the physician present, begin a slow ascent over 2-4 minutes until at surface; physician to evaluation patient condition and perform associated thoracentesis as required
      5) Thoracentesis should be performed as soon as possible after decompression
      6) A Heimlich valve may be attached and further treatment continued as deemed appropriate by the physician
      7) Obtain chest x-ray after chest tube insertion for proper placement
      8) If patient is an outpatient, he may be admitted for observation

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Consent to Treatment

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that a consent for HBOT is signed by every patient prior to **starting a treatment course.** ~~entering the hyperbaric chamber.~~

B. **POLICY:**

1. All patients who are to receive hyperbaric treatments will sign a consent for treatment on the approved form prior to initiating the first treatment.
2. The HBO physician will explain all associated risks of the HBO treatment prior to the signing of the consent.
3. The consent will remain a permanent part of the patient's medical record.

C. **PROCEDURE:**

1. The approved consent form will be utilized in the consent process.
2. During the initial consultation for evaluation for treatment or prior to the first treatment, the patient will sign informed consent.
3. The consent ~~will be appropriately witnessed and~~ will be placed in the patient's medical record.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Contraindications to HBOT**

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To define the absolute and relative contraindications to hyperbaric oxygen therapy (HBOT).

B. **POLICY:**

1. All patients being considered for HBOT will be screened for relative and absolute contraindications prior to treatment.
2. Absolute contraindications are as follows:
   a. Doxorubicin (Adriamycin) may cause cardiac toxicity when combined with HBOT. HBOT is delayed for 1 week after the last dose of doxorubicin
   b. Disulfiram (Antabuse) blocks the production of superoxide dismutase (SOD), which is the body's major protection against oxygen toxicity
   c. Cis-Platinum causes a delay in fibroblast production and collagen synthesis caused by its interference with DNA synthesis
   d. An untreated pneumothorax: If the pneumothorax is treated prior to HBOT, the therapy may be completed
3. The following conditions may be considered relative contraindications to HBOT:
   a. Untreated lung malignancy or metastatic lung malignancy is usually considered contraindications except under extraordinary life-threatening conditions
   b. A history of previous ear surgery
   c. Upper respiratory infections
   d. Chronic sinusitis
   e. Seizure disorders
   f. Severe emphysema and COPD with CO_2 retention
   g. Uncontrolled high fever
   h. History of spontaneous pneumothorax
   i. History of thoracic surgery
   j. History of surgery for otosclerosis
   k. Asymptomatic pulmonary lesions on x-ray
   l. Viral infections
   m. Congenital spherocytosis
   n. Ventilator-dependent patient with FIO_2, 60% or above
   o. Claustrophobia
   p. Pregnancy
   q. Abnormal blood glucose level
   r. Abnormal pulse, BP, temperature and blood glucose level

4. The evaluating physician will review the findings and weigh the benefits of therapy versus the contraindications and may consult with the patient's primary care physician before making the final decision.

Tri-City Healthcare District
Oceanside, California

RETIRE – do not perform any longer

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Ear Exam

REVISION DATE(S):

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. **PURPOSE**~~

~~1. To provide a guide for procedure after initial and daily ear exams.~~

~~2. To provide a procedure for safe removal of impacted cerumen or foreign body prior to HBOT.~~

~~B. **POLICY**~~

~~1. Upon initial and subsequent visits, the patient will receive a visual ear exam with an otoscope by the HBOT physician.~~

~~2. Patients identified with ear problems such as foreign body or buildup of cerumen will:~~

~~a. Be referred to primary care physician for the removal of ear wax -- or~~

~~b. Have ear irrigation performed by qualified HBOT staff~~

~~3. This procedure will not be performed when a vegetable foreign body such as pea, bean or corn kernel obstructs the auditory canal. These vegetables are hygroscopic (they absorb moisture), and solution will cause them to swell, causing intense pain and making removal difficult.~~

~~4. Ear irrigation will not be performed if the patient has a cold, fever, ear infection, or a known injury or rupture of the tympanic membrane.~~

~~C. **PROCEDURE**~~

~~1. Ear irrigation must be performed carefully to avoid causing discomfort or vertigo and to prevent maceration of the skin of the canal. Ear irrigation may contaminate the middle ear if the tympanic membrane is ruptured. For this reason, visual examination of the ear with an otoscope always precedes ear irrigation. Equipment used:~~

~~a. Cerumenex~~

~~b. Irrigating syringe~~

~~c. Irrigating basic~~

~~d. Towels~~

~~e. Cotton-tip applicators~~

~~f. Otoscope~~

~~2. Instill Cerumenex into affected ear 15 minutes prior to irrigation to soften earwax.~~

~~3. Heat irrigating solution in a basin of warm (body temperature 95°-105°F) water. Test the temperature by placing a drop or two on the inner aspect of the wrist.~~

~~4. Wash your hands thoroughly.~~

~~5. Explain procedure to the patient to allay anxiety and to promote cooperation.~~

~~6. Use the otoscope to check the auditory canal.~~

~~7. Assist the patient to a sitting position. If the patient cannot sit, have him lie on his back and tilt his head slightly forward and toward the affected ear.~~

~~8. Place towels around the patient's head and neck to prevent him from getting soiled.~~

~~9. Draw up irrigating solution into syringe and expel the air.~~
~~10. Straighten auditory canal by grasping the helix between the thumb and index finger of your non-dominant hand and pull upward and backward (for a child, pull downward and backward).~~
~~11. Insert the tip of the syringe into the ear canal, pointing upward and toward the posterior ear canal. Do not occlude the ear canal with the irrigating tip.~~
~~12. Direct a slow, stead stream of solution against the canal wall using only sufficient force to remove secretions.~~
~~13. Observe the patient for signs of pain and dizziness. If either occurs, stop the procedure immediately.~~
~~14. Remove the syringe when empty and inspect the return flow. Refill syringe and continue the irrigation until the return flow produces the obstruction. Never use more than 500cc of solution to irrigate.~~
~~15. Inspect the ear canal with otoscope for cleanliness.~~
~~16. Dry the patient's auricle and neck.~~
~~17. Wash your hands thoroughly.~~
~~18.~~**1.** ~~Document procedure including which ear was irrigated, type of solution used, character of solution returned, and appearance of the canal before and after irrigation.~~

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Ear Pressure Equalization**

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To effectively and safely assist the patient in equalizing the ears and sinuses during pressurization.

B. **POLICY:**

1. During the initial patient teaching and as often as required, the patient shall be properly instructed on various techniques to equalize pressure of the ears and sinuses.
2. The patient will return demonstrate these techniques to the HBOT personnel prior to initial and subsequent treatments to avoid barotrauma.

C. **PROCEDURE:**

~~1. Equipment needed:~~
~~a. Water~~
~~b. Afrin nasal spray~~

~~2.~~1. The HBOT physician and/or qualified HBOT staff shall visualize both tympanic membranes prior to initial treatment and as required, utilizing an otoscope.

