TRI-CITY HEALTHCARE DISTRICT
AGENDA FOR A REGULAR MEETING
April 27, 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	Introduction Donald A. Dawkins, Interim Chief Nurse Executive	5 min.	Board Chair
6	Reports – Information Only a) Foundation Update – Jennifer Paroly, President	10 min.	Foundation President
7	March 2023 Financial Statement Results	10 min.	CFO
8	New Business - None	---	---
9	Old Business – a) Consideration and possible action regarding Labor & Delivery	20 min.	Board Chair

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

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

	Agenda Item	Time Allotted	Requestor
10	Chief of Staff -		
	a) Consideration of April 2023 Credentialing Actions and Reappointments Involving the Medical Staff and Allied Health Professionals as recommended by the Medical Executive Committee on April 24, 2023.	5 min.	COS
	b) Nurse Practitioner – Emergency Medicine – Clinical Privilege Request Form		
	c) Nurse Practitioner Standardized Procedures for the Emergency Department at Tri-City Medical Center		
11	Consent Calendar –		
	a) Approval of the renewal of the Medical Directorship for Opioid Stewardship Program with services provided by Ole Synder, M.D. for a term of 12 months, beginning May 1, 2023 and ending April 30, 2024, with an annual and total term cost not to exceed $18,000.		
	b) Administrative committees **A. Policies** **1. Patient Care Services Policies & Procedures** a) Admission of Psychiatric Patients Policy (RETIRE) b) Admission to Crisis Stabilization Unit (CSU) (RETIRE) c) Preceptor Program Procedure d) Safe Surrender e) Swallow Screening in the Adult Patient Procedure f) Titrating Medications, Adult Patients Policy **2. Administrative 200** a) Decorative Material 248 **3. Cardiac Rehab** a) Billing for Cardiac Rehab **4. Emergency Department** a) Elopement, Patient at Risk-Policy b) Wandering Band System Procedure **5. Employee Operation Procedure (EOP) Manual** a) 4084 Disaster Equipment Training, Storage and Use **6. Mammography** a) Mammography Medical Outcomes Audit Policy **7. NICU** a) Patient Assignment NICU (RETIRE) b) Patient Classification (Acuity) in the NICU **8. Outpatient Behavioral Health Services** a) Code Silver Plan b) Medications **9. Pharmacy** a) Medication Error Reduction Plan (MERP) **10. Women & Newborn Services**		

	Agenda Item	Time Allotted	Requestor
	a) Human Immunodeficiency Virus (HIV) Intrapartum, Postpartum and Newborn Management b) Misoprostol [Cytotec] c) Umbilical Cord Blood Banking Private Collection **11. Wound Care** a) Acuity Class System b) Chart Order (RETIRE) c) Collaboration d) Data Management e) Discharge Instructions f) Disseminating Medical Information g) Home Care Referrals h) Medical Equipment Maintenance i) Nurse Visit j) Outcome Designation for Non-Healing Wounds k) Patient Advocacy l) Patient Charges m) Patient Chart (RETIRE) n) Patient Instructions i) Patient Photography j) Patient Reception k) Patient Survey Process (RETIRE) l) Patient Visual-Auditory Privacy m) Program Description n) Registration o) Scheduling p) Staff Development q) Staffing Plan r) Telephone Management s) Wound Measurement t) Wound Staging **12. Wound & Hyperbaric Oxygen** a) Admission Procedure b) Discharge Summary c) Patient Changing Area c) Minutes 1) March 31, 2023, Special Meeting 2) March 31, 2023, Regular Meeting d) Meetings and Conferences – None e) Dues and Memberships – None f) Reports – (Discussion by exception only) 1) Lease Report – (March, 2023) 2) Reimbursement Disclosure Report – (March, 2023)		
12	Discussion of Items Pulled from Consent Agenda	10 min.	Standard
13	Comments by Members of the Public NOTE: Per Board Policy 19-018, members of the public may have three (3) minutes, individually and 15 minutes per subject, to address the Board on any item not on the agenda.	5-10 minutes	Standard

	Agenda Item	Time Allotted	Requestor
14	Comments by Chief Executive Officer	5 min.	Standard
15	Board Communications (three minutes per Board member)	18 min.	Standard
16	Report from Chairperson	3 min.	Standard
17	Total Time Budgeted for Open Session	1.5 hours	
18	Adjournment		

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF INITIAL CREDENTIALS REPORT
April 19, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 4/28/2023 – 3/31/2025)

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 4/28/2023 through 3/31/2025:

- **AQUINO, Suzanne MD/Teleradiology (SHPS)**
- **CHAMSUDDIN, Abbas MD/Teleradiology (The Radiology Group)**
- **GILBERT, Stewart MD/Teleradiology (The Radiology Group)**
- **HAYS, Johnathan MD/Teleradiology (SHPS)**
- **LIU, Jiajing MD/Teleradiology (Transparent Imaging)**
- **PARK, Young In DO/Internal Medicine (Sound)**
- **RUFFOLO, Aldo DO/Teleradiology (SHPS)**
- **SHARSAN, Afsaneh MD/Internal Medicine (Sound)**
- **SHIRLEY, James MD/Teleradiology (SHPS)**
- **VELEZ, Erik MD/Teleradiology (Transparent Imaging)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 1 of 3
April 19, 2023

Attachment B

BIENNIAL REAPPOINTMENTS: (Effective Dates 05/01/2023 – 04/30/2025

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 05/01/2023 through 04/30/2025, 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:

- **BANSAL, Ankush, MD/Pain Medicine/Refer and Follow**
- **BOBICK, Brian, DPM/Podiatric Surgery/Active**
- **CONANT, Reid, MD/Emergency Medicine/Active**
- **ELI, Bradley, DMD/Dentistry/Active Affiliate**
- **FARRELLY, Erin, MD/Orthopedic Surgery/Provisional**
- **KASKA, Serge, MD/Orthopedic Surgery/Provisional**
- **KILE, Jeffrey, MD/Emergency Medicine/Provisional**
- **MORADI, Amir, MD/Otolaryngology/Refer and Follow**
- **NOVAK, Loren, DO/Family Medicine/Active**
- **SPIEGEL, David, MD/Cardiology/Active**
- **YAKHNENKO, Ilya, MD/Internal Medicine/Active**

RESIGNATIONS:

Voluntary:

- **ATHILL, Charles, MD/Cardiology** - effective 04/30/2023
- **BAKSHI, Ankur, MD/Cardiothoracic Surgery** - effective 04/01/2023
- **BIEDERMAN, Bruce, MD/Diagnostic Radiology** - effective 04/17/2023
- **BINIUS, Tracy, MD/Telepsychiatry** - effective 03/08/2023
- **SARKARIA, Paul, MD/Cardiology** - effective 04/30/2023

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
MEDICAL STAFF CREDENTIALS REPORT – Part 2 of 3
April 19, 2023

ADDITIONAL PRIVILEGE REQUEST (Effective 4/28/2023)

The following practitioners requested the following privilege(s) and met the initial criteria for the privilege(s):

- **MOON, Nah, MD** — **OB/GYN**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
CREDENTIALS COMMITTEE REPORT – Part 3 of 3
April 19, 2023

PROCTORING RECOMMENDATIONS

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

- **KILE, Jeffrey, MD** — **Emergency**
- **HOANG, Ngoc , MD** — **Emergency**
- **PATEL, Mihir , MD** — **Telemedicine**
- **SHAPIRO, Robert , MD** — **Urology**
- **SHEREV, Dimitri , MD** — **Interventional Cardiology**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT
April 17, 2023

Attachment A

INITIAL APPOINTMENTS (Effective Dates: 4/28/2023 – 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 4/28/2023 through 1/31/2025.

- **ALSTEEN, Stephaniedd NP/Allied Health Professional (Vituity)**
- **CHUA, Joshua PA/Allied Health Professional (C & E Neurosurgery)**
- **COVINGTON, Emily CRNA/Allied Health Professional (ECHO)**
- **KELLER, Mark CRNA/Allied Health Professional (ECHO)**
- **POLLINGTON, Christopher PA/Allied Health Professional (OSNC)**

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER

INTERDISCIPLINARY PRACTICE REAPPOINTMENT CREDENTIALS REPORT – Part 1of 1

April 17, 2023

Attachment B

BIENNIAL REAPPRAISALS: (Effective Dates 5/1/2023 – 4/30/2025)

Any items of concern will be "red" flagged in this report. The following application was recommended for reappointment to the medical staff office effective 5/1/2023 through 4/30/2025, 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:

- **ALLEN, Matthew, PA-C/Allied Health Professional**
- **BROWNSBERGER, Richard, PA-C/Allied Health Professional**
- **CRESPO, Christopher, PA-C/Allied Health Professional**
- **DEMASCO, Michael, PA-C/Allied Health Professional**
- **GREEN, Kyle, PA-C/Allied Health Professional**
- **HERMANSON, Kathleen, PA/Allied Health Professional**
- **MCNALLY, Paul, NP/Allied Health Professional**
- **MORAN, Bridget, CNM/Allied Health Professional**
- **SCHILLINGER, Stephan, PA-C/Allied Health Professional**

RESIGNATIONS:

- **BYRD, Kristina, AuD/Allied Health Professional**
  Voluntary resignation as requested by the practitioner effective 03/15/2023.
- **GROSS, Hannah, PAC/Allied Health Professional**
  Voluntary resignation as requested by the practitioner effective 04/11/2023.
- **PREGERSON, Heather, PA-C/Allied Health Professional**
  Voluntary Resignation as requested by the practitioner effective 08/01/2022.

Tri-City Medical Center
MEDICAL STAFF

TRI-CITY MEDICAL CENTER
INTERDISCIPLINARY PRACTICE COMMITTEE REPORT– Part 3 of 3
April 17, 2023

PROCTORING RECOMMENDATIONS

- **MORDEN, Jacqueline PAC** — **Allied Health Professional-Emergency**
- **NICHOLS, Melanie PAC** — **Allied Health Professional-Emergency**

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Nurse Practitioner – Emergency Medicine

Provider Name:

Request	Privilege

a. **Training and Experience:**
   1. Certification by the State of California, Board of Registered Nursing as a Nurse Practitioner and certification by board examination from the American Academy of Nurse Practitioners (AANP) or American Nurse Credentialing Center (ANCC);
   2. Recent clinical experience is required of all applicants for appointment and reappointment. Recent clinical experience for initial appointment is defined as having performed at least 100 general patient care cases, which are to be reflective of the scope of privileges requested within the past 2-years.

b. **Licensure and Certification:**
   1. License as a Nurse Practitioner by the State of California, Board of Registered Nursing;
   2. Current Nurse Practitioner Furnishing Number granted by the Board of Registered Nursing;
   3. Current DEA License;
   4. Current BLS (Basic Life Support), ALS (Advanced Life Support) and PALS (Pediatric Advanced Life Support) certifications

c. **Other Requirements:**
   1. Designate Sponsoring Physician

Proctoring:
Twenty-five (25) cases of General Patient Care Privileges. Separate proctoring requirements for advanced privileges listed below.

Reappointment:
Recent clinical experience for reappointment is defined as having performed two-hundred (200) typical general patient care cases (100 must be performed at TCMC) within the past 2-years.

___ **CORE PRIVILEGES**

This following list of core privileges below is representative of the type of privileges that may be performed by Nurse Practitioners (NPs) but does NOT necessarily contain all core privileges that may be performed by NPs in this specialty. **Please mark through and initial any privileges that you do NOT wish to include in your core privileges.**

- Take a focused or completed medical history, which will include the Medical Screening Exam, including past medical, family, social history, review of systems and performing focused or complete physical exam
- Evaluation, emergent management and triage of neonatal, infants, pediatric, adolescents, adults, and geriatric patients
- Perform a physical examination
- Perform occult blood testing
- Order x-ray, other studies, therapeutic diets, physical/rehab, occupational/speech, and respiratory therapies, and nursing services unless otherwise indicated
- Ordering and/or administration of medicine by all routes (orally, IM, IV, PR, aerosolized, inhaler, other) in the Department and by prescription
- Interpret laboratory data
- Interpret diagnostic studies
- Monitor patients throughout procedure and during recovery period
- Determine assessment and interval for follow-up
- Conduct patient and family education
- Manage and provide consultations
- Document patient interactions
- Document care rendered in medical record
- Complete discharge summaries of patients.

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Nurse Practitioner – Emergency Medicine

Provider Name:

Request	Privilege

Anesthesia Category:

___ Dental nerve block

___ Nerve blocks

___ Subcutaneous local anesthetic

Cardiovascular Category:

___ Taking of EKG and recognition of gross abnormalities

Dermatology Category:

___ Digital nail removal

___ Subungual hematoma drainage

___ Treatment of minor 1st and 2nd degree burns

Gastroenterology Category:

___ Collection of specimen: stool

___ Digital rectal exam

___ Hernia reduction

___ Nasogastric intubtion and gastric lavage

___ Performance of anoscopy

___ Removal of foreign bodies from rectum, and other

___ Thrombosed external hemorrhoids

General Surgery Category:

___ Arrest of hemorrhage

___ Debridement, suture, and care of superficial wounds/lacerations (including facial lacerations)

___ Incision and Drainage of superficial skin infections, abscess, Bartholin's abscess

___ Removal of foreign bodies from skin and soft tissue, and other

___ Removal of sutures

___ Soft tissue aspiration

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Nurse Practitioner – Emergency Medicine

Provider Name:

Request	Privilege

Imaging Category:

___ Preliminary interpretation of X-rays

Neurology / Neurosurgery Category:

___ Neurologic examination

___ Spinal immobilization

Orthopedic Category:

___ Dislocation management

___ Emergency fracture management

___ Measurement of compartment pressures

___ Splinting/Casting

___ Strapping and immobilizing of sprains/fractures

Obstetrics / Gynecology Category:

___ Gyn exam

___ Removal of foreign bodies from vagina, and other

___ Incision and drainage of Bartholin's abscess

___ Performance of pelvic exam and pap smear

Ophthalmology Category:

___ Measure intraocular pressure (Tonometry)

___ Ocular irrigation

___ Ophthalmic, visualization of fundus

___ Removal of foreign bodies from eyes, and other

___ Slit lamp examination

Otolaryngology Category:

___ Removal of impacted cerumen

___ Collection of specimens: nasopharyngeal and throat

___ Removal of foreign bodies from ear, nose, throat, other

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Nurse Practitioner – Emergency Medicine

Provider Name:

Request	Privilege

___ Nasal cautery

___ Anterior nasal packing for epistaxis

___ Performance of otoscopy and nasoscopy

___ Peritonsillar abscess drainage

Respiratory Category:

___ Drawing ABGs and interpretation

___ Bronchodilator treatment

___ BVM ventilation

Urology Category:

___ Catheterization and routine urinalysis

___ Management of urinary retention

___ Suprapubic cystotomy placement

Vascular Access Category:

___ Arterial puncture

___ Drawing of venous blood from peripheral site and peripheral IV placement

ADVANCED PRIVILEGES

Initial/Reappointment Criteria: Three (3) cases performed in the past 2-years of each procedure.
Proctoring Criteria: Three (3) cases must be proctored for each procedure.
NOTE: The supervising physician must be physically present in the ED for all advanced privileges

___ Repair of complex lacerations

___ Reduction of Major joints

___ Thoracentesis

___ Lumbar Puncture

___ Endotracheal intubations

___ Arterial line access

___ Arthrocentesis

Tri-City Medical Center
MEDICAL STAFF

Clinical Privilege Request Form

Nurse Practitioner – Emergency Medicine

Provider Name:

Request	Privilege

___ Tube/needle thoracostomy

___ Intraosseous line placement, in adults and infants/children

___ Central IV access, includes midline catheters

APPLICANT:
I certify that I meet the minimum threshold criteria to request the above privileges. I agree to exercise only those services granted to me. I understand that in making this request, I'm bound by the applicable bylaws and/or policies of the hospital and medical staff.