~~3.~~2. With the patient in a comfortable sitting or lying position, have the patient pinch both nostrils, close mouth, and try to softly blow air from their ears. This will force backpressure air through the eustachian tubes retrograde toward the middle ear. The patient should feel their eardrums flex from the pressure.

a. Caution: The patient is not to over-blow, but to gently puff. Over-pressurization can cause damage to the middle ear and cause a rupture, producing vertigo.

~~4.~~3. Having the patient manipulate the jaw can flex the eustachian tubes, causing pressure equalization.

~~5.~~4. With the patient in a sitting or Fowler's position, have the patient take a mouthful of water and forcefully swallow. This, too, can stretch the eustachian tubes, resulting in equalization. Coupling this with manual stimulation to the ears may assist in this procedure.

~~6.~~5. With the patient in a sitting or Fowler's position, have the patient flex the neck in an attempt to touch the ear to the shoulder in both directions. This will stretch the eustachian tubes.

~~7.~~6. Utilizing various techniques, the patient will find the one that works best for them. Provide assistance as required and maintain visual contact with the patient during the course of pressurization and depressurization.

~~8.~~7. The patient having difficulty and unable to equalize should be brought up from the dive and evaluated by the HBOT physician. The patient will be referred for consult with ENT for myringotomy, and the patient will not be treated until this procedure is performed. Frequent observation via otoscope by the HBOT physician or qualified HBOT staff for tube placement and patency shall be performed.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Emergency Evacuation

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish evacuation procedures in the event of a fire, earthquake, bomb threat or any situation that places employees and patients in imminent danger in the Center.

B. **POLICY:**

1. All staff will be trained in emergency evacuation procedure.

C. **PROCEDURE:**

1. In the event of a fire, earthquake, bomb threat, or any situation that places employees and patients in imminent danger, the Center personnel will:
   a. Calm patients and assure their safety
   b. Remove the patients who are in immediate danger first
   c. Activate the hospital emergency notification system giving the exact location of the event, if applicable
   d. Using the designated emergency exits, evacuate all patients to the designated area, as instructed by the appropriate authority.
   e. The Center's manager/charge person will account for all employees and patients and report to the hospital safety officer or representative and/or fire department staff, if present.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Emergency Shutdown

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish the location of reference material pertaining to hyperbaric emergencies.

B. **POLICY:**

1. During an emergency event, the staff of the hyperbaric department will refer to the Emergency Procedures booklet that is located at each chamber.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT:** Fire Alarm

REVISION DATE~~(S)~~: 01/23

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To delineate the procedure to safely remove patients from the hyperbaric chamber in the event of a fire or fire alarm.

B. **POLICY:**

~~1. When the hospital operator has announced a "Code Red" situation, the HBOT personnel will remain by the phone to await notification as to whether the situation is a drill or an actual fire.~~

~~2. The operator will inform the Center personnel whether or not to evacuate patients.~~

~~3.~~1. When a fire occurs in the treatment area or anywhere in the Center, follow the procedure outlined in the policy, "Fire in the Treatment Area".

C. **PROCEDURE:**

1. Should evacuation of the patients be necessary, the HBOT personnel will:
   a. Safely abort HBOT as appropriate. A maximum decompression rate of 60fpm (1 foot per second) shall be utilized.
   b. Reassure patients and maintain a calm atmosphere
   c. Prepare patient(s) for transport to the designated safe location per **department policy.**~~hospital policy~~
   ~~c.~~**d. Follow department evacuation procedures and routes.**
   ~~d. Follow department evacuation procedures and routes according to hospital Code Red procedure~~
   e. Perform system emergency shut-down as indicated
   f. Upon completion of evacuation of all patients to the designated safe area, the Center **manager/supervisor**~~director~~ will contact the hospital command center for appropriate head count of patients and staff and further instruction.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Fire in Treatment Area

REVISION DATE~~(S)~~: 12/10

Department Approval:	**~~02/20~~01/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish procedure guidelines to safely remove patients from the chambers in the event of a fire in the hyperbaric treatment area.

B. **POLICY:**

1. Should a fire be discovered in the HBO treatment area, the HBOT personnel will:
   a. Follow emergency procedures designated for fire in the chamber area
   b. Evacuate all patients from area
   c. Cut off oxygen at the master valve
   ~~d. Notify hospital operator and give appropriate information~~
   ~~e.~~d. Close all doors within the department and attempt to extinguish the fire
   ~~f.~~e. Calm patients and reassure their safety

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT:** Gas & Pressure Safety

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **GENERAL:**

1. The three essential requirements for a fire are a flammable material, a source of ignition, and an oxidizing agent.
2. No smoking or open flames around oxygen or the hyperbaric medicine unit will be allowed at any time.
3. All matches, lighters, cigarettes, cigars, etc. will be removed from the patient prior to entering the clinical area.
4. All persons provided HBOT should be familiar with the following rules regarding the safe handling of all medical gases. They should know the characteristics of all gases.

B. **COLOR CODE:**

1. Oxygen = green or white
2. Air = yellow
3. Carbon dioxide – gray
4. Nitrous oxide = blue
5. Cyclopropane = orange or chromium
6. Helium = brown
7. Ethylene = red
8. Carbon dixide and oxygen = gray and green
9. Helium and oxygen = brown and green

C. **PIPED GAS SYSTEMS:**

1. Connections to piping, regulators, and other appliances should always be kept tight to prevent leakage. Where a hose is used, it should be kept in good condition.
2. Piping systems for gases must not be used as a grounding electrode for electrical devices.
3. Care should be taken to prevent interchanging one piped gas with another.
4. Smoking is prohibited in areas where piped gas systems are installed.
5. All joints in the piping, except those at valves or equipment requiring screw connections, must be made with silver solder or similar high-melting point brazing material.
6. Never use an open flame to detect gas leaks. Use only soapy water.

D. **PIPED GAS SYSTEMS (PRESSURE-REDUCING VALVES):**

1. A pressure-regulating valve must be installed, set to maintain a pressure of 50 psi to 80 psi under normal operating conditions at the point-of-service outlet.
2. A manually operated shut-off valve shall be installed on the high-pressure side of each pressure-regulating valve.

a. NOTE: All Center personnel will be trained in emergency shut-off procedures.

3. After installation of the piping, but before installation of the station outlet valves, the line must be blown clear by means of water-pumped nitrogen or air.

E. **PIPED GAS SYSTEMS (MAIN SHUT-OFF VALVE-STATION VALVE):**

1. The main supply line must be provided with a shutoff valve, located for easy access in an emergency.
2. Each station outlet for oxygen and compressed air must be equipped with either a manually operated or automatic shut-off valve and must be legibly labeled with the name of the gas.

F. **PIPED GAS SYSTEMS (CHECK BANK):**

1. A central supply system must have a primary supply and an adequate reserve supply that will automatically operate if the primary supply becomes exhausted.
2. Enclosures for supply systems must be provided with a door or gate that can be locked.

G. **PIPED SYSTEMS (FLOW METER REDUCTION):**

1. To administer oxygen to a patient, a pressure-compensated flow meter must be used to reduce the 50-psi line pressure to liters per minute.
2. Such flow meters should be checked for accuracy from time to time.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Hyperbaric Oxygen Treatment (HBOT) Treatment Guide

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. The purpose of this document is to:
   a. Define the indications that will be treated at the Center
   b. Outline the treatment protocol for each indication
   c. Describe the rationale for treatment with hyperbaric oxygen
   d. Establish the utilization review process for each indication

B. **POLICY:**

1. An individualized treatment plan will be provided for each patient who qualifies for HBOT and will be based on a recognized treatment protocol.
2. Only those indications that are not considered emergent will be treated at the Center.

C. **PROCEDURE:**

1. Those conditions that are considered emergent will not be treated at the outpatient Center in a monoplace chamber, but will require multiplace in-chamber treatment. They include:
   a. Acute carbon monoxide intoxication
   b. Arterial gas embolism
   c. Gas gangrene
   d. Cyanide poisoning
   e. Decompression illness
2. Conditions and their protocols that are treated at the outpatient Center in a monoplace chamber are:
   a. Actinomycosis
      i. Rationale: Actinomycosis is a bacterial infection caused by actinomyces israilii
      ii. Indications for Treatment: The symptoms of actinomycosis include slow-growing granulomas that later break down, discharging viscid pus containing minute yellowish granules. The treatment includes prolonged administration of antibiotics (penicillin and tetracycline). Surgical incision and drainage of accessible lesions is also helpful. Only after the disease process has shown refractory to antibiotics and after surgery should HBOT be initiated.
      iii. Evaluation:
         1) Consultation by a hyperbaric oxygen physician
         2) Completion of a full hyperbaric medicine screen
         3) Surgical and infectious disease consultations, as indicated

4) Routine laboratory, cardiopulmonary, or radiographic evaluation, as indicated by history
5) Obtain mandatory chest x-ray to rule out untreated pneumothorax

iv. Treatment Protocol: There is no established treatment protocol for actinomycosis. The hyperbaric oxygen physician dictates treatment protocol.

v. ~~(5)~~Utilization Review: There is no established utilization review for actinomycosis.

b. Chronic Refractory Osteomyelitis

i. Rationale: Chronic refractory osteomyelitis is an ischemic and infectious disease. Fibrous tissue produced by the body to isolate the lesion results in tissue PO_2 well below the 30mmHg to 40mmHg range necessary for fibroblast activity, collagen formulation, development of osteoclases, and normal phagocytic action by leukocytes. Periodic elevation of tissue PO_2 with hyperbaric oxygen promotes these activities. The capillary proliferation (neovascularization) that occurs in the affected area allows more effective introduction of antibiotics to the area. Vasoconstrictive action of hyperbaric oxygen reduces local edema.

ii. Indications for Treatment: Primary therapy for osteomyelitis continues to be surgical debridement of necrotic tissue and bone, with appropriate antibiotic therapy. HBOT has been demonstrated to be of adjunctive value in cases that have failed to respond to conventional therapy.

iii. Evaluation:
1) Consultation by a hyperbaric oxygen physician
2) Completion of a full hyperbaric medicine screen
3) Routine laboratory, cardiopulmonary, or radiographic evaluation, as indicated by history
4) Chest x-ray to rule out untreated pneumothorax
5) Recent bone scan of affected area
6) Bone biopsy if needed

iv. Treatment Protocol: The following schedule is recommended for the treatment of this condition; however, all treatments are administered per the physician's protocol specifically tailored for each individual treatment:
1) Treatment schedule **1 or 3**
2) Daily treatments
3) Total of 30 to 60 treatments

v. ~~(5)~~Utilization Review: Utilization review should be performed after 30 treatments. If healing is not complete or if there is persistent drainage from an existing sinus tract, the patient should be evaluated to determine whether or not sequestrum is present or has demarcated. If healing is taking place, HBOT may be continued for a total of 40 to 60 treatments, with peer review after 60 treatments. As many as 100 treatments may be necessary in severe cases to complete the healing process.

c. Diabetic Wounds of the Lower Extremities

i. Rationale: HBOT is recommended in diabetic patients whose wound(s) have failed to respond to standard care with no measurable signs of healing for at least 30 consecutive days.

ii. Indications for Treatment: HBOT is indicated for diabetic wounds of the lower extremities in patients who meet the following three (3) criteria:
1) Patient has Type I or Type II Diabetes and has a lower extremity wound(s) that is due to diabetes
2) Patient has a wound classified as Wagner Grade III or higher (see policy "Wound Staging")
3) Patient has failed an adequate course (30 days) of standard wound treatment

4) NOTE: Standard wound therapy must be used in addition to standard wound care. Standard wound care includes assessment of a patient's vascular status and correction of any vascular problems in the affected limb if possible, optimization of nutritional status, optimization of glucose control, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, appropriate off-loading, and necessary treatment to resolve any infection that might be present.

iii. ~~(3)~~Evaluation:
1) Consultation by a hyperbaric oxygen physician
2) Completion of a full hyperbaric medicine screen
3) Review of previous treatment for 30 days of adequate standard wound therapy
4) Review of nutritional status and glucose control
5) Vascular and infectious disease consultations, as indicated
6) Routine laboratory, cardiopulmonary, or radiographic evaluation, as indicated by history
7) Chest x-ray to rule out untreated pneumothorax

iv. Treatment Protocol: The following schedule is recommended for the treatment of this condition; however, all treatments are administered per the physician's protocol specifically tailored for each individual treatment:
1) Treatment schedule **1 or 3**
2) Daily treatments
3) Total of 30 to 60 treatments (evaluated every 30 treatments)

v. ~~(5)~~Utilization Review: Wounds must be evaluated at least every 30 days during administration of HBOT. Continued treatment is not recommended if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

d. Compromised Skin Grafts and Flaps
i. Rationale: Preparation and preservation of compromised skin grafts and flaps utilize HBOT for graft or flap salvage in cases where hypoxia or decreased perfusion have compromised viability.
ii. Indications for Treatment: Should a graft or flap fail, HBOT may be used to prepare the already-compromised recipient site for a new graft or flap. It does not apply to the initial preparation of the body site for a graft. HBOT is not necessary for normal, uncompromised skin grafts or flaps.
iii. Evaluation:
1) Consultation by a hyperbaric oxygen physician
2) Completion of a full hyperbaric medicine screen
3) Surgical and infectious disease consultations, as indicated
4) Routine laboratory, cardiopulmonary, or radiographic evaluation, as indicated by history
5) Chest x-ray to rule out untreated pneumothorax

iv. Treatment Protocol: The following schedule is recommended for the treatment of this condition; however, all treatments are administered per the physician's protocol specifically tailored for each individual treatment:
1) Treatment schedule **1 or 3**
2) Daily treatments
3) Total of 40 treatments (evaluated every 30 treatments)

v. ~~(5)~~Utilization Review: Utilization review is required after 20 treatments after preparing a recipient site for a flap or graft, and following 20 treatments after a flap or graft has been placed into its recipient site.