_____
Print Applicant Name

_____
Applicant Signature

_____
Date

→ *Applicant is responsible for obtaining Sponsoring Physician's Signature and completion of below:* ←

SPONSORING PHYSICIAN:
As sponsoring physician of this Allied Health Professional, I agree to be held responsible for the performance of the Nurse Pracitioner while providing services at Tri-City Medical Center

_____
Print Name of Sponsoring Physician

_____
Sponsoring Physician Signature

_____
Date

Approval:

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

_____
Date

NURSE PRACTITIONER

STANDARDIZED PROCEDURES for the EMERGENCY DEPARTMENT AT TRI-CITY MEDICAL CENTER

INTRODUCTION TO THE STANDARDIZED PROCEDURES

The purpose of the Standardized Procedures is to establish the legal authority for the diagnosis and treatment of patients by the nurse practitioner (NP). It is also to define the scope of practice of the NP at ***Tri-City Medical Center (TCMC)*** in order to meet the legal requirements for the provision of health care by NPs as required by California law.

These Standardized Procedures are based on the Guidelines established by the Board of Registered Nursing.

In order to provide the highest standard of care, these Standardized Procedures incorporate the following qualities:

ADAPTABILITY, in order to allow for the unique management needs of each individual patient,
FLEXIBILITY, to accommodate the rapidly changing and complex nature of the health care field and to acknowledge that medicine is not an exact science,
PRACTICALITY, in order to be useful in a setting that must incorporate a variety of educational backgrounds and personal management styles, and

The Standardized Procedures consist of the following:

GENERAL POLICIES: Define the general conditions of and give authorization to the NP to implement the Standardized Procedures.

HEALTH CARE MANAGEMENT STANDARDIZED PROCEDURES: Delineate the medical functions requiring a standardized procedure, and through use of policies and protocols, define the circumstances and requirements for their implementation by the NP.

STATEMENT OF APPROVAL AND AGREEMENT

I certify as my signature represents below, as a Nurse Practitioner requesting AHP status and clinical privileges at TCMC that in making this request, I understand and I am bound by these standardized procedures, the clinical privileges granted, the Medical Staff Bylaws, Medical Staff Rules & Regulations, and Department Rules and Regulations, and policies of the Medical Staff and TCMC. As the sponsoring physician, I agree as my signature represents below to accept and provide ongoing assessment and continuous overview of the Nurse Practitioner's clinical activities described in these practice prerogatives while in the hospital.

By signing this Statement of Approval and Agreement we, the below named:

- Approve of the Standardized Procedures and all the policies and protocols contained in this document;
- Agree to maintain a collaborative and collegial relationship;
- Agree to abide by the Standardized Procedures in theory and practice; and
- No physician shall provide concurrent supervision for more than four (4) NPs.

_____

Nurse Practitioner Date

_____

Sponsoring Physician Date

_____

Sponsoring Physician Date

_____

Sponsoring Physician Date

_____

Sponsoring Physician Date

_____

Sponsoring Physician Date

GENERAL POLICIES

It is the intent of this document to authorize the NPs identified in the Statement of Approval and Agreement at Facility to implement the Standardized Procedures without the immediate supervision or approval of a physician. The Standardized Procedures, including all the policies and protocols, are defined in this document and will be referred to generally as the "Standardized Procedures". It is not the intent to have the NPs independently diagnosing, treating or managing all the patient conditions they might encounter, but rather to utilize their assessment and health care management skills in conjunction with the Standardized Procedures and the collegial physician-NP relationship, to meet the health care needs of the patients.

DEVELOPMENT, REVISION AND REVIEW

The Standardized Procedures have been developed collaboratively by the NPs and physician(s) according to guidelines as required by the Board of Registered Nursing, Title 16, California Code of Regulations (CCR), Section 1474 and the Medical Board of California, Title 16.

APPROVAL AND AGREEMENT

All NPs and physicians will signify agreement to the Standardized Procedures following the approval process. Signature on the Statement(s) of Approval and Agreement implies the following:

- approval of all the policies and protocols in this document,
- the intent to abide by the Standardized Procedures, and
- the willingness to maintain a collegial and collaborative relationship with all the parties.

SETTING

The NPs will perform these Standardized Procedures at Facility as part of the NP's practice at the practice setting.

RECORD OF AUTHORIZED NPS

The Statement of Approval and Agreement signed by the NPs will act as the record of NPs authorized to implement the Standardized Procedures.

EDUCATION AND TRAINING

The NPs must have the following:

- Possession of a current valid California License as a Registered Nurse;
- Licensed by the State of California, Board of Registered Nursing as a NP;
- Furnishing Number;

- DEA Number;
- Certification by the American Nurses Credentialing Center (ANCC) and/or the American Academy of NPs (AANP). Maintaining Certification is required; and
- Any required certification as defined by facility

SETTING OF CLINICAL CARE

NP will function within the Facility

A. Supervision: The NP will be managing primary, secondary and tertiary care conditions as outlined below. In addition, physician consultation may be sought for the following situations and any others deemed appropriate.
    a. Problem not resolving as anticipated
    b. Acute decompensation of patient condition
    c. H&P or workup inconsistent with clinical picture
    d. All emergency conditions requiring prompt medical intervention after stabilizing care has been started. This includes the prompt consultation and/or transfer of patients in areas where physician supervision is off-site or only available by telecommunication.
    e. Upon the request of patient, NP, or physician.

B. Supervision. Supervising physician will be defined as a MD or DO who is working within the same Facility, or one who provides medical direction as determined by the facility administrator or FMD.

SCOPE OF SUPERVISION

Appropriate level of consultation will be provided by a physician who will be available by person or through telecommunication. For furnishing purposes, the physician may supervise no more than 4 NPs at one time. The scope of supervision will be guided by the type of clinical problem.

The standardized procedure protocols developed for use by the NPs are designed to describe the steps of medical care for given patient situations. They may be used in the following circumstances.

1. Common acute and chronic problems that are stable (primary). These are conditions typically defined through ESI categorization as levels 4 &/or 5. The NP is authorized to perform history and physical (H&P), order appropriate diagnostics and manage the condition. Management generally includes: treatment, prevention and patient education under the direction of a supervising physician.
2. Uncommon or unstable conditions (secondary). These are conditions that can be defined through ESI categorization as 2 or 3. The NP is authorized to perform H&P, order appropriate diagnostics and manage the condition. Management generally includes: treatment, prevention and patient education under the direction of a supervising physician.
3. Acute life threatening conditions (tertiary). The NP is authorized to perform H&P, order appropriate diagnostics and manage the condition. Management generally includes: treatment, prevention and patient education under the direction of a supervising physician.

4. Medical Screening Exams. The NP is qualified based on hospital bylaws.

RECORD KEEPING

It is the responsibility of the NP to comply with Facility required keeping of medical records, ensuring these are completed and signed at the completion of each clinical shift.

HEALTH CARE MANAGEMENT

Each level of health care management (primary, secondary and tertiary) will be authorized to guide the NP on a clinical disease or disorder as long as it is performed under their educational training and competency.

HEALTH CARE MANAGEMENT - PRIMARY CARE

POLICY

Primary Care includes common acute and self-limiting conditions such as but not limited to: rash, pharyngitis, URI, UTI, viral syndromes, STD's, otitis media, sinusitis, bronchitis, as well as family planning services/education and health care promotion and maintenance. These conditions are generally categorized as ESI 4 and 5 in the Emergency Department. The NP is authorized to diagnose and manage Primary Care conditions under the following protocols:

PROTOCOLS

1) A treatment plan is developed based on appropriate history, assessment plus differential diagnosis and the resources listed in this document.

2) Lab work and diagnostic studies ordered are appropriate to the condition being evaluated.

3) Referrals and therapies such as physical therapy, occupational therapy, dietary counseling and psychological services ordered as appropriate to the condition and consistent with internal policies.

4) All other applicable Standardized Procedures in this document are followed during health care management.

5) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

HEALTH CARE MANAGEMENT - SECONDARY CARE

POLICY

Secondary Care conditions may be unfamiliar, uncommon, unstable or complex conditions such as: abdominal pain, unstable insulin dependent diabetes, acute panic/anxiety attack etc. These conditions are generally categorized as ESI 3 in the Emergency Department. The NP is authorized to evaluate, treat and refer out Secondary Care conditions under the following protocols:

PROTOCOLS

1) Assessment to the level of surety plus differential diagnosis.

2) A physician is communicated with regarding the evaluation, diagnosis and/or treatment plan.

3) Management of the patient is either in conjunction with a physician, or through a referral to a treatment facility providing a higher level of care, or by 911/EMS referral.

4) The physician is notified if her/his name is used on a referral to a specialty physician or department.

5) The consultation or referral is noted in the patient's chart including name of physician.

6) All Secondary Care charts are reviewed by and co-signed by a physician.

7) All other applicable Standardized Procedures in this document are followed during health care management.

8) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

HEALTH CARE MANAGEMENT - TERTIARY CARE

POLICY

Tertiary Care conditions are acute, life-threatening conditions such as: BP 180/120, acute chest pain/pressure, acute asthma attack, anaphylaxis, trauma, etc. These conditions are generally categorized as ESI 1, 2 in the Emergency Department. The NP is authorized to evaluate Tertiary Care conditions under the following protocols:

PROTOCOLS

1) Initial evaluation and stabilization of the patient while 911/EMS is called may be performed with concomitant notification and immediate management by a physician. For facilities where physician is onsite, the NP may continue the management of these patients as delegated and/or in conjunction with that said physician.

2) The referral is noted in the patient's chart including name of physician and/or entity referred to.

3) All other applicable Standardized Procedures in this document are followed during health care management.

4) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

PROCEDURES

POLICY

The NP may perform the listed procedures under the following protocols. The following list is not exhaustive and may incorporate those defined within a facility's delineation of privileges:

- Suture removal
- Incision and Drainage of abscess
- Pelvic exam, vaginal foreign body removal,
- Ordering of IV fluids and blood products
- Insertion of: subcutaneous drains, Foley catheters, injections, IV sites, nasogastric tunes, oropharyngeal airway
- Removal of: ocular foreign bodies, subcutaneous foreign bodies, digital nails, impacted cerumen
- Performance of: local and topical anesthesia, nerve blocks, dressings/bandages, ear lavage, nasal cautery of epistaxis, incision of external thrombosed hemorrhoid, IO cannulation, nail trephination, ocular tonometry, venipuncture, wound management and repair, slit lamp exam, arterial puncture for ABG, venipuncture
- Splinting and strapping
- Laceration repair
- Bronchodilator treatment
- Any advanced privileges (such as central venous access, lumbar puncture, packing of epistaxis, major joint reduction, arthrocentesis, paracentesis, thoracentesis, complex laceration repair etc.) as defined by Facility policy and delineation of clinical privileges. Competency as defined by Facility protocols and proctoring processes.

PROTOCOLS

1) The NP has been trained to perform the procedure(s) and has been observed satisfactorily performing the procedure(s) by another provider competent in that skill. This process may be defined by Facility policy.

2) The NP is following standard medical technique for the procedures as described in the resources listed in this document.

3) Appropriate patient consent is obtained before the procedure.

4) All other applicable Standardized Procedures in this document are followed during health care management.

5) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

FURNISHING DRUGS AND DEVICES

POLICY

The NP is authorized to verbally order, or write a transmittal order for, drugs or devices under the following protocols (Business & Professions Code, Div. 2, Ch. 6, Article 8):

PROTOCOLS

1) The NP has a current Furnishing number and DEA number.

2) The drugs and devices ordered are consistent with the NP's educational preparation or for which clinical competency has been established and maintained.

3) The drug or device ordered is appropriate to the condition being treated.

4) All drugs and devices ordered are per the recommendations in the resources listed in this document, and are as specified in the Standardized Procedure for Furnishing Scheduled Drugs.

5) Patient education is given regarding the drug or device.

6) The Name, Furnishing number, and DEA Number of the NP is written on the transmittal order (prescription).

7) The Statement of Approval and Agreement signed by the NPs will act as the record of NPs authorized to Furnish.

8) No single physician will **supervise** more than four NPs at any one time.

9) A physician must be available at all times in person or by telephone contact.

10) Ability to Furnish is a part of the NP's annual evaluation.

11) All other applicable Standardized Procedures in this document are followed during health care management.

12) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

FURNISHING SCHEDULED DRUGS PATIENT SPECIFIC PROTOCOL

POLICY

The NP is authorized to Furnish Scheduled controlled substances per the following protocols:

PROTOCOLS

1) The NP follows the provisions of the Standardized Procedure for Furnishing.

2) The NP has registered with the DEA for authority to order Schedule II–V controlled substances.

3) The NP has completed a Board of Registered Nursing approved continuing education course or successfully completed the required pharmacological content for Schedule II controlled substances in a board approved NP educational program.

4) The Scheduled substances that may be ordered are on the List of Scheduled Drugs in this document.

5) The NP's Furnishing and DEA numbers are on a secure transmittal order.

6) All practice policies on pain management, Scheduled drug contracts, DEA requirements, etc. are adhered to.

7) Schedule II-V substances may be ordered when the patient is in one of the following categories and under the following conditions:

CATEGORIES

System	Examples
Respiratory	Injury, cough, pulmonary infection, pneumothorax
Dermatology	Shingles; dermal injuries and burns
Musculoskeletal	Severe strain or sprain; fracture; acute arthritis; inflammatory disorders; dislocation; crush injury and contusions; compartment syndrome
Gynecology	Ovarian cyst; PID; severe dysmenorrhea; undifferentiated pain, complications of pregnancy
Neurology	Headache; brain tumor; SAH; brain infection; myofascial pain or neuropathies; seizure disorders; radiculopathy
EENT	Marked pain from EENT infection or injury
GU/GI	Urinary calculi; pyelonephritis; bowel obstruction; perforated viscous; intra-abdominal infection Trauma; undifferentiated GI/GU pain
Cardiovascular	ACS; dissection; aneurysm; vascular obstruction
Psychiatric	Mania; psychosis; panic and anxiety; undifferentiated mental health condition

LIST OF SCHEDULED DRUGS

:

SCHEDULE V DRUGS

Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

DRUG	INDICATION
Robitussin AC	Cough
Phenergan/Codeine	Cough
atropine-diphenoxylate	Diarrhea
Cyclobenzaprine	Muscle Spasm
Lacosamide	Seizures
pregabalin	Pain

SCHEDULE IV DRUGS

Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

DRUG	INDICATION
Alprazolam	Anxiety
Clonazepam	Anxiety
Diazepam	Anxiety, Sedation, seizure
Lorezepam	Anxiety, sedation, seizure
Midazolam	Anxiety, sedation, seizure
Temazepam	Anxiety, sleep
Triazolam	Anxiety, sleep
carisoprodol	Pain, Muscle Spasm
Chlordiazepoxide	Anxiety, sedation
Phenobarbitol	Seizures
Zolpidem	Sleep

Tramadol	Pain

SCHEDULE III DRUGS

Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

DRUG	INDICATION
Tylenol w/ Codeine	Pain, cough
Buprenorphine	Narcotic Withdrawal
aspirin-butalbital-caffeine	Headache
Fiornal w/ Codeine	Headache

SCHEDULE II DRUGS

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

DRUG	INDICATION
Hydromorphone	Pain
Methadone	Chronic Pain
Meperidine	Pain
Oxycodone	Pain
Fentanyl	Pain
SUFentanil	Pain
Morphine	Pain
Codeine	Pain
Hydrocodone	Pain
belladonna-opium	Pain
cocaine 4%	Epistaxis

MEDICATION MANAGEMENT

POLICY

The NP is authorized to transmit an order for drugs and devices under the following protocols:

PROTOCOLS

1) All the drugs and devices ordered are per the recommendations in the Resources section of this document.

2) The ordering of drugs or devices includes initiating, altering, discontinuing and/or renewing of prescriptive medications and/or their over-the-counter equivalents.

3) Medication evaluation includes the assessment of:
   - Other medications being taken.
   - Prior medications used for current condition.
   - Medication allergies and contraindications, including appropriate labs and exams.

4) The drug or device is appropriate to the condition being treated:
   - Lowest dosage effective per pharmaceutical references.
   - Not to exceed upper limit dosage per pharmaceutical references.
   - Generic medications are ordered if appropriate.