e. Soft Tissue Radionecrosis

i. Rationale: Generally the same mechanisms that produce osteoradionecrosis cause soft tissue radionecrosis. This situation arises chiefly from extensive radiation and sometimes surgery to tumors in the head and neck. Radiation damage appears to be of two different types, depending on the length of time that has elapsed after radiation therapy. Immediately after radiation, while the tissues are visibly erythematous, acute intracellular destruction blocks healing. Six to twelve months later the endothelium of the medium-sized blood vessels supplying the area begins to proliferate, decreasing the blood supply. Soft tissue destruction and orocutaneous fistula formation is common. Concomitant infection exacerbates the problem.
   1) Radiation enteritis sometimes occurs as a result of bowel damage from radiation treatments from bladder and ovarian cancers. Manifestation may present as multiple bowel ulcerations, painful cramping and/or peristaltic disturbances.
   2) Hyperbaric oxygen is considered only as an adjunct to treatment. Meticulous local wound care including debridement and surgery (if necessary) must be pursued.

ii. ~~(2)~~Indications for Treatment: Clinical and historical evidence of soft tissue radionecrosis

iii. ~~(3)~~Evaluation:
   1) Consultation by a hyperbaric oxygen physician
   2) Completion of a full hyperbaric medicine screen
   3) Routine laboratory, cardiopulmonary, or radiographic evaluation, as indicated by history
   4) Recent radiograph of the affected part
   5) Chest x-ray to rule out untreated pneumothorax

iv. ~~(4)~~Treatment Protocol: The following schedule is recommended for the treatment of this condition; however, all treatments are administered per the physician's protocol specifically tailored for each individual treatment:
   1) Treatment schedule **1 or 3**
   2) Daily treatments
   3) Total of 30 to 60 treatments

v. ~~(5)~~Utilization Review: Utilization review should be performed after 20 to 40 treatments. When a good granulation bed has been started, split thickness skin grafting may be possible.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Hyperbaric Oxygen Treatment (HBOT) Treatment Schedule

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide the HBOT physician treatment choices for the monoplace hyperbaric environment based on certain criteria and treatment diagnosis.

B. **POLICY:**

1. The patient shall be properly evaluated by the hyperbaric oxygen physician for the appropriateness of HBOT.

C. **PROCEDURE:**

1. Clinical indications for treatment at 2.0 ATA **or 2.4 ATA** include:
   a. Acute peripheral arterial insufficiency
   b. Acute traumatic peripheral ischemia
   c. Crush injury, compartment syndrome
   d. Chronic refractory osteomyelitis
   e. Compromised skin grafts
   f. Progressive necrotizing infection
   g. Osteoradionecrosis
   h. Soft tissue radionecrosis
2. In the monoplace chamber environment, the patient is exposed to 100% oxygen throughout the entire treatment.
3. Patient travels to and from treatment depth over a ~~5 to 10~~**8 to 15**-minute period to allow for proper ear/sinus equalization. Start time at treatment depth 10 minutes after leaving the surface even if the patient is still traveling to treatment depth.
4. The patient remains at treatment depth for 90 to 120 minutes.
5. The schedules below allow for variations in treatment time:

SCHEDULES	ATA	DESCENT TIME	TX TIME	ASCENT TIME	AIR BREAKS
SCHEDULE 1	2.0	8-15 minutes	90 minutes	8-15 minutes	NA
SCHEDULE 2	2.0	8-15 minutes	120 minutes	8-15 minutes	NA
SCHEDULE 3	2.4	8-15 minutes	90~~10~~ minutes	8-15 minutes	5-minute breaks twice ~~at 30-minute intervals~~

Under Schedule 3, the patient is instructed ~~at 30-minute intervals~~ to place an air-breathing device over their nose and mouth to breathe air for 5-minute periods to allow oxygen tension in the blood to decrease. This lessens the potential for CNS oxygen toxicity to develop.

7. The patient is continually supervised to watch for symptoms of oxygen toxicity. The staff uses the acronym VENTID-C to help identify signs and symptoms of oxygen toxicity:
   V: Tunnel vision
   a. E: Ears ringing (tinnitus)
   b. N: Nausea/vomiting
   c. T: Twitching of muscles (most common around eyes and lips)
   d. I: Irritability/anxiety
   e. D: Dizziness/incoordination
   f. C: Convulsion
2. 8. Because the breathing media is oxygen, no decompression obligation is incurred. Do not exceed the recommended ascent rate of 30 feet per minute.
3. 9. Documentation of the treatment schedule and a record of events during the treatment are maintained in departmental log or approved annotation process for the department. Entries are made in the patient record according to hospital policy.

B. D Reference: Undersea and Hyperbaric Medical Society Hyperbaric Oxygen Therapy Committee Report, 1999, and American College of Hyperbaric Medicine, Preferred Practice Protocols, 1995.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Inspection of HBO Chambers

REVISION DATE~~(S)~~: 12/10

Department Approval:	**~~02/20~~01/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that chamber inspections are performed and documented per manufacturer specifications.

B. **POLICY:**

1. All chambers must have documented daily, weekly, ~~semi-annual,~~ and annual inspections according to chamber manufacturer guidelines.
2. Annual **inspection will be coordinated through the BIOMed Department**~~and semi-annual inspections will be coordinated through Paradigm Medical Management, who will arrange inspection and maintenance through the chamber manufacturer.~~
3. Specific instructions will be obtained from the manufacturer's manual.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Management of Oxygen Toxicity Seizure

REVISION DATE~~(S)~~: 12/10

Department Approval:	**~~02/20~~01/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To safely and effectively manage a patient who is displaying signs and symptoms of oxygen toxicity during HBOT.

B. **POLICY:**

1. All patients will be closely monitored during therapy for evidence of oxygen toxicity.
2. The HBOT staff will understand that there may be a total lack of symptoms prior to the patient going directly into a tonic-clonic seizure.
3. The operator will remain alert at all times and be prepared to act immediately.

C. **PROCEDURE:**

1. Patients experiencing signs and symptoms of oxygen toxicity will be safely removed from the chamber following emergency decompression procedure.
2. The supervising HBOT physician will be notified immediately.
3. The signs and symptoms are described below. The most commonly used acronym to describe signs and symptoms of oxygen toxicity is V.E.N.T.I.D.-C.
   a. V: Tunnel vision
   b. E: Ears ringing (tinnitus)
   c. N: Nausea/vomiting
   d. T: Twitching of muscles (most common around eyes and lips)
   e. I: Irritability/anxiety
   f. D: Dizziness/incoordination
   g. C: Convulsion
4. In the event of a seizure:
   a. The depth shall be maintained until the patient is stabilized and breathing (traveling to the surface during the tonic-clonic phase can result in gas embolism or pneumothorax)
   b. As soon as the patient is removed from the chamber, the RN will start an IV line using 250ml of ½ normal saline and administer 2mg of Ativan IV STAT over a 1-minute period. If seizure persists, give an additional 2mg of Ativan IV over 1 minute. Rate of injection should not exceed 2mg per minute
      i. NOTE: If the seizure persists, call 911.
   c. The patient will be placed on EKG monitor, the vital signs obtained, and the respirations closely observed
   d. HBOT physician will do a thorough patient evaluation
   e. The time, duration, and the type of seizure will be documented in the patient record

f. Patients with no history of seizures will be admitted to the hospital by the HBOT physician or the Center's medical director for evaluation and treatment
g. Patients with a history of seizures will also be evaluated by HBOT physician, and the primary care physician is notified

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Oxygen Supply Failure

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish procedure guidelines in the event of an oxygen supply failure.

B. **POLICY:**

1. All HBOT staff will be trained to safely manage oxygen supply failure.

C. **PROCEDURE:**

1. Should the oxygen supply fail during a treatment of patients, the HBO personnel will:
   a. Check the 0_2 supply indicator
   b. Check the departmental oxygen supply gauge for ample pressure
   c. If unable to quickly resolve the problem, the treatment shall be aborted
   d. Reassure patients of their safety and begin ascent when ready
   e. Observe normal travel rate for ascent (1 fps) maximum
   f. Document all problems encountered
   g. Contact hospital engineering department **and Airgas** for assistance in troubleshooting the problem
   h. No treatments will be initiated or continued utilizing "emergency gas" supply
   i. Test all lines and chamber function prior to future treatments to ensure all problems have been resolved

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: **Patient Screening For Contraindications To HBOT**

REVISION DATE~~(S)~~: 12/10

Department Approval:	**~~02/20~~01/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**01/23**
Administration Approval:	**02/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that all patients referred for HBOT are properly screened for contraindications prior to initiating therapy.

B. **POLICY:**

1. All patients referred for hyperbaric oxygen treatment will be screened for contraindications to therapy.
2. Patients who have been identified with one or more absolute contraindications will not be admitted for treatment in the hyperbaric oxygen program.
3. Patients with relative contraindications may be considered for HBOT and will be approved for treatment only by a qualified HBOT physician.

C. **PROCEDURE:**

~~1. Utilizing the HBOT Screening form, the HBOT staff and physician completes the screening process.~~

~~2.~~1. The HBOT physician will define the plan of care and order testing as appropriate.
~~3.~~2. Patients not approved for therapy will be referred back to the physician requesting HBOT.
~~4.~~3. When a relative contraindication has been identified, the HBOT physician may consult with the patient's primary physician prior to making a decision.
~~5.~~4. A patient approved for treatment will sign their consent on the approved form.
~~6.~~5. The HBOT staff will ensure that the testing is completed and results are in the medical record for the physician's review.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Patient/Family Orientation to HBOT

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that all patients and their families/caregivers will receive adequate explanation, training and orientation prior to treatment.

B. **POLICY:**

1. All patients who are to receive HBOT will be oriented to HBOT prior to treatment.
2. Orientation and patient education will be documented using the approved education forms.

C. **PROCEDURE:**

1. Using the approved forms, the patient and their family/caregiver will be given an initial orientation to the program.
2. Patient education will be provided as needed on an ongoing basis while the patient is in the treatment program.
3. Education provided and response to education will be documented in the medical record.
4. Written information will be given to the patient/family at the outset of treatment.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Physician Credentialing Criteria

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **POLICY:**

1. The qualifications for supervising hyperbaric oxygen therapy is based on the following requirement:
2. The physician must be credentialed by the hospital. At a minimum, the following elements have been established by the medical center as criteria for the covering physicians:
3. A physician practicing hyperbaric medicine is a fully licensed physician who has been granted privileges in hyperbaric medicine by the medical staff of the hospital.
4. Completion of a recognized hyperbaric medicine training program, as established by either the American College of Hyperbaric Medicine (ACHM) or the Undersea and Hyperbaric Medical Society (UHMS) with a minimum of 40-60 hours of training documented by a certificate of completion.
5. Completion of medical education in hyperbaric medicine with a minimum of 16 hours every 2 years after initial credentialing.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Pneumothorax in the Chamber

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure safe removal of a patient from the chamber when it has been determined that the patient has had a pneumothorax.

B. **POLICY:**

1. When it is determined that a patient is experiencing a pneumothorax, every effort will be made to safely remove the patient from the chamber before initiating CPR.
2. All HBOT staff will be trained in the safety procedures for safe removal of patients from the chamber.

C. **PROCEDURE:**

1. The patient will experience sudden stabbing chest pain, apprehension, and respiratory distress that worsens with decompression.
2. The supervising physician will be notified immediately
3. The patient will be recompressed to the original treatment pressure or to the pressure level that the patient is comfortable.
4. ~~The ER is notified,~~ **The staff will call 911** and transportation to the ER is arranged.
5. Under the supervision of the HBOT physician, the patient is decompressed at a deliberate, constant, rapid rate.
6. The patient is transported immediately to the ER for evaluation and treatment.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Pre-Treatment Assessment

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure the patient is appropriately evaluated prior to each treatment.

B. **POLICY:**

1. All patients receiving Hyperbaric Oxygen Treatment (HBOT) will be appropriately assessed by qualified personnel prior to receiving therapy.

C. **PROCEDURE:**

1. HBO staff will inform the patient of all procedures and treatment protocols.
2. HBO staff will inquire whether the patient has taken their medications as prescribed, if diabetics have had a chance to eat their meal, and that the blood glucose checks have been performed.
3. During initial visit to the unit, a qualified member of the Center staff shall conduct $TCPO_2$ measurements of the wound site (if ordered), obtain pictures for data collection and progress reports, and attain appropriate labs with chest x-ray for evaluation by the HBO physician.
4. HBO staff will ensure that all IV access lines, drains, tubes, catheters, dressings, and clothing are properly checked and adjusted prior to and following therapy.
5. An HBOT staff member will perform a basic physical assessment and obtain vital signs for all patients prior to therapy. Any value outside the set guidelines will be brought to the attention of the HBO physician prior to placement in the chamber.
   a. Temperature: The HBO physician will be notified of temperature >101°F prior to therapy. NOTE: Patients with an elevated temperature are significantly prone to oxygen toxicity during HBOT due to increased metabolism.
   b. Blood Pressure: The HBO physician will be notified prior to therapy for systolic (SBP) <100 or >185 / Diastolic (DBP) <60 or >105.
   c. Pulse: The HBO physician will be notified for any occasion of symptomatic bradycardia (<60 bpm) or symptomatic tachycardia (>100 bpm) or the incidence of irregular heart rate not originally noted during the physician consult.
   d. Respiration: The HBO physician will be notified for any incidence of labored or difficulty breathing that is abnormal from the patient's normal cycle.
   e. Blood Glucose: All abnormal glucose levels will be reported to the HBO physician. Patients will be referred to their primary physician or ER as appropriate (see policy for Hypo- and Hyperglycemia).
6. The HBO staff will conduct a safety check of each patient prior to placing the patient in the hyperbaric chamber. Guidelines for these checks are outlined in the chamber's manufacture's manual and also in conjunction with UHMS Guidelines. No substitution or omission of these

checks are permitted. A list of personal items, clothing or other agents not allowed in the chamber environment will be posted in plain view of the patients in the department. A thorough explanation and patient teaching checklist will be utilized for each patient and addressed daily throughout the patient's course of treatment.