5) A plan for follow-up is written in the patient's chart.

6) The prescription must be written in patient's chart including name of drug, strength, instructions and quantity, and signature of the NP.

7) All Scheduled substances are ordered in consult with a physician

8) Consultation with a physician, if made, is noted in the patient's chart, including the physician's name.

9) All other applicable Standardized Procedures in this document are followed during health care management.

10) All General Policies regarding Review, Approval, Setting, Education, Evaluation, Patient Records, Supervision and Consultation in these Standardized Procedures are in force.

Tri-City Medical Center

TCHD BOARD OF DIRECTORS
DATE OF MEETING: April 27, 2023
Medical Director - Opioid Stewardship Program

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

Physician's Names: Ole Snyder, M.D.

Area of Service: Medical Director- Opioid Stewardship Program

Term of Agreement: 12 months, Beginning May 1, 2023 until April 30, 2024

Maximum Totals: Within Hourly and/or Annualized Fair Market Value: YES
Renewal, no change in rate

Hourly Rate	Maximum Hrs./Month	Maximum Cost/Month	Annual / Term Cost NTE
$150/hr.	10 hours	$1,500	$18,000

Description of Services:

- Medical Directorship agreement with responsibilities over the newly established opioid stewardship program with duties to include leading a multidisciplinary team to provide best practice recommendations in inpatient, ED, and outpatient settings.
- In collaboration with District representatives, the Medical director will help develop policies and protocols that will drive community standards to reduce opioid consumption, dispensing, and dependence through innovative programs. Not only are these programs expected to provide a service that enhances the health and wellness of the community we serve, but will work to establish a positive alliance and reputation within our local community.
- The medical director will have shared responsibility for the quality of the program

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: Ellen Langenfeld, Director-Pharmacy Services / Gene Ma, M.D., Chief Medical Officer

Motion:

I move that the TCHD Board of Directors authorize the renewal of the Medical Directorship for Opioid Stewardship Program with services provided by Ole Snyder, M.D. for a term of 12 months, beginning May 1, 2023 and ending April 30, 2024, for an annual and total term cost not to exceed $18,000.

ADMINISTRATION CONSENT AGENDA
April 17th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
Patient Care Services Policies & Procedures		
1. Admission of Psychiatric Patients Policy	RETIRE	Forward to BOD for Approval
2. Admission to Crisis Stabilization Unit (CSU)	RETIRE	Forward to BOD for Approval
3. Preceptor Program Procedure	3 year review, practice change	Forward to BOD for Approval
4. Safe Surrender	3 year review	Forward to BOD for Approval
5. Swallow Screening in the Adult Patient Procedure	3 year review, practice change	Forward to BOD for Approval
6. Titrating Medications, Adult Patients Policy	3 year review, practice change	Forward to BOD for Approval
Administrative 200		
1. Decorative Material 248	3 year review, practice change	Forward to BOD for Approval
2. Equipment Medical Device Reporting-Sequester 201	3 year review	Forward to BOD for Approval
Cardiac Rehab		
1. Billing for Cardiac Rehab	3 year review	Forward to BOD for Approval
Emergency Department		
1. Elopement, Patient at Risk-Policy	3 year review	Forward to BOD for Approval
2. Wandering Band System Procedure	3 year review	Forward to BOD for Approval
Emergency Operation Procedure (EOP) Manual		
1. 4084 Disaster Equipment Training, Storage and Use	3 year review, practice change	Forward to BOD for Approval
Mammography		
1. Mammography Medical Outcomes Audit Policy	3 year review, practice change	Forward to BOD for Approval
NICU		
1. Patient Assignment NICU	RETIRE	Forward to BOD for Approval
2. Patient Classification (Acuity) in the NICU	3 year review, practice change	Forward to BOD for Approval
Outpatient Behavioral Health Services		
1. Code Silver Plan	NEW	Forward to BOD for Approval
2. Medications	3 year review	Forward to BOD for Approval
Pharmacy		
1. Medication Error Reduction Plan (MERP)	1 year review, practice change	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
April 17th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
Women & Newborn Services		
1. Human Immumodeficiency Virus (HIV) Intrapartum, Postpartum and Newborn Management	3 year review, practice change	Forward to BOD for Approval
2. Misoprostol [Cytotec]	3 year review, practice change	Forward to BOD for Approval
3. Umbilical Cord Blood Banking Private Collection	3 year review, practice change	Forward to BOD for Approval
Wound Care		
1. Acuity Class System	3 year review, practice change	Forward to BOD for Approval
2. Chart Order	RETIRE	Forward to BOD for Approval
3. Collaboration	3 year review, practice change	Forward to BOD for Approval
4. Data Management	3 year review	Forward to BOD for Approval
5. Discharge Instructions	3 year review, practice change	Forward to BOD for Approval
6. Disseminating Medical Information	3 year review	Forward to BOD for Approval
7. Home Care Referrals	3 year review, practice change	Forward to BOD for Approval
8. Medical Equipment Maintenance	3 year review	Forward to BOD for Approval
9. Nurse Visit	3 year review, practice change	Forward to BOD for Approval
10. Outcome Designation for Non-Healing Wounds	3 year review, practice change	Forward to BOD for Approval
11. Patient Advocacy	3 year review, practice change	Forward to BOD for Approval
12. Patient Charges	3 year review, practice change	Forward to BOD for Approval
13. Patient Chart	RETIRE	Forward to BOD for Approval
14. Patient Instructions	3 year review, practice change	Forward to BOD for Approval
15. Patient Photography	3 year review, practice change	Forward to BOD for Approval
16. Patient Reception	3 year review, practice change	Forward to BOD for Approval
17. Patient Survey Process	RETIRE	Forward to BOD for Approval
18. Patient Visual-Auditory Privacy	3 year review	Forward to BOD for Approval

ADMINISTRATION CONSENT AGENDA
April 17th, 2023

CONTACT: Candice Parras, CNE

Policies and Procedures	Reason	Recommendations
19. Program Description	3 year review, practice change	Forward to BOD for Approval
20. Registration	3 year review	Forward to BOD for Approval
21. Scheduling	3 year review, practice change	Forward to BOD for Approval
22. Staff Development	3 year review	Forward to BOD for Approval
23. Staffing Plan	3 year review	Forward to BOD for Approval
24. Telephone Management	3 year review, practice change	Forward to BOD for Approval
25. Transportation	3 year review, practice change	Forward to BOD for Approval
26. Wound Measurement	3 year review, practice change	Forward to BOD for Approval
27. Wound Staging	3 year review, practice change	Forward to BOD for Approval
Wound & Hyperbaric Oxygen		
1. Admission Procedure	3 year review	Forward to BOD for Approval
2. Discharge Summary	3 year review	Forward to BOD for Approval
3. Patient Changing Area	3 year review	Forward to BOD for Approval

Tri-City Medical Cen
Oceanside, California

RETIRE – Inpatient Behavioral Health Services Suspended

PATIENT CARE SERVICES

ISSUE DATE:	08/01	SUBJECT:	Admission of Psychiatric Patients
REVISION DATE:	11/02, 02/03, 02/05, 09/06, 12/07, 05/11	POLICY NUMBER:	II.A

Department Approval:	~~12/15~~05/20
Clinical Policies & Procedures Committee Approval:	~~01/16~~06/20
Nursing Leadership~~Executive Council~~ Approval:	~~01/16~~
Division of Psychiatry Approval:	~~06/17~~09/20
Medical Executive Committee Approval:	~~07/17~~10/20
Administration Approval:	04/23
Professional Affairs Committee Approval:	~~10/17~~ n/a
Board of Directors Approval:	10/17

~~A. POLICY:~~

~~1. The Behavioral Health 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 primary psychiatric disorders.~~

~~2. Patients may be admitted to the Behavioral Health Service in the following ways:~~

~~a. Following triage, assessment, and medical stabilization in the Emergency Department.~~

~~b. Following crisis stabilization in the Crisis Stabilization Unit (CSU).~~

~~c. Direct Admissions:~~

~~i. Following a physician-to-physician consultation between one of the attending psychiatrists on staff and a psychiatrist from a community program facilitated by the BHU Assistant Nurse Manager (ANM), Charge RN, or Psychiatric Liaison.~~

~~d. Following medical stabilization on one of Tri-City Medical Center's inpatient units.~~

~~i. The Psychiatrist/AHP, and/or Psychiatric Liaison, BHU ANM, and BHU Charge RN will serve as resources in the evaluation of patients who have psychiatric and medical, surgical, or obstetrical co-morbid conditions.~~

~~ii. The Psychiatrist/AHP, Psychiatric Liaison, and/or BHU ANM will assist in assuring that all requirements for 72 hour and 14 day holds are met during patients' stays on these other units.~~

~~iii. Processes will be in place for consultation and admission to the Behavioral Health Service; patients with psychiatric illnesses who meet severity of illness criteria will be discharged from inpatient encounter and admitted to the behavioral health service when they are considered medically stable in accordance with hospital in-house policy.~~

~~3. See Inpatient Behavioral Health Unit Policy: Inpatient Admission Criteria for appropriate admissions for inpatient psychiatric treatment.~~

~~4. See Behavioral Health Unit Policy: Exclusionary Criteria for categories of patients who will not be admitted to the Inpatient Behavioral Health programs.~~

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

~~1. Behavioral Health Unit Policy: Inpatient Admission Criteria~~

~~2. Behavioral Health Unit Policy: Exclusionary Criteria~~

~~3.~~1. ~~Patient Care Services: Plan for Nursing Care~~

Tri-City Medical Center
Oceanside, California

RETIRE - CSU suspended

PATIENT CARE SERVICES

ISSUE DATE: 10/17

SUBJECT: Admission to the Crisis Stabilization Unit (CSU)

REVISION DATE(S):

Department Approval:	~~10/16~~04/20
Clinical Policies & Procedures Committee Approval:	~~12/16~~05/20
Nurse Executive Council Approval:	~~01/17~~06/20
Division of Psychiatry Approval:	~~06/17~~09/20
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~07/17~~10/20
Administration Approval:	04/23
Professional Affairs Committee Approval:	~~10/17~~ n/a
Board of Directors Approval:	10/17

~~A. PURPOSE:~~

~~1. To define appropriate methods for admitting a patient to the Crisis Stabilization Unit (CSU)~~

~~2. To ensure patient rights are respected for those patients receiving behavioral health services at Tri-City Healthcare District (TCHD).~~

~~B. POLICY:~~

~~1. Every patient must present to the Emergency Department (ED) and receive medical screening examination (MSE), prior to acceptance of the patient to the CSU.~~

~~2. All clinical interventions are aimed at rapid stabilization of the patient's condition, and focused on improved coping skills and increased motivation to change in order to re-establish the patient's psycho-social level of functioning and overall homeostasis.~~

~~3. Patients being admitted to the CSU must be discharged from the ED and admitted to the CSU with a new visit number (financial number [FIN]).~~

~~C. PROCEDURE FOR CRISIS STABILIZATION UNIT (CSU):~~

~~1. If a patient is medically cleared and meets the CSU admission criteria, the ED physician(MD) collaborates with the psychiatrist or Allied Health Professional (AHP) for acceptance to CSU~~

~~2. Once accepted for admission, a member of the ED staff (MD, Charge nurse, or RN) contacts the CSU charge nurse to make admission arrangements.~~

~~3. Transfer the patient to the CSU via wheelchair, dressed in a hospital gown and escorted by an EMT or nurse.~~

~~4. On arrival to CSU, the patient and the patient's belongings will be scanned by metal detector and locked up in the appropriate, assigned patient locker.~~

~~5. Use all available information to complete a comprehensive evaluation and perform a brief mental status examination:~~

~~a. The clinical assessment will include the following:~~

~~i. General patient information~~

~~ii. A presenting problem and precipitating factors~~

~~iii. The legal status of the patient~~

~~iv. Psychiatric history (including past psychiatric hospitalizations)~~

~~v. Whether the patient has any co-occuring substance use disorder (S-BIRT)~~

~~vi. A screening for acute and/or past trauma (LES)~~

vii. An inventory of the patient's strength, resilience factors, and current level of functioning
viii. A history of coping strategies and crisis resolution tools that have worked in the past
ix. A risk for self-harm/suicidal risk evaluation (C-SSRS)
x. A risk for Violence/danger to others evaluation (BROSET)
xi. Clinical impressions and recommendations
xii. An inquiry whether or not the patient has an advance directive
xiii. An inquiry whether or not the patient has a conservator

b. The assessment will result in the following:
i. A DSM 5 diagnosis
ii. A treatment plan developed by the CSU treatment team with input from the patient
iii. A discharge plan appropriate to the clinical presentation and recommendations from the CSU treatment team.

6. Document available treatment information, including names, disciplines, and contact information, current and past medications prescribed, reported medication compliance, and consult with outpatient providers and or patient support with verbal and or written permission. The CSU nursing staff will focus on the medication history and medication reconciliation.
7. In the event a patient denies permission to contact family, friends, or other care providers, and the patient is in an emergent crisis situation, gather collateral information, without the patient's consent, from providers and patient support if vital for crisis stabilization treatment, clinical intervention, treatment goals and discharge planning.
a. Collateral information will be collected by CSU staff, but patient care information will not be disclosed unless consent is obtained by the patient.
8. In case the patient is not admitted to an acute inpatient setting, CSU staff will make sure the following steps are adhered to:
a. Make sure the patient understands and agrees with the discharge plan
b. Assure the patient has sufficient medications and/or prescriptions for medication to fill at local pharmacy (sufficient to bridge the gap until the patient is able to be seen by the outpatient provider)
c. Coordinate for pick up and or transportation needs
d. Review the appropriate outpatient resources and referrals with the patient and family or friend, as indicated. All minors will have discharge plans reviewed with legal parent or guardian
e. Develop a safety plan, if indicated, and document in medical record
f. Encourage patient to ask for help from support and professional providers when in crisis immediately
g. All patients will be provided the San Diego County Access and Crisis Line phone number 1-888-724-7240
9. Provide the patient with the referral site and the time and date for the appropriate outpatient follow up services and document the information in the patient's medical record.
a. During regular office hours, staff will assist patients with making contact with the appropriate referral source and make follow up appointment.

D. **RELATED DOCUMENT(S):**
1. Behavioral Health Services: 72 Hour Hold Evaluation and Treatment of Involuntary Patient
2. Behavioral Health Services: Exclusionary Criteria

Tri-City Medical Center	Patient Care Services
PROCEDURE:	**PRECEPTOR PROGRAM**
Purpose:	To outline the procedure for Preceptor Program at Tri-City Healthcare District (TCHD).

A. **DEFINITIONS:**

1. Preceptors are Registered Nurses (RN) that have successfully completed the Tri-City Healthcare District (TCHD) Preceptor training and have been ~~endorsed~~ **approved** by management with their signature on the Preceptor Application Form.
2. Precepting consists of one to one (1:1) training of new employees**/contracted staff** to the department during the official orientation period per Administrative Policies: 457 New Hire Orientation and 458 Competency.

~~3.~~

~~4.~~**3.** The Preceptor Program does not apply to working with students; please refer to Patient Care Services Policy: Nursing Students in Patient Care Areas.