7. All patients are to be dressed in approved clothing and checked by the hyperbaric staff prior to therapy. Hospital garments are provided for each patient and will be enforced by the staff at all times for safety reasons.
8. A designated and certified hyperbaric technician will operate the chamber in accordance with protocol set forth by the HBOT physician and UHMS Guidelines. At no time will the chamber be left unattended while pressurized with a patient. The patient will remain n full view of the operator or inside observer at all times for safety reasons.
9. Deviation from treatment protocol without HBOT physician orders is strictly forbidden except in an emergency that would cause injury or death to the patient or operator, such as fire in the chamber or fire in the chamber room/immediate vicinity of the department that would impede safe treatment of the patient.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Reporting Structure

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish structure and reporting responsibilities for the hyperbaric medicine operations.

B. **POLICY:**

1. The Center is directed and supervised by the program director.
2. The program director reports to the hospital administrator, as directed by the hospital administration.
3. The medical staff is directed and supervised by the medical director.
4. The medical director coordinates medical staffing in collaboration with the program director and manager and is responsible for the administration of medical operations and standards.
5. The Center operation is assessed through the use of performance indicators. Identified problems are seen as opportunities for improvement and discussed at the medical staff meetings. Recommendations offered by the staff are integrated into the action plans to improve Center operations.
6. All Center staff members are required to participate in the Center's performance improvement process.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT:** Safety Committee

REVISION DATE(~~S~~): 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To establish guidelines for a Safety Committee for the Center in compliance with NFPA 99-19.

B. **POLICY:**

1. A Safety Committee will be established and will be responsible for safety- and equipment-related policies and procedures instituted in the Center.
2. The Safety Committee will meet, at a minimum, quarterly and more frequently as needed.
3. The Safety Committee will be responsible for regulating all machinery and materials that enter the Center.
4. The Safety Committee will also be responsible for assuring that all preventative maintenance is performed on associated Hyperbaric Oxygen (HBO) equipment.
5. The Safety Committee will report its findings to the hospital's Environment of Care Committee and the Center's medical staff during their regularly scheduled meetings.
6. The hyperbaric manager will be a member of the hospital Environment of Care Committee.
7. The Safety Committee will be chaired by HBOT Safety Officer and will include:
   a. HBOT manager/Center's clinical manager
   b. Hospital representatives from departments such as Engineering and Biomedical Engineering

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Transcutaneous 02 Monitoring

REVISION DATE(~~S~~): 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To provide standard guidelines for accurate transcutaneous oxygen ($TcPO_2$) measurements.
2. $TcPO_2$ is one tool in the overall evaluation process that may be useful in determining whether a patient may benefit from Hyperbaric Oxygen Treatment (HBOT).
3. $TcPO_2$ may also be used to help determine the level of amputation by allowing surgeons to predict healing capability.

B. **POLICY:**

1. During the evaluation process, the HBOT physician will assess for the need for $TcPO_2$ monitoring.
2. **Only trained personnel** ~~Only certified personnel (certified hyperbaric technician or certified vascular technician)~~ will perform all $TcPO_2$ procedures.
3. The reading/interpretation will be performed by a qualified physician, i.e., a vascular surgeon or physician trained in the reading/interpretation of $TcPO_2$.

C. **PROCEDURE:**

1. $TcPO_2$ will be performed on extremities only.
2. For Medicare patients, refer to listing of ICD-10 codes at the end of the policy that support medical necessity.
3. The designated physician will review results of all studies.
4. All centers will calibrate their monitors to 44.0° C.
5. Prior to the study, the sensor will be cleaned and calibrated according to the manufacture's instructions.
6. The $TcPO_2$ training checklist will be used for the step-by-step procedure:
   a. Sensor/site location will be determined by:
      i. Protocol: Minimum of 2 sites to include proximal-to-wound and distal-to-wound. If the procedure is being done to assist in an amputation, evaluation of the opposite limb is recommended. Reference site can be on chest at left 2nd intercostal space or by pulse oximetry. Reference site determines systemic hypoxia.
      ii. Mapping Study: Will include bilateral sites at predetermined levels such as BKA, AKA, and transmetatarsal sites.
      iii. Physician-Driven: Physician will determine number of site and site location.
      iv. $TcPO_2$ Wound Site Photography: The documentation of $TcPO_2$ may include photography of the probe's application sites at the physician's discretion.

7. Study should be performed in a warm, quiet environment with no distractions. The patient's extremities should be covered with a blanket, and patient is asked to try to remain still and do not cross legs.
8. Procedure must be thoroughly explained to the patient before proceeding with the study.
9. $TcPO_2$ study will consist of the following:
   a. A baseline reading after 10 minutes at 1 ATA on room air for each site in the study.
   b. After determining the lowest reading on room air or the closest site to the wound, a timed study will be done.
   c. Timed Study: 30 minutes total to include 5-minute break between elevation and 100% 0_2. Take a reading at each timed increment:
      i. 10 minutes air _____
      ii. 5 minutes elevation of both extremities, 45° _____
         a) (3) 5-minute air break extremities level
      iii. 3, 4, 5 and 10 minutes – 100% 0_2 readings _____
   d. Reference sites are used to determine systemic hypoxia and if necessary can be done by pulse oximetry instead of the chest lead.
10. If patient is an HBOT patient, $TcPO_2$ at HBO treatment depth should be performed within first few treatments to provide evidence of oxygenation. For this procedure, only one site is necessary -- usually the site closest to the wound. If the results of the 1 ATA challenge are considered to be in the "gray" area, a hyperbaric oxygen challenge may be needed. This requires an HBOT consultation with the inherent risks and costs associated.
    i. Subsequent $TcPO_2$ may be performed midway through treatment regimen.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Vacuum-Assisted Closure Device

REVISION DATE~~(S)~~: 12/10

Department Approval:	~~02/20~~01/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	01/23
Administration Approval:	02/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. **PURPOSE:**

1. To ensure that a wound VAC device is managed appropriately prior to and after each session of Hyperbaric Oxygen Treatment (HBOT).

B. **POLICY:**

1. HBOT staff will be trained to manage the wound VAC device.

C. **PROCEDURE:**

1. Prior to entering the hyperbaric chamber, these instructions will be followed:
   a. The wound VAC device/canister will be disconnected from the VAC dressings after clamping the clamps on the dressing and canister tubing.
   b. Once the patient is secured and ready to go into the chamber, cover the end of the connector with sterile 4x4 gauze or other approved absorbent dressing to contain any secretions remaining in the tubing.
   c. Once the gauze is in place, unclamp the tubing to allow for pressure changes in the VAC tube and dressing.
   ~~d. Cover the entire VAC dressing and tubing with a moist 100% cotton material such as a towel or pillowcase.~~
   ~~e.~~d. After the treatment, reconnect the VAC device to the dressing and turn the therapy unit on. Ensure there are no leaks in the seal.

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
January 26, 2023 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held via teleconference at 3:30 p.m. on January 26, 2023.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Steven Dietlin, Chief Executive Officer
Candice Parras, Chief, Patient Care Services
Ray Rivas, Chief Financial Officer
Dr. Gene Ma, Chief Medical Officer
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.

   Chairperson Chavez welcomed everyone to today's meeting as we celebrate our return to in-person meetings. He stated from the beginning of the pandemic, the safety of our patients, staff and community has been our primary priority. With that in mind, our current meeting guidelines provide for masking at all times.

2. Approval of Agenda

   It was moved by Director Sanchez and seconded by Director Gleason to approve the agenda as presented. The motion passed unanimously (7-0).

3. Pledge of Allegiance

   Director Chavez led the Pledge of Allegiance.

4. Public Comments – Announcement

   Chairperson Chavez read the Public Comments section listed on the January 26, 2023 Regular Board of Directors Meeting Agenda. He asked that members of the public wishing to speak submit a speaker card at this time.

5. Reports – Information Only

a) Auxiliary Scholarship Report – Scholarship Committee Chair

Bunny McElliott, Auxiliary Scholarship Committee Chair reported the annual Scholarship event will be held on Tuesday, April 18, 2023. She explained that the Committee would not be requesting monetary support from the Board this year due to a carryover from the previous two years of $14,500.00. Ms. McElliott expressed her appreciation for the Board's incredible support.

b) Radiology Report – Dr. Gene Ma

Dr. Gene Ma, Chief Medical Officer provided an update on Radiology Services, He discussed the new partnership with Imaging Healthcare Specialists. Through the partnership, a structure was created that includes both local radiologists and teleradiology to continue to provide care in our community. Dr. Ma introduced members of the team that were instrumental in brining this service to fruition.

6. December, 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 – $163,709
- Operating Expense – $179,339
- EBITDA – ($3,427)
- EROE – ($10,633)

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

- Average Daily Census – 117
- Adjusted Patient Days – 43,253
- Surgery Cases – 2,709
- ED Visits – 28,497

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

- Net Operating Revenue – $27,686
- Operating Expense – $30,845
- EBITDA – ($781)
- EROE – ($2,028)

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

- Average Daily Census – 114
- Adjusted Patient Days – 6,653
- Surgery Cases –410
- ED Visits – 4,317

Mr. Rivas presented two graphs which reflected trending of the Average Length of Stay (ALOS) and Average Daily Census (ADC).

7. New Business

a) Consideration of nomination to serve on the San Diego Local Agency Formation Commission (LAFCO) as a Regular and Alternate Special District Member

Chairperson Chavez explained we have an opportunity to nominate a Board Member to serve on the San Diego Local Agency Formation Commission as a regular and alternate special district board member. He asked if any Board member would like the opportunity to serve. No Board member indicated their desire to be nominated.

No action taken.

b) Consideration of Resolution No. 822, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Termination of the North San Diego County Health Facilities Financing Authority, Approving the Form of, and Authorizing the Executive and Delivery of a Termination Agreement and Authorizing the Taking of Certain Actions in Connection Therewith.

Board Counsel Jeff Scott provided background information on the North San Diego County Health Facilities Financing Authority and the fact that the Joint Powers Authority is no longer required under California law. The Resolution brought forward today will terminate the agreement with the North San Diego County Health Facilities Financing Authority.

There were no questions or comments from Board members.

It was moved by Director Coulter to approve Resolution No. 822, a Resolution of the Board of Directors of Tri-City Healthcare District Authorizing Termination of the North San Diego County Health Facilities Financing Authority, Approving the Form of, and Authorizing the Executive and Delivery of a Termination Agreement and Authorizing the Taking of Certain Actions in Connection Therewith. Director Gleason seconded the motion.

The vote on the motion was as follows:

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

8. Old Business - None

9. Chief of Staff –

a) Consideration of January 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as recommended by the Medical Executive Committee on January 23, 2023

b) Consideration of Clinical Privilege Request Form – Orthopaedic Surgery

On behalf of Dr. Showah, Chief of Staff, Dr. Gene Ma, Chief Medical Officer presented the Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners as well as the Clinical Privilege Request Form for Orthopaedic Surgery. Dr Ma also pulled the initial appointment of Nikhil Murthy, M.D.at Dr. Showah's request.

It was moved by Director Mizell to approve the January 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Practitioners. and the Clinical Privilege Request Form minus the appointment of Dr. Nikhil Murthy, M.D as recommended by the Medical Executive Committee on January 23, 2023. Director Coulter seconded the motion.

The vote on the motion was as follows:

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

10. Consideration of Consent Calendar

It was moved by Director Gleason to approve the Consent Calendar. Director Younger seconded the motion.

The vote on the motion was as follows:

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

11. Discussion of items pulled from Consent Calendar - None

12. Comments by Members of the Public –

Chairperson Chavez recognized the following individuals who requested to speak under Public Comments:

- Brian Ramos
- Matthew Luna
- Victor Roy
- Rob Howard
- Kim Fluharty
- Miles Sweeney
- Cathy Cronce
- Alease Buddy
- Chris Hart
- Melissa Sanchez

13. Comments by Executive Leadership and Chief Executive Officer

Mr. Ray Rivas, CFO, Candice Parras, CNE and Dr. Gene Ma, Chief Medical Officer made comments primarily responsive to the public speakers.

Mr. Steve Dietlin, CEO echoed some of the comments made by other leadership team members. He emphasized it takes a team and everyone working together to deliver our mission for our community every day. He recognized and thanked the Tri-City team, including clinical and non-clinical employees, the Medical Staff, the Board of Directors, the Foundation and the Auxilians, along with many community team members as well for their contributions to Tri-City's mission each and every day.

Mr. Dietlin reported that the District is proudly participating in the State Worker Retention Program and has taken steps to maximize the state match for all qualifying team members at Tri-City.

Mr. Dietlin stated, as most are aware he is retiring from Tri-City, and it has been his distinct honor and privilege to serve the District over the past decade alongside the thousands of Tri-City team members and community leaders to deliver our mission to advance the health and wellness of our community. Mr. Dietlin commented that many challenges have faced Tri-City over the years, including the pandemic, and the Tri-City team has risen to meet each challenge. He is proud of the collective accomplishments of our Tri-City Team working in unison to deliver quality healthcare for our community. Mr. Dietlin reported in the last year alone, Tri-City, in partnership with the County of San Diego, broke ground on a 16-bed inpatient psychiatric health facility as part of an improved care coordination model for mental health services that will work in unison with community crisis stabilization units. We ae completing installation of a 3T MRI, and kicked off our ED remodel project funded by the Tri-City Hospital Foundation that will improve the look, feel and function of the ED.

14. Board Communications

Board members made comments primarily in response to the concerns from the public speakers.

Board members also commented on the fact that this Board works very well together and is passionate about the health and wellness of our community.

15. Report from Chairperson

Chairperson Chavez re-emphasize that this Board gets along and works well together. The Board understands that we have a lot of work to do.

Chairperson Chavez reported on the Request for Proposal for a search firm to find a new CEO. He commented that the RFP which is published on the District's website stipulates very clearly that the Board wants to hire a company that recognizes the uniqueness and diversity of our community.

Chairperson Chavez commented on an issue the hospital is facing with LAFCO and the need for the public's support.

Chairperson Chavez reported due to a scheduling conflict the Board will be moving their March meeting to Friday, March 31st and it will also be the first meeting without our CEO.