B. **PROCESS TO BECOME A NEW PRECEPTOR:**

1. The RN must demonstrate effective qualities of precepting in daily clinical performance such as:
   a. Demonstrated willingness to share information and teach others as seen in patient family education, working with students in clinical rotations and working with all members of the Healthcare team.
   b. Consistency in demonstrating TCHD Service Standards with all members of the healthcare team, patients, families and visitors.
   c. Clinical knowledge and practice in accordance with TCHD Policies and Procedures.
   d. Not on a performance action plan within the past six (6) months.
2. If the above qualifications have been met the RN may request ~~endorsement on~~ a preceptor Application Form from the department **Nurse Leader (NL)**~~Management team (Manager/Assistant Nurse Manager [ANM]).~~**CNM**
3. Once the Preceptor Application Form is signed by the **NL**~~Manager/ANM~~**CNM**, the **for is submitted to the Education Department**~~RN must take the form to the department Clinical Educator /Clinical Nurse Specialist (CNS)~~ to be enrolled into the Preceptor Training module in NetLearning.
4. ~~Upon successful completion of the Preceptor Training Module in NetLearning, the RN must take one copy of their transcript (proof of completion) to their Clinical Educator/CNS and one copy of their transcript (proof of completion) to the Manager/ANM**CNM** to begin preceptor assignments.~~
5. **4.** In order to **be assigned as a preceptor and** become eligible for Preceptor Differential Pay in accordance with the California Nurses Association contract, the RN must successfully complete:
   a. Application process
   b. Preceptor class. If a preceptor class is not offered the nurse must complete the following:
      i. Preceptor Training **learning managemen sysem**~~Net Learning~~ module
      ii. One on one training with Clinical Educator/**NL**~~CNS or Manager~~

C. **PROCESS FOR PRECEPTORS WHO TRANSFER TO A DIFFERENT DEPARTMENT:**

1. When an RN who has completed the preceptor training and transfers to a different department, they will not be required to re- take the preceptor training.
2. The **NL**~~Manager/ANM/Clinical~~**CNM and** Educator~~/CNS~~ will determine when an RN will be assigned as a preceptor based upon the RN demonstrated Preceptor qualities.

D. **PRECEPTOR ASSIGNMENTS:**

1. Manager is responsible for designating and communicating the process within the department for Preceptor assignments, monitoring and evaluation for continued Precepting.

Patient Care Services Content Expert	Clinical Policies & Procedures Committee	Nursinge Leadership ~~Executive Committee~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
12/12, 01/17, **02/23**	12/12, 02/17, 11/18, **02/23**	12/12, 11/18, **03/23**	n/a	n/a	01/13, 01/19, **03/23**	01/19, **0423**	02/13, n/a	02/13, 02/19

2. The NL~~Manager CNM~~ is responsible for determining duration of training and orientation for new hire RN's and transfers to the department.
3. Preceptor Performance Evaluation Forms can be utilized by all staff working directly with Preceptors to evaluate performance as needed. It is the responsibility of the Preceptor to utilize the feedback to improve skills and performance.
4. All Performance Evaluation Forms are the responsibility of the Manager and will be kept in the employee file in the department.

E. **ESSENTIAL PRECEPTOR DUTIES AND RESPONSIBILITIES:**

1. Function as a clinical role model for Nursing knowledge, practice and technical skill.
2. Orient and train new staff using the department skills checklist.
3. Provide written documentation of the orientee's skills and progress on the skills checklist.
4. Demonstrate positive service standards in the delivery of care with the orientee.
5. Provide a rich learning environment with effective communication and feedback.
6. Complete the Orientation Performance Evaluation Form with the orientee, providing effective feedback on their performance while continuing to motivate a positive attitude towards orientation and the department.
7. Provide written documentation of the orientees performance on the orientation performance evaluation form for each orientee daily/weekly according to department guidelines.

F. **PRECEPTOR FLOATING:**

1. If it is the primary preceptor's turn to float and there is another RN on the unit who is a designated preceptor, the orientee assigned to the preceptor may stay and orient with that other preceptor. If there is not another preceptor on that shift, then the primary preceptor would skip that float.

G. **PRECEPTOR PAY:**

1. RN Preceptor is eligible for Preceptor Differential when orienting new RN's to the department.
2. Preceptor is responsible for identifying the shift and hours they ~~are available for~~ precepted~~ing~~.
3. Float staff, per-diem registry, students are considered part of the RNs professional responsibility and as such are not compensated with a preceptor differential.

H. **FORM(S):**

1. Case Management Orientation Performance Evaluation Form
2. Circulating Case Evaluation Tool
3. Orientation Evaluation of Preceptor Form
4. Preceptor Application Form
5. RN Orientation Performance Evaluation Form
6. Scrubbing Case Evaluation Tool

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

1. Administrative Human Resources Policy: New Hire Orientation 8610-457
2. Administrative Human Resources Policy: Competency 8610-458
3. Patient Care Services Policy: Nursing Students in Patient Care Areas

Tri-City Medical Center

Employee ID # _____

Orientee Name _____

Dept _____

Case Management Orientation Performance Evaluation Form

1. Orientee complete self evaluation column and develop orientation goals to discuss with Preceptor.
2. Preceptor complete Preceptor evaluation column
   - ✓ Review form and discuss orientation performance with orientee before signing form.
   - ✓ Complete one orientation performance evaluation each shift OR each week per your department guidelines.

Date(s): _____ of shift(s) worked with orientee during the week

	Orientee Self Evaluation of Performance			**Preceptor** Evaluation of Orientee Performance			**Scoring:** **2** Requires Assistance **3** Performs Independently **Not Observed -** Did not perform during shift, no opportunity
Standard	**2**	**3**	**Not Obs**	**2**	**3**	**Not Obs**	
Performs an Accurate Assessment of Patient's Needs.							Performs Patient Assessment within Standard of Care for dept.
							Collaboration with multi-disciplinary team members as needed.
Comment:							
Initiate and implement an individualized transition plan							Coordination of discharge planning with patient/family,
							Provide Patient Choice for any applicable needs.
							Send referrals to appropriate providers.
							Performs accurate documentation in EMR per Dept specific process.
Comment:							
Integrates transition/discharge plan into the patient specific Cerner Depart.							Updates Discharge Plan/Depart as needed
							Notification to MD/Nursing Staff
							Notification to patient/family
Comment:							
Case Management Assessment/Ongoing Note(s) is Accurate and Appropriate, including using SBAR							Report is accurate and timely
							Follows Dept process for Hand off Communication using Allscripts Case Management Census
Comment:							
Utilizes InterQual for Severity of Illness/Intensity of Service (SI/IS) guidelines to perform and document clinical reviews.							Performs InterQual Review to identify appropriateness of Level of Care (ICU/CCU, DOU/Telemetry, Med/Surg, etc).
							Performs Continued Stay, Retroactive, and Discharge Reviews as per Dept Policy (Pt Care Mgmt Utilization Review Process).
							Appropriately identifies admission criteria for Observation vs Inpatient status.

Comment:							
	Orientee Self Evaluation of Performance			Preceptor Evaluation of Orientee Performance			**Scoring:** **2** Requires Assistance **3** Performs Independently **Not Observed -** Did not perform during shift, no opportunity
Standard	**2**	**3**	**Not Obs**	**2**	**3**	**Not Obs**	
Workflow Prioritization							Appropriately prioritizes work flow based on discharge needs.
							Referrals made to other disciplines as needed.
Comment:							
Professionalism **TCMC Service Standards**							Professional with patients, family, and visitors.
							Demonstrates effective interpersonal skills with the health care team and coworkers
Comment:							
Physician Orders							Verbal orders (V.O.) are only during an emergency. Telephone orders (T.O.) are only when an MD can't enter an order into Cerner.
							Patient class/status (INPT vs OBS, SDS, etc) orders need to be written by the MD in Cerner before patient is discharged. Do not take V.O. or T.O. from MDs/NPs for pt class changes.
							Follows Physicians Orders PCS Policy IV.M
Comment:							
Goals for next week							

Orientee's Printed Name:_____ **Signature:**_____

Preceptor's Printed Name:_____ **Signature:**_____

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

CIRCULATING CASE EVALUATION TOOL

Date: _____

Employee: _____ Preceptor: _____

Procedure #1: _____ Procedure #2: _____

Procedure #3: _____ Procedure #4: _____

1=Observation Only; Did Not Perform
2= Requires Assistance Inconsistent performance often not meeting expectations; rarely demonstrates desired behaviors without prompting or directions.
3=Performs Independently Generally meets most expectations; demonstrates desired behavior without prompting; recognizes own limitations and seeks guidance appropriately.
4=Can Teach Others Consistently meets or exceeds all expectations; demonstrates desired behaviors independently and possesses knowledge base sufficient to share knowledge and skills with others.

PRE-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Room organization								
Reviews and follows preference card								
Patient assessment and documentation								
Pre-procedure verification/documentation								
Patient and family education								
Communicates patient changing status								
Able to organize patient care while remaining flexible to changing needs of the patient								

INTRA-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Assist with anesthesia induction								
Knowledge of instruments and procedure								
Positioning the patient								
Prepping the patient								
Documentation & Lab forms								
Specimen handling procedures								
Aseptic technique								
Medications and solutions properly labeled								
Participates in Time Out								
Rapport with staff and MD's								

POST-OPERATIVE PHASE	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Reporting skills: change of shift/PACU/ICU								
Room turnover								

Comments: _____

TIME IN		TIME OUT		TIME IN		TIME OUT	

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

Tri-City Medical Center

Employee ID # _____

Preceptor Name _____

Orientation Evaluation of Preceptor Form

Orientee Instructions:

1. Please complete evaluation form on your preceptor.
2. Please return to your Clinical Educator who will forward to the Clinical Manager.

Name of Orientee Completing Form: _____

Department: _____

Date: _____

Name of Preceptor Being Evaluated by Orientee: _____

My preceptor:	Strongly Disagree	Disagree	Agree	Strongly Agree
Worked with me on my goals for the day	1	2	3	4
Assessed my skill level before introducing new learning experiences	1	2	3	4
Acted as a role model for:				
Assessment Skills	1	2	3	4
Clinical and Technical Skills	1	2	3	4
Knowledge of Standards & Policies	1	2	3	4
Clinical documentation (Cerner)	1	2	3	4
Service Excellence	1	2	3	4
Provided instructions and explanations for:				
Procedures & tasks	1	2	3	4
Clinical documentation (Cerner)	1	2	3	4
Nursing Practice	1	2	3	4
Provided supportive learning environment	1	2	3	4
Used effective communication to provide constructive feedback	1	2	3	4

Please turn-in completed form to the Clinical Educator/CNS/Manager

Tri-City Medical Center

Employee ID # _____ Dept:_____

New Preceptor Name

_____

Preceptor Application Form

RN instructions:

1. Review PCS Procedure [Preceptor Program] to ensure you meet the qualifications for participation.
2. Obtain endorsement of your application with evaluation and signature by your Manager/ ANM.
3. Take signed application to your Clinical Educator / CNS for enrollment into the Preceptor Training net learning module (TCMC Librarian will only grant access to module upon receipt of this application).
4. Upon completion of the module notify your Manager/ANM and Clinical Educator/CNS to begin receiving preceptor assignments.

Nurse Name: (Printed)	Strongly Disagree	Disagree	Agree	Strongly Agree
Provides consistent clinical documentation in a timely manner	1	2	3	4
Provides a supportive learning environment for staff, students	1	2	3	4
Demonstrates the ability to teach and evaluate clinical performance of students in clinical rotations within the dept	1	2	3	4
Uses effective communication with all members of the healthcare team, patients, visitors and families	1	2	3	4
Has completed Department specific skills checklist and demonstrates ability to teach to the skills checklist				
Assessment and Care of Patients admitted to Dept	1	2	3	4
Operation and Troubleshooting of Dept Equipment	1	2	3	4
Knowledge of Nursing Standards, Policies & Procedures	1	2	3	4
Professionalism and Service Standards	1	2	3	4
Total Score (must be ≥24) to participate in Preceptor Program	**Total Score = _____**			

1. **This Nurse has at least 6 months experience at TCMC in this department.**
2. **I support this Nurse (RN) participating in TCMC Preceptor Program:**

_____ / _____ Date: _____

Manager / ANM (print name) (signature)

Department: _____ Cost Center: _____

RN Orientation Performance Evaluation Form

Instructions:

1. **Orientee:**
   a. Score each standard you demonstrate during the shift(s), to reflect the level of support you need. (2) or (3)
2. **Preceptor:**
   a. Reviews orientee's self assessment scores and provide preceptor scores for each standard you observe performed during the shift. Mark not observed for the items you do not have a chance to perform.
   b. Review and discuss orientation performance with orientee and plan goals together, then both sign completed form.
   c. Forward the completed "orientation performance evaluation form" to your department Clinical Educator/CNS.
   d. Please complete one orientation performance evaluation each shift OR each week per your department guidelines

Orientee Name:_____ **Mentor/Preceptor Name:**_____
Date(s):_____ **Number of shifts worked with orientee:**_____ **Orientation Week #**_____

Place checkmark where applicable: 2 Requires Assistance 3 Performs Independently

	Orientee Self Evaluation			Preceptor Observed Evaluation			
Standard	2	3	N/A	2	3	N/A	
Performs an Accurate Patient Assessment.							Performs Patient Assessment within Standard of Care for Department.
							Recognizes Normal and Abnormal findings on exam.
							Comments:
Recognizes change in patient's condition.							Changes recognized and appropriate intervention taken.
							When calling a Physician, communicates accurate patient information and is able to anticipate needed orders for patient.
							Comments:
Seeks out, reviews and interprets lab results.							Obtains lab/test results in timely manner in Cerner/ Medical Record.
							Reports Critical Values Accurately and timely.
							Correlates labs and diagnostics to the patient's clinical picture.
							Comments:
Nursing Report is Accurate and Appropriate.							Report is accurate and timely.
							Procedural Hand off communication process is accurate.
							Comments:
Delivery of Care / Workflow Priorities in Patient Care.							Appropriately identifies priorities of care for patients according to unit specific standards of care and appropriate to each patients level of acuity.
							Delegates to healthcare team appropriate to their scope of practice.
							Comments:

	Orientee Self Evaluation			Preceptor Observed Evaluation			
Standard	**2**	**3**	**NA**	**2**	**3**	**NA**	
Integrates Patient Assessment and Patient information into the Nursing Care Plan.							Completes a Patient Admission accurately and timely.
							Updates Care Plan in accordance with unit specific guidelines.
							Patient teaching is accurate.
							Comments:
Professionalism Service Excellence							Provides emotional support to patients, family, and visitors.
							Demonstrates effective interpersonal skills with the health care team.
							Comments:
Medication Administration							Follows rights before administering medications.
							Demonstrates understanding of meds action, onset-duration, indications for use, side effects, anticipated prn response
							Documents in barcode medication administrator device correctly including prn response.
							Patient teaching for medications, indications, side effects is accurate.
							Comments:
Physician Orders							Notes and implements Physician's orders accurately and in a timely manner.
							Repeats back all telephone orders including medications.
							Comments:

Preceptor Feedback to Orientee	Comments:
Goals for next week:	1. 2.
Number of patients	**Patient(s) Acuity**

Updated Skills Checklist_____**(initial)**

Orientee's Signature:_____**Preceptor's Signature:**_____

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

SCRUBBING CASE EVALUATION TOOL

Date: _____

Employee: _____ Preceptor: _____

Procedure #1: _____ Procedure #2: _____

Procedure #3: _____ Procedure #4: _____

1=Observation Only; Did Not Perform
2= Requires Assistance Inconsistent performance often not meeting expectations; rarely demonstrates desired behaviors without prompting or directions.
3=Performs Independently Generally meets most expectations; demonstrates desired behavior without prompting; recognizes own limitations and seeks guidance appropriately.
4=Can Teach Others Consistently meets or exceeds all expectations; demonstrates desired behaviors independently and possesses knowledge base sufficient to share knowledge and skills with others.

PERFORMANCE CRITERIA	SELF EVALUATION OF PROCEDURE #				PRECEPTOR EVALUATION OF PROCEDURE #			
	1	2	3	4	1	2	3	4
Demonstrates knowledge of case								
Reviews and follows preference card								
Demonstrates knowledge of equipment/instruments								
Uses strict aseptic technique in opening of supplies								
Performs proper surgical scrub								
Correctly gowns and gloves self								
Correctly gowns and gloves other team members								
Demonstrates knowledge and ability of draping								
Demonstrates knowledge of instrument set-up								
Medications & Solutions properly labeled								
Participates in Time Out								
Demonstrates organizational skills								
Attempts to anticipate needs of surgeon								
Demonstrates knowledge and ability in handling suture								
Demonstrates accuracy of sponge, sharps & instrument counts								
Demonstrates knowledge & proper application of Standard and Isolation precautions								
Performs thorough and efficient post-operative case clean-up/turnover								

Comments: _____

TIME IN		TIME OUT		TIME IN		TIME OUT	

Employee Signature: _____ Date: _____

Preceptor Signature: _____ Date: _____

Tri-City Health Care District
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE: 02/01 **SUBJECT:** Safe Surrender

REVISION DATE(S): 05/02, 05/03, 04/04, 12/05, 09/06, 11/09, 02/13, 04/14, 03/18, 05/20

Patient Care Services Content Expert Approval:	~~02/20~~02/23
Clinical Policies & Procedures Committee Approval:	~~03/20~~02/23
Nursing Leadership~~Executive Committee~~ Approval:	~~04/20~~03/23
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~04/20~~03/23
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**
1. To provide guidance for Tri-City Healthcare District (TCHD) employees accepting custody of newborns up to 72 hours old who are voluntarily surrendered by a parent or other person with legal custody.
2. To implement the requirements of the Safely Surrendered Baby Law.

B. **POLICY:**
1. In compliance with Senate Bill 1368, TCHD has designated the Emergency Department (ED) as the safe surrender site within the facility and the employees on duty in the ED to receive abandoned newborns.
2. Any officer, employee or medical staff member on duty at the hospital must accept physical custody of an abandoned newborn up to 72 hours old.
3. No person or entity that accepts a surrendered newborn will be subject to civil, criminal, or administrative liability for accepting and caring for the child in the good faith belief that action is required or authorized by this law. This includes situations where the child may actually be older than 72 hours, or where the surrendering person did not have lawful physical custody of the infant.
4. The consent of the parent or other relative surrendering the newborn is not required for the Medical Screening Exam (MSE).
5. Newborns abandoned in accordance with law are eligible for MediCal coverage.
6. When a newborn is surrendered, the registered nurse (RN) will:
    a. Follow ED Standard for triage of patients using Baby DoeA MSE and any necessary medical care must be provided. (See Administrative Policy: EMTALA: Emergency Medical Screening 506)
    b. Document number of coded newborn bracelet and matching coded ID arm bracelet of the person surrendering the newborn, as well as any information the surrendering individual provided regarding newborn. (i.e. age, health history, or other pertinent information.)
    c. Access an abandoned newborn packet (Located at ED Triage, Charge Desk, and Radio Room.)
        i. Contents of the packet must include a coded, confidential identification (ID) ankle bracelet; a matching coded arm ID bracelet; a coded, confidentially identified family medical history questionnaire (English and Spanish versions); campaign brochure and law fast facts sheet (English and Spanish) and a stamped envelope addressed to TCHD.

d. Place the coded ID bracelet on the newborn.
e. Make a good faith effort to give the matching coded ID arm bracelet to the person surrendering the newborn. This will facilitate reclaiming the infant later.
f. Make a good faith effort to give the person surrendering the newborn a coded, confidential family medical history questionnaire, campaign brochure, law fast facts sheet, and a stamped addressed envelope.
g. Notify Child Protective Services (CPS) of the surrender as soon as possible and in no event later than 48 hours. CPS must assume temporary custody of the newborn immediately on receipt of notification, and must investigate.
h. Notify Social Services Department. .

7. If a person surrendering a newborn request that TCHD returns the newborn to her/him, the hospital must do so if TCHD still has custody and if the dependency petition has not been filed. Contact Administration or Legal Services prior to returning newborn.
8. If a health practitioner at TCHD reasonably suspects that the child has been the victim of abuse or neglect, he/she must notify CPS rather than returning the child. Voluntary surrender of a newborn in accordance with law is not in and of itself a basis for reporting abuse or neglect. The statute does not provide immunity from personal injury or wrongful death, including malpractice claims. Legal counsel should be consulted immediately with questions.
9. If a dependency petition has already been filed through CPS, the person surrendering the newborn may reclaim the child within fourteen (14) days of the surrender. If TCHD still has physical custody of the newborn, a copy of the court order should be obtained, reviewed, and referred to legal counsel before releasing the child.
10. Any identifying information that pertains to a parent or individual who surrenders a newborn pursuant to the Safely Surrendered Baby Law that is obtained as a result of the questionnaire or in any other matter, must not be disclosed by any personnel of a Safe Surrender site that accepts custody of an infant.

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

1. Safely Surrendered Baby Medical Questionnaire – English: http://www.cdss.ca.gov/cdssweb/entres/forms/English/SOC861.pdf
2. Safely Surrendered Baby Medical Questionnaire – Spanish http://www.cdss.ca.gov/cdssweb/entres/forms/Spanish/SOC861SP.pdf
3. Safely Surrendered Baby Campaign Brochure http://www.cdss.ca.gov/Portals/9/FMUForms/M-P/PUB400.pdf?ver=2017-10-26-110106-193
4. Safely Surrendered Baby Law Fast Facts – English http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/2_ENG_SSBFactSheet.pdf?ver=2017-09-05-161625-780
5. Safely Surrendered Baby Law Fast Facts – Spanish http://www.cdss.ca.gov/Portals/9/OCAP/PDFs/Fact%20Sheets/Fast%20Facts%20SP.pdf?ver=2017-09-05-161628-437

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

1. Administrative Policy: EMTALA: Emergency Medical Screening 506

E. **REFERENCE(S):**

1. California Hospital Association (2019). *California Hospital Consent Manual*. Sacramento, CA: California Hospital Association.
2. Safely Surrendered Baby Law; Senate Bill No. 1368, Chapter 824
3. Cal. Health and Safety Code (HSC) § 1255.7 (1973).

Tri-City Medical Center	~~Distribution:~~Patient Care Services
PROCEDURE:	**SWALLOW SCREENING IN THE ADULT PATIENT**
Purpose:	To screen for appropriateness of oral intake.
Supportive Data:	The swallow screen is performed on ~~any medically stable~~ patients who **are~~is~~** at risk for aspiration secondary to the inability to swallow safely. This includes the nursing assessment of patient alertness, respiratory status, secretion management, voice quality and an effective cough. Oral intake is contraindicated if any of the above are compromised. This would constitute failure of the swallow screen. **A physician order is not required prior to performing a swallow screen.**

A. **PROCEDURE:**

1. Prior to three (3) Ounce Water Protocol check patient's ability to swallow by giving the patient a teaspoon of water and assess for **the following:**
   - **a.** **~~l~~L**aryngeal movement
   - **b.** **C**~~c~~lear vocal quality
   - **c.** **C**~~c~~oughing
   - **d.** C~~c~~hoking
   - **~~a.~~e.** ~~or T~~throat clearing during swallowing up to one minute; If able to swallow without difficulty proceed to 3 Ounce Water Protocol.
2. 3 Ounce Water Protocol:
   - a. Observe patient.
     - i. If patient is not alert,~~ then~~ make patient nothing by mouth (NPO) until alert and then screen the patient.
     - ii. If patient is alert, face is symmetrical, and tolerating their own secretions, proceed with swallow screen.
       1) Sit patient upright.
       2) Ask patient to drink entire 3 ounces (90 mL) of water from a cup or through a straw in sequential swallows without stopping.
       3) Assess patient for coughing, choking, or throat clearing during swallowing and up to one minute after drinking.
   - b. Results
     - i. Pass: Able to drink 3-ounces of water sequentially without overt signs or symptoms of aspiration.
     - ii. Fail: Inability to drink the entire amount sequentially or demonstration of coughing or choking during trial.
3. If patient passes protocol, diet per physician/Allied Health Professional~~'s~~ order.
4. If patient fails protocol:
   - a. Keep NPO, notify the physician as needed.
   - b. Obtain order for Swallow Evaluation by Speech Pathologist as needed.
5. Document results in electronic health record under Swallow Screen.

B. **REFERENCE(S):**

1. Suiter DM, Leder SB, Karas DE. The 3 ounce (90 mL) water swallow challenge: A screening test for children with suspected oropharyngeal dysphagia. Otolarygology Head & Neck Surgery 2009;140:187-190.
2. Suiter DB, Leder SB. Clinical utility of the 3 ounce water swallow test. Dysphagia 2008; 23:244-250
3. Suitor, D. S., Sloggy, J., & Leder, S.B. (2014). Validation of the Yale Swallow Protocol: A Prospective Double-Blinded Videofluoroscopic Study. *Dysphagia*, 199-203.

Patient CareServices Content Expert	Clinical Policies & Procedures	Nursinge Leadership ~~Executive Council~~	Medical Staff Department or Division	Pharmacy & Therapeutics Committee	Medical Executive Committee	Admini stration	Professional Affairs Committee	Board of Directors
6/06, 7/09, 1/12, 10/16, 10/19, **01/23**	09/11, 4/15, 11/16, 11/19, **01/23**	10/11; 4/15, 01/17, 02/20, **02/23**	n/a	n/a	11/11; 05/15, 01/17, 03/20, **03/23**	04/20, **04/23**	1/12; 06/15, n/a	6/15, 02/17, 04/20

Tri-City Medical Center
Oceanside, California

PATIENT CARE SERVICES

ISSUE DATE:	**04/05**	**SUBJECT:**	**Titrating Medications, Adult Patients**
REVISION DATE~~(S)~~:	**08/07, 02/09, 12/11, 05/12, 06/17 03/19**		

Patient Care Services Content Expert Approval:	**~~03/18~~09/22**
Clinical Policies & Procedures Committee Approval:	**~~04/18~~09/22**
Nursing Leadership ~~Executive Committee~~ Approval:	**~~04/18~~10/22**
Pharmacy & Therapeutics Committee Approval:	**~~05/18~~10/22**
Critical Care Committee Approval:	**~~02/19~~02/23**
Medical Executive Committee Approval:	**~~02/19~~03/23**
Administration Approval:	**~~03/19~~04/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**03/19**

A. PURPOSE:
1. To define the manner in which medications requiring titration to patient effect are utilized.

B. POLICY:
1. It is the policy of Tri City Healthcare District to allow orders for medication titration, which is the progressive increase or decrease of the medication dose in response to the patient's clinical status.
   a. This policy pertains to the areas where titration occurs (Intensive Care Unit, Emergency Department, Post-Anesthesia Care Unit, Pain Clinic, Endoscopy, Interventional Radiology, Labor and Delivery).
2. All orders for medications that require titration must include the following:
   a. Medication name
   b. Medication route
   c. Initial or starting rate of the infusion
   d. Defined maximum rate of infusion
   e. Defined incremental units for which the infusion rate may be increased or decreased
   f. Defined frequency for how often the infusion rate may be adjusted
   g. Objective clinical endpoint (RASS score, Pain score, heart rate, systolic blood pressure, etc.)
3. Medications ordered for titration must be approved by the Pharmacy and Therapeutics Committee. Safe dose ranges for medications that are to be titrated must be reviewed and approved by that committee.
   a. A dose limit (maximum and minimum limits) at which the licensed independent practitioner must be called for each titrated medication must be set. These dose limits will correspond to the maximum and minimum dose ranges defined in the Alaris Medication Safety System Infusion pumps.
   b. If a titrated medication continues at or above the dose limit, the Registered Nurse (RN) shall contact the licensed independent practitioner ordering the titrated medication to approve the current dose at least every 24 hours by writing specific orders with a new dose limit at which he/she should be contacted.
   c. Clinical staff must assess the patient frequently when titrating mediations to detect potential problems as early as possible.

4. The attached table defines the medications currently approved for titration.

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

1. Patient Care Services Policy: Medication Administration
2. Titratable Drips Reference

Drip Reference

DRUG	STANDARD CONCENTRATION	CHART IN	RECOMMENDED DOSE RANGE	RECOMMENDED TITRATION PARAMETER
Vasoactive Drugs				
Amiodarone (Nexterone)	150 mg / 100 mL D5W 360 mg / 200 mL D5W	mg/min		**Bolus:** 150 mg over 10 minutes Followed by: **Infusion:** 1 mg/min for 6 hours then 0.5 mg/min for 18 additional hours
Clevidipine (Cleviprex)	25 mg / 50mL	mg/hr	1-21 mg/hr	**Cardiovascular Surgery (A-line required)** **Starting rate:** 1 mg/hr **Titrate by:** double the dose every 90 seconds initially. Once approaching target BP, increase dose by less than double, and lengthen time between adjustments to 5 to 10 minutes. 1 to 2 mg/hr dose increases produces ~ 2 to 4 mmHg SBP reduction. Keep SBP <165mmHg **Max rate:** 21 mg/hr **For ~~Acute~~ Ischemic or Hemorrhagic Stroke or Hypertensive Crisis (A-Line is NOT required)** **Starting rate:** 1 mg/hr **Titrate by:** double the dose every 5 minutes until desired BP is reached. Note that 1 to 2 mg/hr dose increases produces ~ 2 to 4 mmHg SBP reduction. **Max rate:** 21 mg/hr
Diltiazem (Cardizem)	125 mg / 125 mL NS/D5W	mg/hr	5 – 15 mg/hr	**Starting rate:** 5 mg/hr **Titrate by:** 2.5 mg/hr every 15 min to keep SBP < 165 mmHg and/or keep HR < 120 BPM **Max rate:** 15 mg/hr
Dobutamine (Dobutrex)	500 mg / 250 mL D5W	mcg/kg/min	2 – 20 mcg/kg/min	**Starting rate:** 2.5 mcg/kg/min **Titrate by:** 0.5 mcg/kg/min every 15 min to keep SBP > 90mmHG and/or MAP > 65mmHg. **Max rate:** 20 mcg/kg/min
Dopamine	400 mg / 250 mL D5W	mcg/kg/min	2 – 20 mcg/kg/min	**Starting rate:** 5 mcg/kg/min **Titrate by:** 2 mcg/kg/min every 5 min to keep SBP > 90mmHg and/or MAP > 65mmHg **Max rate:** 20 mcg/kg/min
Epical (Adrenalin/calcium)	2 mg Epinephrine, 1 Gm CaCl / 250 mL D5W	mcg/min	1 – 40 mcg/min *Weight based for CV Surgery Patients* 0.01 – 0.5 mcg/kg/min	**Starting rate:** 2 mcg/min **Titrate by:** 2 mcg/min every 5 min to keep HR > 60 BPM and/or SBP > 90 mmHg and/or MAP > 65mmHg **Max rate:** 40 mcg/min *Weight based for CV Surgery Patients* **Starting rate:** 0.02 mcg/kg/min **Titrate by:** 0.02 mcg/kg/min every 5 min to keep SBP greater than 90 or CI > 2. **Max rate:** 0.5 mcg/kg/min