16. Adjournment

There being no further business, Chairperson Chavez adjourned the meeting at 4:45 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

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

January 26, 2023 – 2:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 2:00 p.m. on January 26, 2023.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Absent was Director Coulter and Director Chaya

Also present were:

Steve Dietlin, Chief Executive Officer
Ray Rivas, Chief Financial Officer
Candice Parras, Chief Nurse Executive
Dr. Gene Ma, Chief Medical Officer
Jeremy Raimo, Senior Director, Business Development
Susan Bond, General Counsel
Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant

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

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Younger to approve the agenda as presented. The motion passed (5-0-0-2) with Directors Coulter and Chaya absent.

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

   Chairperson Chavez made an oral announcement of the items listed on the January 26, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included two matters of Existing Litigation, one matter of Potential Litigation, Reports Involving Trade Secrets and Public Employee Appointment: CEO.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Mizell to go into Closed Session at 2:05 p.m. The motion passed (5-0-0-2) with Directors Coulter and Chaya absent.

5. At 3:22 p.m. the Board returned to Open Session with all Board members present including Directors Coulter and Chaya.

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

The Board met in closed session to discuss two potential litigation matters pursuant to Government Code 54956.9 (c).

The Board heard reports involving both matters and took no action.

The Board discussed two existing related litigations: Medical Acquisitions Company v. TCHD and TCHD v. Medical Acquisition Company – Case Nos. 2014-00009108 and 214-00022523 and took no action.

The Board also discussed two reports involving Trade Secrets related to possible new programs and services and took no action.

Lastly, the Board discussed the appointment of a new Chief Executive Officer.

7. Adjournment

Chairperson Chavez adjourned the meeting at 3:25 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

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

February 13, 2023 – 3:00 o'clock p.m.

A Special Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:00 p.m. on February 13, 2023.

The following Directors constituting a quorum of the Board of Directors were present via teleconference:

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy M. Younger

Also present were:

Jeff Scott, Board Counsel
Teri Donnellan, Executive Assistant
Rick Crooks, Security Protection Agent

1. The Board Chairperson, Director Chavez, called the meeting to order at 3:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Director Younger to approve the agenda as presented. The motion passed unanimously (7-0).

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

   Chairperson Chavez made an oral announcement of the items listed on the February 13, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: CEO and one matter of Potential Litigation.

4. Motion to go into Closed Session

   It was moved by Director Gleason and seconded by Director Mizell to go into Closed Session at 5:40 p.m. The motion passed unanimously (7-0).

5. At 5:40 p.m. the Board returned to Open Session with attendance as listed above and also included Steve Dietlin, CEO, Ray Rivas, CFO, Candice Parras, CNE and Dr. Gene Ma, Chief Medical Officer.

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

The Board in closed session discussed the appointment of the CEO and directed Board Counsel to work with the CEO Ad hoc Search Committee to finalize a contract with HealthSearch Partners and place on the February Regular Board agenda for approval.

The Board met in closed session to discuss one Potential Litigation Matter pursuant to Government Code 54956.9 (c) and directed the Board Chairman to take appropriate action.

7. Adjournment

Chairperson Chavez adjourned the meeting at 5:45 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending January 31, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	Lease Term Beginning	Lease Term Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	(a)	50,630.88	07/01/17	06/30/27	**OSNC - Carlsbad** 6121 Paseo Del Norte, Suite 200 Carlsbad, CA 92011	7095
Cardiff Investments LLC 2729 Ocean St Carlsbad, CA 92008 **V#83204**	Approx 10,218	$2.58	(a)	38,026.00	07/01/17	07/31/24	**OSNC - Oceanside** 3905 Waring Road Oceanside, CA 92056	7095
Creek View Medical Assoc 1926 Via Centre Dr. Suite A Vista, CA 92081 V#81981	Approx 6,200	$2.70	(a)	20,197.50	07/01/20	06/30/25	**PCP Clinic Vista** 1926 Via Centre Drive, Ste A Vista, CA 92081	7090
JDS FINCO LLC 499 N EL Camino Real Encinitas, CA 92024 V#83694	Approx 2,460	$2.15	(a)	7,169.67	04/01/20	03/31/23	**La Costa Urology** 3907 Waring Road, Suite 4 Oceanside, CA 92056	7082
Mission Camino LLC 4350 La Jolla Village Drive San Diego, CA 92122 V#83757	Appox 4,508	$1.75	(a)	15,486.58	09/01/21	10/31/31	**Seaside Medical Group** 115 N EL Camino Real, Suit A Oceanside, CA 92058	7094
500 W Vista Way, LLC & HFT Melrose P O Box 2522 La Jolla, CA 92038 V#81028	Approx 7,374	$1.67	(a)	12,780.08	07/01/21	06/30/26	**Outpatient Behavioral Health** 510 West Vista Way Vista, Ca 92083	7320
Nextmed III Owner LLC 6125 Paseo Del Norte, Suite 210 Carlsbad, CA 92011 V#83774	Approx 4,553	$4.00	(a)	23,297.92	09/01/21	08/31/33	**PCP Clinic Cairsbad** 6185 Paseo Del Norte, Suite 100 Carlsbad, CA 92011	7090
OPS Enterprises, LLC 3617 Vista Way, Bldg. 5 Oceanside, Ca 92056 #V81250	Approx 7,000	$4.12	(a)	30,907.00	10/01/12	01/31/23	**North County Oncology Medical Clinic** 3617 Vista Way, Bldg 5 Oceanside, Ca 92056	7086
SCRIPPSVIEW MEDICAL ASSOCIATES P O Box 234296 Encinitas, CA 234296 V#83589	Approx 3,864	$3.45	(a)	14,447.11	06/01/21	05/31/26	**OSNC Encinitas Medical Center** 351 Santa Fe Drive, Suite 351 Encinitas, CA 92023	7095
SoCAL Heart Property LLC 1958 Via Centre Drive Vista, Ca 92081 **V#84195**	Approx 4,995	$2.50	(a)	17,473.44	07/01/17	06/30/27	**OSNC - Vista** 1958 Via Centre Drive Vista, Ca 92081	7095
TCMC, A Joint Venture 3231 Waring Court, Suit D Oceanside, CA 92056 V#83685	Approx 1,444	$2.59	(a)	3,754.00	02/01/20	01/31/23	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**234,170.18**				

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

Tri-City Medical Center

ADVANCED HEALTH CARE FOR YOU

Education & Travel Expense
Month Ending January 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8740	MASTERS	11223 EDU	5,000.00	77123	STEIN ALONA
8740	ACLS	11923EDU	150.00	82656	ADAYA, ALEX
8740	ACLS	10523 EDU	151.00	83913	PARKER MICAL
8740	ONS/ONCC CHEMOTHERAPY	121522 EDU	200.00	84203	WILSON CHLOE
8740	LVN PROGRAM	10523 EDU	2,000.00	84209	CUNNYNGHAM ANGELA
8756	STROKE CONFRENCE	11923 EDU	699.00	79956	REELING, CAROL

**This report shows reimbursements to employees and Board members in the Education & Travel expense category in excess of $100.00.
**Detailed backup is available from the Finance department upon request.