Drip Reference

DRUG	STANDARD CONCENTRATION	CHART IN	RECOMMENDED DOSE RANGE	RECOMMENDED TITRATION PARAMETER
Epinephrine (Adrenalin)	4 mg / 250 mL NS 8 mg / 250 mL NS	mcg/min	1 – 40 mcg/min *Weight based for CV Surgery Patients* 0.01 – 0.5 mcg/kg/min	**Starting rate:** 2 mcg/min **Titrate by:** 2 mcg/min every 5 min to keep HR > 60 BPM and/or SBP > 90 mmHg and/or MAP > 65mmHg **Max rate:** 40 mcg/min *Weight based for CV Surgery Patients* **Starting rate:** 0.02 mcg/kg/min **Titrate by:** 0.02 mcg/kg/min every 5 min to keep SBP greater than 90 or CI > 2.2. **Max rate:** 0.5 mcg/kg/min
Esmolol (Brevibloc)	2500 mg / 250 mL NS/D5W	mcg/kg/min	50 – 300 mcg/kg/min	**Starting rate:** 50 mcg/kg/min **Titrate by:** 50 mcg/kg/min every 5 min. Keep HR <120bpm and/or SBP < 165mmHg **Max rate:** 300 mcg/kg/min
Isoproterenol (Isuprel)	1 mg / 250 mL D5W	mcg/min	2 – 10 mcg/min	**Starting rate:** 1 mcg/min **Titrate by:** 1mcg/min every 10 min to keep HR > 60bpm **Max rate:** 10 mcg/min
Labetalol (Normodyne)	200 mg / 200 mL D5W	mg/min	0.5 – 8 mg/min	**Starting rate:** 2 mg/min **Titrate by:** 0.5 mg/min every 15 min to keep HR < 120 bpm and/or SBP < 165 mmHg. **Max rate:** 8 mg/min Recommended to not exceed 300 mg in 24hr.
Lidocaine	2000 mg / 500 mL D5W	mg/min	1-4 mg/min	**Starting rate:** 2 mg/min **Titrate by:** adjustment per MD **Max rate:** 4 mg/min
Milrinone (Primacor)	20 mg / 100 mL D5W	mcg/kg/min	0.125 - 0.75 mcg/kg/min	Fixed rate to be ordered and adjusted by MD **Max rate:** 0.75 mcg/kg/min
Nicardipine (Cardene)	20 mg / 200 mL NS 40 mg / 200 mL NS	mg/hr	5 – 15 mg/hr	**Starting rate:** 5 mg/hr **Titrate by:** 2.5 mg/hr every 15 min to keep SBP < 165mmHg **Max rate:** 15 mg/hr
Nitroglycerin (Tridil)	50 mg / 250 mL D5W	mcg/min	5 – 400 mcg/min	**Starting rate:** 5 mcg/min **Titrate by:** 5 mcg/min every 5 min up to 20 mcg/min. If no response at 20 mcg/min, may increase by 10 mcg/min every 5 min to keep SBP < 165mmHg and/or titrate for chest pain relief **Max rate:** 400 mcg/min
Nitroprusside (Nipride)	50 mg / 250 mL D5W	mcg/kg/min	0.25 – 10 mcg/kg/min	**Starting rate:** 0.25 mcg/kg/min **Titrate by:** 0.25 mcg/kg/min every 5 min to keep SBP < 165 mmHg **Max rate:** 10 mcg/kg/min
Norepinephrine (Levophed)	4 mg / 250 mL NS 16 mg/250 mL NS	mcg/min	2 – 30 mcg/min	**Starting rate:** 2 mcg/min **Titrate by:** 2 mcg/min every 5 min to keep SBP > 90mmHg and/or MAP > 65mmHg **Max rate:** 30 mcg/min

Drip Reference

DRUG	STANDARD CONCENTRATION	CHART IN	RECOMMENDED DOSE RANGE	RECOMMENDED TITRATION PARAMETER
Phenylephrine (Neosynephrine)	50 mg / 250 mL NS 100 mg/250 mL NS	mcg/min	40 – 180 mcg/min	**Starting rate:** 40 mcg/min **Titrate by:** 20 mcg/min every 5 min to keep SBP > 90 mmHg and/or MAP > 65 mmHg **Max rate:** 180 mcg/min
Vasopressin (Vasostrict)	40 units / 50 mL NS 40 units / 100 mL NS	units/min	0.03 units/min	**Starting rate:** 0.03 unit/min **Titrate by:** per MD **Max rate:** 0.04 unit/min
Sedatives				
Dexmedetomidine (Precedex)	400 mcg / 100 mL NS/D5W	mcg/kg/hr	0.2 – 1.4 mcg/kg/hr	**Starting rate:** 0.4 mcg/kg/hr **Titrate by:** 0.1 mcg/kg/hr every 30 min to achieve RASS of 0 to -2 if on mechanical ventilation or to achieve desired effect if not on mechanical ventilation **Max rate (Intubated):** 1.4 mcg/kg/hr **Max rate (Non-Intubated):** 0.8 mcg/kg/hr
Lorazepam (Ativan)	50 mg / 50 ml NS	mg/hr	1 – 10 mg/hr	**Starting rate:** 1 mg/hr **Titrate by:** 1 mg/hr every 15 min as needed to achieve RASS 0 to -2 or RASS -4 to -5 while on paralytics or asynchronous ventilations **Max rate:** 10 mg/hr
Midazolam (Versed)	50 mg / 50 ml D5W/NS	mg/hr	1 – 10 mg/hr	**Starting rate:** 1 mg/hr **Titrate by:** 1 mg/hr every 15 min as needed to achieve RASS 0 to -2 or RASS -4 to -5 while on paralytics **Max rate:** 10 mg/hr
Propofol (Diprivan)	1000 mg / 100 mL	mcg/kg/min	5 - 80 mcg/kg/min	**Starting rate:** 10 mcg/kg/min **Titrate by:** 5 mcg/kg/min every 5 min PRN to desired RASS 0 to -2 or RASS -4 to -5 while on paralytics. **Max rate:** 80 mcg/kg/min
Pain/Analgosedation				
Fentanyl	1000 mcg / 100 ml NS	mcg/hr	50-200 mcg/hr	**Starting rate:** 50 mcg/hr **Titrate by:** 50 mcg every 15 minutes to goal RASS 0 to -2 or keep goal pain scale at less than or equal to 2 or at or lower than patient reported acceptable pain level. **Max rate:** 200 mcg/hr
Ketamine	100 mg / 100 mL NS 500 mg / 500 mL NS	mg/kg/hr	0.2 – 2.5 mg/kg/hr	**Starting rate:** 0.2 mg/kg/hr **Titrate by:** 0.1 mg/kg/hr every 15 min to goal RASS 0 to -2 **Max rate:** 2.5 mg/kg/hr
Morphine	100 mg / 100 mL NS	mg/hr	1 - 20 mg/hr	**Starting rate:** 2 mg/hr **Titrate by:** 1 mg every 30 min to keep goal pain scale at less than or equal to 2 or at or lower than patient reported acceptable pain level. **Max rate:** 20 mg/hr
Neuromuscular Blocking Agents (NMB) • Ensure patient is on adequate sedation at RASS goal and pain is controlled before starting neuromuscular blockade • Consider loading dose before starting neuromuscular blockade drip				

Drip Reference

DRUG	STANDARD CONCENTRATION	CHART IN	RECOMMENDED DOSE RANGE	RECOMMENDED TITRATION PARAMETER
• Evaluate renal function and/or concurrent steroid usage prior to selecting neuromuscular blockade drip • Duration of NMB should be limited as much as possible (<48 hour). Recommend discussing with MD if longer duration is necessary • Ensure patient has ocular lubricant ordered to avoid corneal abrasion				
Cisatracurium (Nimbex)	100 mg / 100 mL NS	mcg/kg/min	1-10 mcg/kg/min	**Starting rate:** 3 mcg/kg/min **Titrate by:** 0.3 mcg/kg/min every 10 min to goal train-of-four 2:4 and/or vent synchrony, and/or Bedside Shivering Assessment Scale Score of 0 **Max rate:** 10 mcg/kg/min
Vecuronium (Norcuron)	100 mg / 100 mL NS	mcg/kg/min	0.8 - 1.7 mcg/kg/min	**Starting rate:** 0.8 mcg/kg/min **Titrate by:** 0.3 mcg/kg/min every 10 min to goal train-of-four 2:4 or vent synchrony, Bedside Shivering Assessment Scale Score of 0 **Max rate:** 1.7 mcg/kg/min
Others				
Alteplase (Activase)	1 mg/mL once reconstituted	mg	50 - 100 mg	**Indication: Acute Ischemic Stroke** 0.9 mg/kg (maximum total dose: 90 mg) **Patient weight <100 kg:** 0.09 mg/kg (10% of 0.9 mg/kg dose) as an IV bolus over 1 minute, followed by 0.81 mg/kg (90% of 0.9 mg/kg dose) as a continuous infusion over 60 minutes **Patient weight ≥100 kg:** 9 mg (10% of 90 mg) as an IV bolus over 1 minute, followed by 81 mg (90% of 90 mg) as a continuous infusion over 60 minutes **Indication: Pulmonary Embolism** **PE, acute (hemodynamically stable, intermediate to high risk [submassive]):** 100 mg infused over 2 hours **PE, acute (hemodynamically unstable, high risk [massive]):** 100 mg infused over 2 hours. Patients with impending cardiac arrest: 20 mg bolus, followed by 80 mg infused over the next 2 hours.
Bumetanide (Bumex)	25 mg / 100 mL	mg/hr	0.5 – 2 mg/hr	**Starting rate:** 0.5 mg/hr **Titrate by:** 1 mg/hr as needed based on adequate response **Max rate:** 2 mg/hr
Glucagon	5 mg / 50 mL NS	mg/hr	3 – 5 mg/hr	**Indication: Beta-Blocker or Calcium Channel Blocker Overdose** **Starting rate:** 3 mg/hr **Titrate by**: per MD to achieve adequate hemodynamic response

Drip Reference

DRUG	STANDARD CONCENTRATION	CHART IN	RECOMMENDED DOSE RANGE	RECOMMENDED TITRATION PARAMETER
		mcg/min	*5 – 15 mcg/min*	**Max rate:** 5 mg/hr ***Indication: Anaphylaxis (refractory to epinephrine) in patients on beta-blocker therapy*** **Starting rate:** 5 mcg/min **Titrate by**: per MD to maintain SBP > 90 **Max rate:** 15 mcg/min
Furosemide (Lasix)	100 mg /100 mL NS	mg/hr	10 – 80 mg/hr	**Starting rate:** 10 mg/hr **Titrate by:** 5mg/hr every hour to keep urine output > 20ml/hr **Max rate:** 80 mg/hr
Insulin	100 units / 100 mL NS	units/hr	0.5 – 20 units/hr	Titrate per order set protocol
Naloxone	10 mg / 100 mL D5W	mg/hr		**Starting rate:** 0.4 mg/hr **Titrate by:** 0.4mg/hr every 2 min to desired effect. Titrate to adequate ventilation and prevent withdrawal symptoms **Max rate:** N/A
Oxytocin (Pitocin)	30 units / 500 mL NS	milliunit/min		Refer to Pitocin Administration for Induction/Augmentation of Labor protocol for instructions
Sodium Chloride 3% (Hypertonic Saline)	3% NaCl / 500mL bag (3g NaCl/100mL = 15g NaCl/500mL = 513 mEq NaCl/1000mL = 1027 mOsm/1000 mL)	mL/hr		**Bolus:** 100-250mL over ~~15-20~~**30** minutes **(peripheral or central line)** • *May only be prescribed by Neurology, Neurosurgery, Critical Care or Pulmonary physicians and shall be reserved for administration in critical care settings. Exception: Any location in emergent situation with continuous monitoring pending transfer to critical care area.* • ***Central line is preferred. However, if only peripheral line available, use large-bore vein and rate should not exceed 50 mL/hr. Any rate above 50 mL/hr should be given via central line.*** **Infusion:** **Starting rate:** 25 mL/hr **Titrate by**: fixed rate unless otherwise specified by MD **Max rate:** 100 mL/hr

*HR = heart rate
*SBP = systolic blood pressure
*MAP = mean arterial pressure
*RASS = Richmond agitation sedation scale
*CI = Cardiac Index

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE:	11/94	SUBJECT:	Decorative Material
REVISION DATE:	03/00, 02/06, 01/09, 09/10, 01/11 01/17, 08/20	POLICY NUMBER:	8610-248

Administrative Content Expert Approval:	~~06/20~~12/22
Administrative Policies & Procedures Committee Approval:	~~06/20~~01/23
Environmental Health & Safety Committee Approval:	03/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~07/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. PURPOSE:

1. The purpose of this policy is to provide for the safety of patients, staff and visitors of the Medical Center by ~~setting forth guidelines for the use of decorative materials within the Medical Center.~~**ensuring decorations are safe and do not present a fire hazard.** This policy is in accordance with local and state Fire Codes.

B. POLICY:

1. **Natural cut trees, garlands or wreaths are allowed.**
2. **In accordance with California State Fire Marshal's requirements, all Christmas trees and** decorations ~~shall~~**are to be prepared and sprayed with flame retardant chemicals and certified as such. Proof must be affixed to the decoration or made available for verification (usually found on product packaging).**
~~1.~~3. **Decorations in the facility must be made of flame-retardant paper.**
   a. **Fadeless flame-retardant paper may be purchased at school supply stores.**
   b. **Proof must be affixed to the decoration or made available for verification (usually found on product packaging).**
4. **Incandescent Decorative lights are prohibited**
5. **UL Listed LED battery operated lights are allowed. Under strict controlled conditions electric lights are only allowed in the main lobby.**
6. **Lighted candles are** not **allowed in the hospital at any time.**
7. **Ceiling tiles and wall material must not be penetrated or disturbed. This includes the taping or stapling of decorations.**
8. **The point-of-service manager is responsible to ensure compliance with all fire safety rules.**
9. **Decorations may** be hung in ~~a way as to obstruct exits, exit lights, fire sprinkler heads,~~**rooms that have closed door (break room, offices, etc.). Decorations may not be strung down the exit corridors.**
10. **Decorations may not be hung on** fire ~~alarm~~ **sprinklers, light fixtures or on fire rated doors (including patient room doors).**
~~2.~~11. ~~Stairways, corridors, and exit ways shall not be obstructed and~~**The following should be kept "clear and unobstructed" at all times:**
   a. **Fire** pull stations, ~~hose cabinets, or~~
   ~~a.~~b. ~~f~~Fire extinguishers~~.~~
   c. **Exit doors~~,~~**
   d. **Exit paths~~,~~**
   e. **Exit signs~~,~~**

f. Stairwell landing~~,~~
g. Crash carts~~,~~
h. Med gas shut off valves~~,~~
i. Electrical panels ~~and~~
~~b.~~j. Any way finding signage~~.~~

~~3. Decorative materials shall not be hung from the sprinkler heads.~~
~~4. All decorative materials need to be approved by the Director of Facilities or the Director of Safety/Environment of Care Officer.~~
~~5. Use only materials labeled nonflammable or flame retardant in your displays (includes artificial trees).~~
~~a. Have documentation (i.e., package labeling) to this effect on file in your department for Fire Department review if necessary.~~
~~6. Live trees are prohibited.~~
~~The Fire Marshall permits electric lights only in the main lobby under strictly controlled conditions. All other areas may use only battery operated lights~~

Tri-City Healthcare District
Oceanside, California

ADMINISTRATIVE
DISTRICT OPERATIONS

ISSUE DATE:	01/87	SUBJECT:	Equipment/Medical Device Reporting/Sequestering
REVISION DATE:	12/91, 08/94, 05/96, 01/99, 05/02, 02/03, 04/06, 02/11, 08/14, 06/17, 05/20	POLICY NUMBER:	8610-201

~~Department~~Administrative Content Expert Approval:	~~04/20~~01/23
Administrative Policies & Procedures Committee Approval:	04/2001/23
Environmental Health & Safety Committee Approval:	03/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. To assure that safe medical device reporting/sequestering is implemented. To assure that medical devices on the market are safe and effective through user facility reporting, identification, tracking and corrective actions. For purposes of this policy, the Risk Manager is designated as the hospitals official contact for the Food and Drug Administration (FDA).

B. DEFINITION(S):

1. Patient – A "patient" of a facility is (1) an individual being diagnosed, or treated, or receiving medical care under the auspices of the facility, from medical personnel working in, for or who are otherwise affiliated with a device user facility; or (2) an employee of the facility who suffers death, serious illness, or serious injury from a device used at or by the facility, and, as a consequence, becomes a patient.
2. Affiliated – Affiliated is defined to include medical personnel who are associated with a device user facility and is interpreted to include physicians with admitting privileges.
3. Medical Device – An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part or accessory which is:
   a. Not a drug or biologic.
   b. Recognized in the official national formulary, or the USP, or any supplement to them.
   c. Intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment or prevention of disease, in man or other animals, or;
   d. Intended to affect the structure of any function of the body, or other animals, and which does not achieve its primary intended purposes through chemical action within, or on, the body of man or other animals; and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
      i. (Per Safe Medical Devices Act (SMDA) 1990 and Medical Device Amendments, 1992)
4. Examples of Devices – Anesthesia machines, defibrillators, pacemakers, hemodialysis machines, heart valves, catheters, thermometers, patient restraints, contact lenses, hearing aids, blood glucose monitors, x-ray machines, tampons, ventilators, wheelchairs, bedside commodes, infusion pumps, laser, electrosurgery, etc.
5. Serious Illness and Serious Injury – An illness or injury that a) is life threatening, b) results in permanent impairment of a body function or permanent damage to a body structure, c)

necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.

C. **POLICY:**

1. In compliance with Safe Medical Devices Act, all incidents that reasonably suggest that there is a probability that a medical device or user error caused or contributed to a death, serious illness or serious injury of a patient or employee of the facility, will be reported to the appropriate persons and/or organization.

D. **STAFF RESPONSIBILITY:**

1. In the event of a patient death, serious injury or illness, whether it is due to equipment/product failure or user error the staff member responsible for the patient shall follow these procedures.
   a. Immediately notify the Department Director or Supervisor of the occurrence who will then notify Administration and Risk Management.
   b. Immediately sequester the equipment/product.
   c. Preserve evidence.
   d. Maintain control settings as existed at the time of injury (if applicable), i.e., power settings, gas flow
      i. Device is not to be cleaned or processed.
      ii. Universal precautions to be used in handling all accessory components, or related equipment.
      iii. Device will be kept intact for impoundment.
2. Sequestering the Equipment/Device (to preserve evidence):
   a. Notify Biomedical Engineering of equipment failure. Notify Risk Management of all sequestering, whether a product or equipment.
   b. Maintain the equipment/device in a secure place under the care of an individual who will be able to testify that the device has been preserved in its original condition until arrangements are made with Risk Management for further safekeeping through off-site or on-site storage as needed.
   c. When the decision to sequester is made, the equipment/supplies shall be disconnected from the patient and power supply without changing any control settings or turning the equipment off (if possible). No cleaning or processing of the equipment/supplies shall occur until the Risk Manager has identified if these processes will hinder subsequent investigation. All equipment and associated supplies shall be preserved as found. The equipment/supplies will be sequestered by the user department, biomedical engineer, or Risk Manager as appropriate.
   d. Whenever any piece of equipment is to remain sequestered, the Department Director will provide for replacement of the equipment and notify physicians who use this equipment.
      i. Preserve original packaging of the device if possible.
   e. Complete Quality Review Report, which includes:
      i. Name of patient
      ii. Date and time of patient injury
      iii. Description of event in detail and patient outcome
      iv. Description of malfunction and condition of device upon removal
      v. Biomed Data Control number if possible and manufacturer, model name, serial or lot number
      vi. Verification of notification to supervisor
      vii. Notations of settings as existed at the time of injury
   f. Risk Management and Biomedical Engineering (if equipment) will determine if the product/equipment is to be returned to the manufacturer (if patient injury).
   g. Equipment, instruments or supplies potentially involved in a patient's adverse occurrence are not to be returned to the manufacturer, or discarded until authorization is given by the Risk Manager.

E. **RISK MANAGEMENT DEPARTMENT REPORTING RESPONSIBILITY:**

1. Risk Management will report patient deaths, serious illness and injury or user error resulting from a medical device to the Food and Drug Administration (FDA) within 10 work days, California Department of Public Health (CDPH) within 5 days, and to the manufacturer, if known.
2. The Risk Management Director will also notify the professional liability carrier and Administration.

F. **REPORTING SCHEDULE:**

1. A facility will be treated as first becoming aware of information when medical personnel, who are employed by or otherwise formally, affiliated with the facility, become aware of information with respect to a device in the course of their duties.
2. The Risk Manager shall determine if the event is reportable under the SMDA. Reports will be sent to:
   a. The manufacturer of the device for incidents involving serious illness, serious injury, or death.
   b. The FDA if the event resulted in death or for any serious outcome where the manufacturer is unknown.
3. If determined to be reportable, the Medwatch Form 3500A will be completed by the Risk Manager according to SMDA regulations, starting from when the hospital first became aware that the device may have caused or contributed to the event.
4. Each device user facility is required to submit to FDA, on a semiannual basis (January 1 and July 1), a summary of the reports that it has submitted to the FDA and to manufacturers. If no reports have been submitted, no summary need be sent.
5. Reporting Format: The Risk Management Director will, at a minimum, include information such as the identity of the reporting facility, product name, model, serial number, name of manufacturer, if known, and a description of the event.
6. The Risk Manager shall be responsible for maintaining a separate "File of Device Reportable Incidents." See Attachment A

G. **U.S. Food and Drug Administration (FDA) CONTACT WITH THE HOSPITAL:**

1. If an FDA inspector visits the hospital for any purpose related to medical devices, he/she will be directed to the Risk Manager. The Risk Manager will ask for, review, and record the inspector's credentials prior to providing requested information.
2. Written or telephone inquiries from FDA representatives will be directed to the Risk Manager for response.

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

1. Medical Device Incident Flow Chart

I. **REFERENCE(S):**

1. Administrative Policy #501, Adverse Events, Mandatory Reporting of
2. Medical Device Amendments, 1992
3. Patient Care Services Patient Owned/Supplied Equipment Brought into the Facility
4. The Safe Medical Device Act 1990 (SMDA), Medical Device Reporting for User Facilities. Retrieved from: https://www.fda.gov/downloads/MedicalDevices/.../UCM095266.pdf

Tri-City Medical Center
Oceanside, California

CARDIAC REHABILITATION SERVICES

ISSUE DATE: 11/88 **SUBJECT: Billing for Cardiac Rehab**

REVISION DATE: 2/06, 11/07, 12/12

Cardiac Rehabilitation Department Approval:	~~02/20~~03/23
Division of Cardiology Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. To establish guidelines for the billing process for the Cardiac Wellness Program.

B. **POLICY:**

1. To ensure that certain requirements are met before enrolling a patient into Phase II and IV of the Cardiac Wellness Program.

C. **PROCEDURE:**

1. TCMC admitting and registration department shall be responsible for:
   a. Verifying insurance coverage
   b. Scanning into the system the insurance authorization when necessary
   c. Ensuring information is correctly entered in Cerner system
2. Upon enrollment into the program, patients shall receive a specific account number for the cardiac rehabilitation program (CRP). All insuranc/e accounts shall receive a (CRP) after their account, whereas all cash accounts shall receive a (CRPM). Two face sheets and two sheets of labels will be printed and given to the CR department for the patient's medical record.
3. All non-contracted Phase II patients shall be billed on a daily basis. Maintenance patients shall be billed on a monthly basis. The maintenance billing shall be done before the end of every month.
4. The charges for each patient are entered in the computer using the patient's most recent CRP or CRPM number.
5. Each patient shall be billed according to his or her program status (Phase) in the Cardiac Wellness Program. This status/including insurance information shall be listed on the patient's exercise flow sheet.
6. The phases are listed as follows:
   a. Phase I – (inpatient)
   b. Phase II – first one to twelve weeks of cardiac rehabilitation
   c. Phase IV – (maintenance) – ongoing program
7. Patient's registering as a cash account shall be coded in Admitting as a CRPM. All others shall be coded as CRP
8. All patients in Phase II shall be charged for "monitored exercise" after each individual visit on a daily basis. All Phase IV (maintenance) patients shall be billed a monthly charge of a "full month", a "spouse" charge, a "½ month", or a "six month subscription".
9. To perform the actual billing, you need to select log on to "compass" open the "*batch charge entry*" application and proceed as follows:
10. Enter patient's last name, first name in appropriate window and press "enter."
11. Select the appropriate patient (there may be more than one, so you may need to compare DOB), select the *"recurring CRP"* or *"recurring CRPM"* encounter.
12. Go to the drop-down menu and select ***"cardiac rehab charge."***

13. Select appropriate charges (you may select more than one charge at a time) and click on "submit button to move to charge window.
14. If correct charge is chosen and you are satisfied with selection, press, "submit charges." Otherwise, at this point, you may make any necessary changes to your selection.
15. Once selection is correct, press "enter"
16. Information shall be filed.

D. **EXCEPTION DETAIL REPORT:**

1. The Exception Detail Report shall be printed daily and reviewed for errors by the department Clinical Manager, and when she/he is not there, it shall be monitored by the person in charge of doing the daily billing.
2. All errors shall be investigated and corrected immediately.

Tri-City Medical Center
Oceanside, California

EMERGENCY DEPARTMENT

ISSUE DATE:	SUBJECT: Elopement, Wandering, Patient at Risk from ED
REVISION DATE(S): 08/08; 02/11	

Emergency Department Approval:	~~02/20~~01/23
Department of Emergency Medicine Approval:	n/a
Pharmacy and Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~04/20~~04/23
Professional Board Committee Approval:	n/a
Board of Directors Approval:	04/20

A. DEFINITIONS:
1. To define a process for the management, prevention and documentation of patients who are at risk for leaving the Emergency Department (ED) without authorization.

B. POLICY:
1. Identify patients at risk for wandering and/or for leaving the ED without authorization.
2. Appropriate steps shall be taken to attempt to prevent at risk patients from leaving the ED without authorization.

C. PROCEDURE:
1. Staff interventions:
   a. Identify patient is at risk.
   b. Have patient undress and don a hospital gown.
   c. Apply Wandering Band.
   d. Alert Charge RN, Physician/Allied Health Professional (AHP), Security and Team members of patient at risk.
   e. Communicate patient is at risk from care-giver to care-giver.
   f. Assign a Sitter and communicate responsibilities of assignment.
   g. Escort all patients at risk for elopement to the restroom and monitor the door.
2. Identifiers for patients at risk for elopement:
   a. History of wandering or elopement.
   b. Restless, agitation and pacing.
   c. Verbalizing intent to leave.
   d. Confusion or change in mental status.
   e. Request clothing and/or personal belongings.
   f. Active 5150 hold.
3. Patient determined to be missing:
   a. Any staff observing an at risk patient attempting to leave the premises without authorization shall attempt to prevent such departure. Should the attempt fail, the staff member shall immediately notify the Charge RN.
   b. When identified, the Charge RN will notify the attending physician, Security, Police Department, ED Clinical Manager, Administrative Coordinator, and family as appropriate.
   c. Attempts shall be made to locate the patient. Hospital security and/or law enforcement shall be notified as appropriate.

D. DOCUMENTATION:

1. Complete a clinical note in the patient's chart, which includes a summary of the events that led to the incident, actions for prevention instituted, the time the patient was determined missing, attempts to locate patient, who was notified of the patient's elopement, and actions taken for retrieval.

Tri-City Medical Center	Emergency Department
PROCEDURE:	WANDERING SYSTEM (ELOPEMENT PREVENTION) 7010-017
Purpose:	Detailed information on use of Accutech Wandering System.
Supportive Data:	Accutech Quick Reference Guide.
Equipment:	Accutech Wandering System, arm bands, LT22/LT23 tags.
Issue Date:	04/06

A. **DEFINITIONS:**

1. The Accutech Wandering System is a patient monitoring system to help the Emergency Department staff ensure the safety and well-being of patients at risk for elopement in the Emergency Department. The system is designed to monitor patients with a small plastic tag attached to a bracelet that the patient wears while being treated in the Emergency Department. The tag is programmed into the wandering system and if the patient gets too close to an exit the Emergency Department staff is notified with a loud beeping noise (doors automatically lock for 10-15 seconds) or alarm sound if the doors are open. There are two (2) monitoring screens and one (1) monitoring computer located throughout the Emergency Department for the staff to view which exit the patient is trying to elope through.

B. **POLICY:**

1. All Patients at risk for wandering outside of the Emergency Department treatment area will have an Accutech wrist band attached. At risk patients include but not limited to 5150, minor children without parental supervision, confused patients and/or patients with dementia or Alzheimer's.

C. **PROCEUDRE:**

1. **Activating/Deactivating Tags:**
   a. With no tag in the TAD unit, slide the power switch to the "ON" position. The TAD power LED illuminates. If it doesn't, check the TAD's 9-volt battery. **Note:** If a tag is in the receptacle and the power to the TAD is cycled, the tag may be turned on or off unintentionally.
   b. Place the tag into the tag receptacle on the back of the TAD unit in proper orientation for the tag (meaning the tag with the name "Accutech" is facing the receptacle and the name is face up).
   c. The signal strength LEDs on the TAD indicates the current state (on or off) of the tag.
   d. To turn on or off the tag, press and release the TAD button. The WAIT LED will illuminate for about a second (do not remove the tag while the WAIT LED is on) and the signal strength LEDs will change accordingly.
   e. Once activated, if the "low battery" LED on the TAD blinks, this indicates the tag should not be used and should be replaced.
   f. After turning on or off the tag, make sure to turn off the TAD unit to save the battery. **It is essential that the tags be turned off in between patients to save the internal batteries.**
2. **How to Attach LT22/32 Tags:**
   a. With the bracelet snaps facing in the same direction as the Accutech logo, slide the plastic bracelet through the slots on the tag.
   b. Adjust the band length to the nearest accommodating hole for a comfortable fit around the patient's extremity. **Note:** Once the bracelet is secured it cannot be adjusted.
   c. Put the male part of the snap through the selected hole, fold over the female part of the snap and secure to the male part by squeezing until it snaps together.
   d. Using scissors, carefully trim off any excess bracelet material.

Department Review	Department of Emergency Medicine	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
04/20, 02/23	n/a	n/a	n/a	05/20, 04/23	n/a	04/06, 02/11, 05/20

Tri-City Medical Center
Oceanside, California

EMERGENCY OPERATIONS PROCEDURE MANUAL

~~TRI-CITY MEDICAL CENTER Emergency Preparedness~~	~~Section: Emergency Preparedness Management Disaster Plan~~ ~~Subject: Disaster Equipment Training, Storage and Use~~ ~~Policy Number: 4084 Page 1 of 4~~
~~Department: Emergency Department Specific~~	~~EFFECTIVE: 11/05~~ ~~REVISED:~~

ISSUE DATE: 11/05

SUBJECT: Disaster Equipment ~~Training~~Maintenance, Distributions,Storage and Use

REVISION DATE:

POLICY NUMBER: 4084

Department Approval:	08/21
Environmental Health and Safety Committee Approval:	03/23
Medical Executive Committee Approval:	n/a
Administration Approval:	04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

~~A. EMPLOYEE SCREENING, TRAINING AND DISTRIBUTION OF THE USE OF POSITIVE AIR PURIFYING RESPIRATORS (PAPR)~~

~~1. Health Screening for Use of PAPR~~

~~a. Respirator Screening Protocol:~~

~~i. All staff is required to have annual screening through the Employee Health Department.~~
~~Compliance is monitored through annual competency requirements.~~

~~ii. Respirator Screening Questionnaire is confidential, evaluated by Employee Health Nurse and stored in the Employee Health Office.~~

~~2. Training and Refresher~~

~~a. Train the Trainer Course~~

~~i. Hazmat for Health Care – Paul Penn, Instructor. 16-hour training course.~~

~~ii. Hospital-wide Initial Training Course – 6 hours, Core Decontamination Team held once per year.~~

~~b. Refresher Training is conducted annually for all Decontamination Team members~~

~~c. Hospital Patient Decontamination Team has quarterly training sessions.~~

~~d. Emergency Dept. staff are trained in Patient Decontamination on a bi- Monthly basis.~~

~~e. Community or regional training programs are offered to all Decontamination Team members when available~~

~~f. ED Physician Training; is provided annually by the Infection Control Nurse, on recognizing chemical, biological, and radiological agents.~~

~~g. "Just in Time" training is given by Hospital EOC/Safety Officer or Designee, in an emergency situation that would exceed current staffing capacity.~~

~~3.~~A. DISTRIBUTION OF PAPR AND RELATED PERSONAL PROTECTIVE EQUIPMENT:

~~a.~~1. Activation of distribution of PPE is based upon decisions made by~~rest with any of the~~

~~following~~:

~~1)~~**i.** Emergency Department Clinical Manager would determine need for Emergency Department response. Notification to Hospital Administration for activation of Code Orange

~~2)~~**ii.** Incident Commander under the Hospital Incident Command System (HEICS). Code Orange activated per Hospital Administrative Policy & Procedure # 4070 - Disaster Plan Activation

B. **STORAGE, MAINTENANCE, MANAGEMENT AND USE OF POWERED AIR PURIFYING RESPIRATOR (PAPR)**

1. Regulatory References:

a. 29CFR 1910.134: Training, Respiratory Protection Program requirements NIOSH: Respiratory Cartridge Selection

~~a.~~**2. Battery Charging**:

~~b.~~**a.** Exhausted Batteries should be charged for 16-24 hours.

~~c.~~**b.** The charging station is operational when the green LED light is on.

i. Insert the charging lead into the battery pack.
ii. The LED light will turn off.
iii. When charged, the LED light will turn back on.

~~d.~~**3. Battery Life**

~~e.~~**a.** Batteries have a charge/discharge life of about 500 cycles.

~~f.~~**b.** Batteries will last longer if they are not completely discharged before charging; the time a fully charged battery will run is 8 hours.

~~g.~~**c.** Batteries should not be exposed to high temperatures.

~~h.~~**d.** Batteries will lose about 1% of their charge each day they are not used. (About 5 minutes running time a day.)

~~i.~~**e.** Batteries not used for six months may lose their ability to take a Full charge. Several charge/rundown cycles may restore the Battery capacity.

~~j.~~**4. Storage Safety**

~~k.~~**a.** Do not charge multiple batteries in an enclosed cabinet without ventilation.

~~l.~~**5. Attaching Cartridges**:

~~m.~~**a.** Remove three appropriate cartridges from their packaging.

~~n.~~**b.** Remove screw caps from each cartridge but keep them for future use.

~~o.~~**c.** Make sure the air inlet insert is seated inside each of the three rubber air inlets and that the threads and sealing surfaces are free of dirt and debris.

~~p.~~**d.** Screw cartridges onto threaded inlets: hand-tighten only to achieve airtight seals.

~~q.~~**e.** OVER-TIGHTENING CAN DISTORT OR DISPLACE THE SEAL!!!

~~r.~~**6. Connecting Air Blower/Filtration Unit**:

~~s.~~**a.** Place the hose clamp onto the breathing tube. Slide breathing tube over the unit outlet and tighten the clamp.

~~t.~~**b.** Make sure the breathing tube is secured and that the end of the tube is visible between the clamp and the unit.

~~u.~~**7. Performance Check**:

~~v.~~**a.** 1With the breathing tube disconnected from the unit and the system running, insert the base of the flow meter into the unit outlet.

~~w.~~**b.** Make sure unit and flow meter are resting in a vertical position. Prop unit up so lower cartridge is not blocked.

~~x.~~**c.** Check the center of the float rests above at least 6 cfm.

i. If flow is less than 6 cfm than replace cartridges and check flow again.
ii. If flow is still below 6 cfm refer to trouble shooting guide; do not use units with flow rates less than 6 cfm.

~~y.~~**d.** Make sure the respirator headpiece is connected to the unit and that air is flowing before donning the respirator headpiece.

~~z.~~**8. Adjusting Belt Length/Donning PAPR**:

~~aa.~~**a.** Pull the belt through the unit bracket so the buckle centers at your waist.

~~bb.~~**b.** Place the unit against your lower back with the breathing tube extending upward.

~~cc.~~**c.** Tighten the belt around your waist so the unit rests comfortably and securely against your lower back.

~~dd.~~**d.** Plug the PAPR into a fully charged battery pack and attach the battery pack to the belt.

~~ee.~~**9. Cleaning and Inspection**:

~~ff.~~**a.** Clean the unit and the battery case with mild cleaning solutions only. Solvents can damage the plastic.

~~gg.~~**b.** Examine the unit housing for cracks. Replace if cracked or damaged! DO NOT USE!

~~hh.~~**c.** Examine the intake manifold. The presence of particulates or dust may indicate a damaged filter, an improper seal of the cartridge or an incorrect selection of cartridge.

~~ii.~~**d.** Examine outside of battery pack for crack. Replace if cracked or damaged! DO NOT USE!

~~jj.~~**e.** Inspect the breathing tube and replace if punctured, cracked or worn.

~~kk.~~**f.** Bend the tube to verify that is it flexible.

~~ll.~~**10. Storage:**

~~mm.~~**a.** Store at room temperature in a dry and uncontaminated area.

~~nn.~~**b.** Replace screw caps on cartridges for storage.

~~oo.~~**11. Storage Location:**

~~pp.~~**a.** All Emergency Decontamination and Surge Capacity Equipment is stored in the Utility Container adjacent to the Security Trailer. The Container Keys are available during off-shifts by on-duty security personnel. The equipment stored in the container includes the following:

i. PPE:
ii. Surge Equipment and Shelters
iii. Decontamination Tent and equipment
iv. Generator and lights
v. Rolling Carts

C. **REPLENISHMENT OF PPE AND DECONTAMINATION EQUIPMENT:**

1. Annual review and / or post event review, if equipment was used for assessment of condition. This is coordinated by the Environment of Care Committee and the Hospital EOC/Safety ~~Officer~~**Manager**.
   a. Funding:
      i. Annual Budget review via Environment of Care Committee and the EOC/Safety ~~Officer~~**Manager**
      ii. Departmental funding
      iii. Grants and/ or State / Federal Sources for equipment
   b. Regional Cache
      i. Acceptance from Regional cache if available.
      ii. See policy: Acceptance of Regional Cache/Transfer of Cache.

Tri-City Medical Center
Oceanside, California

MAMMOGRAPHY WOMEN'S CENTER

ISSUE DATE:	05/11	SUBJECT:	Mammography Medical Outcomes Audit
REVISION DATE~~(S)~~:	03/13, 01/19		

Mammography Department Approval:	~~10/17~~01/23
Department of Radiology Approval:	~~10/18~~02/23
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	~~11/18~~03/23
Administration Approval:	~~01/19~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	01/19

A. AUTHORIZED TO PERFORM:
1. Computer data input and output coordinated by Mammography supervisor. Pathology reports and mammography exams are correlated and presented to the lead interpreting Radiologist for review and presentation at the Radiology Division meeting.

B. PURPOSE:
1. To statistically aggregate patient mammography data outcomes for physician analysis and to comply with Mammography Quality Standard Act (MQSA) standards.

C. POLICY:
1. Medical Audit analysis will be prepared, reviewed and presented semi-annually at the Radiology Division meeting. Audit analysis must be retained for 36 months.

D. PROCEDURE:
1. Tri-City Medical Center's system for tracking positive mammograms is as follows:
   a. Mammograms with "suspicious" or "highly suggestive of malignancy" assessment:
      i. The interpreting radiologist will explain the results to the patient.
      ii. The radiologist will dictate and finalize the report.
      iii. The report will automatically be sent to the referring physician.
      ~~iv.~~ Mammography department's patient coordinator will **request the order from ordering physician's office by a phone call or a fax request to follow up radiologist's recommendations for new findings.** ~~phone the referring physician office to follow up radiologist's request for new findings.~~
      v. The letter will be mailed to the patient, within 5 working days, indicating the need to follow-up with their physician on any abnormal finding.
      vi. Mammography supervisor tracks pathology results for all breast biopsies. The pathology report is verbally called and faxed to the ordering physician by **pathologist's office/ Lab** ~~the mammography supervisor~~ within 24-48 hours of result.
      vii. Once pathology report has been called into ordering physician the report is then scanned into PAC system for radiology-pathology correlation by lead interpreting radiologist. The pathology reports are given to the Mammography Supervisor who will document this information into patient's mammogram's chart through computerized mammography medical audit.
      viii. Women's Diagnostic tracking system for "positive mammography findings" as "suspicious or highly suggestive Malignancy":

ix. 1) Determines whether biopsies are done on the patient by tracking the list of Birads 4&5 through Discern Analysis on Cerner

x. 2) Determines whether the biopsy specimen was benign or malignant by tracking pathology on patient's power chart and directing the report to lead interpreting physician for correlation.

xi. 3) Facility provides list of any non-compliant patients who were recommended biopsy but not result were obtained. Facility documents all attempts to provide this information.

E. **TO RETRIEVE CLINICAL OUTCOMES DATA:**

1. Log on to Cerner application mammography
2. Select Medical Audit icon
3. Select date range and run reports
4. Print rep011and submit to lead interpreting radiologist for review and presentation
5. Place report in Medical Audit Binder for documentation.

F. **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	Women and Newborn Services Neonatal Intens
PROCEDURE:	**PATIENT ASSIGNMENT NICU**
Purpose:	To provide safe nursing care for all NICU patients b competency. To communicate and document patien guidelines.

RETIRE – incorporated into NICU Policy: Patient Classification in the NICU

A. **POLICY**

1. The Assistant Nurse Manager (ANM) or designee, who is a professional registered nurse, is responsible for patient care assignments at the beginning of each shift. A patient classification system is utilized. Nurse/patient ratios will be maintained to meet patient needs and Title XXII Regulations. The NICU Manager, ANMs or designee are responsible for monitoring appropriate patient assignments.
2. The NICU Nurse Manager has accountability for staffing and work schedules.

B. **PROCEDURE:**

1. The ANM or designee determines the number of registered nurses for the NICU based upon the information obtained utilizing the Cerner acuity tool. This includes appropriate personnel to staff for the patient population. Reference Policy: Patient Classification in the NICU.
2. The ANM or designee develops the patient assignment utilizing the following criteria:
   a. The complexity of the patient's condition and the required nursing care.
   b. The knowledge and the skill of the nursing staff member to effectively assess and care for the patient.
   c. The type of technology employed in providing nursing care with consideration given to the knowledge and skill required to effectively use the technology.
   d. The degree of supervision required by each nursing staff member based on his/her previous assessed level and current level of competence in relation to the nursing care needs of the patient.
   e. Relevant infection control and safety issues.
   f. The patient's geographical location within the NICU.
   g. Continuity of care by reassigning staff to patients for whom they previously provided care, including designated primary and associate nurses.
3. The assignment sheets include:
   a. Date and shift
   b. Location
   c. Manager
   d. ANM, or Designee
   e. Licensed personnel
   f. Unlicensed personnel used as support staff
   g. Preceptees/Orientees
   h. Agency/Float personnel
4. Document the Following on the assignment sheet:
   a. Each patient assigned to an RN. The following positions may be utilized to assist the RN assigned to the patient and should be indicated on the assignment sheet:
      i. An RN with a partial assignment
      ii. Assignment/Break Nurse
      iii. Charge Nurse
      iv. ANM
   b. Indicate the name of the TCMC NICU nurse assigned as a resource nurse/preceptor as appropriate.

Department Review	Perinatal Collaborative Practice	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
06/14	06/14, 02/18, 08/21	n/a	n/a	02/22, 04/23	10/14, 03/18, n/a	09/10, 08/12, 11/14, 03/18

c. Document break/ meal times and when necessary, in-service/meeting times on the break/meal log form per current labor laws and TCMC policy. All employees working a shift of six hours or more will receive an unpaid meal period of 30 minutes. Meal period breaks are extended over enough hours to minimize the number of nurses out of the unit requiring coverage.

d. Document the name of the RN providing relief.

e. Orientees are not utilized as direct care providers without supervision by TCMC NICU RN staff.

f. Update the assignment sheet as patients are admitted or discharged, when a patient's acuity changes, and as personnel and/or assignments change.

g. The assignment sheets are archived by the TCMC NICU Nurse manager or designee. The archived sheets will be retained for the period of time as prescribed by the regulatory agencies.

5. Staffing for Periods of High Census

a. The NICU will maintain a staffing strategy in order to accommodate staffing needs when census is high.

b. The manager and designee (e.g. assistant nurse manager (ANM)/relief charge nurse) will make all attempts to use NICU core staff in an effort to provide consistency of care. Only nurses who are NRP certified can float to NICU. RNs that are floated to the NICU will only take care of CCS defined continuing care patients that do not require higher levels of care or competencies, (i.e., ventilator support, NCPAP, central lines or impending invasive procedures). Competencies of care will be documented for patient assignment.

c. An RN who floats to NICU shall be assigned a resource nurse who may or may not be the ANM/relief charge nurse. On occasions when treatment modalities that the float RN does not feel competent performing arise unexpectedly, the resource nurse will perform the tasks for the float RN or the ANM/relief charge nurse will reassign the patient to ensure safe care.

d. NICU will typically only take floats when there are appropriate acuity patients that can be assigned to them. Pre-booking through registry can be done during times that normally require a higher number of staff.

e. Travelers are required to have the same competencies as the core staff in NICU. Attending high-risk deliveries is optional, especially for those who are only committed for a short time. Travelers may be given the opportunity to orient to high-risk deliveries, if requested.

C. **REFERENCE(S):**

1. California Code of Regulation, Title 22: Social Security, Volume 28, Revised, November 29, 1996. Barclays Law Publishers, South San Francisco, CA.
1. California Children's Service Manual of Procedures, Section 3.25.2.A2C
2.

Tri-City Medical Center	Women and Newborn Services Neonatal Intensive Care Unit (NICU)
PROCEDURE:	**PATIENT CLASSIFICATION (ACUITY) IN THE NICU**
Purpose:	The purpose of the Patient Classification System ~~and tools~~ is to determine the nursing care needs of the individual NICU patients that reflect the assessment by the professional registered nurse. ~~The framework for the Patient Classification system is the AACN Synergy Model for Patient Care that the needs or characteristics of patients and families influence and drive the characteristics or competencies of nurses. Synergy results when the needs and characteristics of a patient, clinical unit or system are matched with a nurse's competencies.~~

~~A. **CARE PROVISION:**~~

~~1. Synergy Model for Patient Care: The Tri-City Healthcare District (TCHD) model for nursing care that links clinical practice with patient outcomes:~~

~~2. Levels of Care: Categories that define the intensity of care requirements for individual patients based on the profession registered nurse's assessment. The levels of care follow a decreasing level of intensity:~~

~~a. Level 10 - 1 RN to 1 patient~~
~~i. Care Intensity 1:1 — High ADL Needs~~
~~ii. Care Intensity 1:1 — Moderate ADL Needs~~
~~iii. Care Intensity 1:1 — Minimum ADL Needs~~

~~b. Level 9 – 1 RN to 2 patients~~
~~i. Care Intensity :High Care Needs — High ADL Needs~~

~~c. Level 8 -1 RN to 2 patients~~
~~i. Care Intensity High Care Needs — Moderate ADL Needs~~

~~d. Level 7 -1 RN to 2 patients~~
~~i. Care Intensity High Care Needs — Minimum ADL needs~~

~~e. Level 6 – 1 RN to 3 patients~~
~~i. Care Intensity Moderate Care Needs — High ADL needs~~

~~f. Level 5 1 RN to 3 patients~~
~~i. Care Intensity Moderate Care Needs — Moderate ADL needs~~

~~g. Level 4 – 1 RN to 3 patients~~
~~i. Care Intensity Moderate Care Needs — Minimum ADL needs~~

~~h. Level 3 – 1 RN to 3 patients~~
~~i. Care Intensity Minimum Care Needs — High ADL needs~~

~~i. Level 2 – 1 RN to 3 patients~~
~~i. Care Intensity Minimum Care Needs — Moderate ADL needs~~

~~j. Level 1 – 1 RN to 3 patients~~
~~i. Care Intensity Minimum Care Needs — High ADL needs~~

~~k. Please see Appendix A and B for additional information concerning Levels of care~~

~~B.~~A. **RESPONSIBILITIES:**

1. **The bedside nurse will complete the designated Patient Classification system (acuity) tool each shift to determine the patient's current level of acuity. The charge nurse or designee is** ~~The NICU Manager, Assistant nurse managers (ANMs) or designees are~~ responsible ~~to~~ **for** ~~ensure~~ **ensuring** ~~that the professional registered nurse complete~~ the ~~Patient Classification~~**tool** ~~for their patient(s) each shift~~**is completed.**
2. **The charge nurse or designee** ~~The NICU Manager and/or the ANMs~~ will ensure that the Patient Classification system for the NICU is utilized accurately **by auditing the results.**
~~2.~~3. **Acuity forms will be collected each day and saved electronically.**
~~3. Nursing is responsible for Patient Classification utilizing the Cerner Acuity Powerform.~~

NICU Department Review	Perinatal Collaborative Practice	Division of Neonatology	Pharmacy and Therapeutics	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors
~~01/14~~08/21, 08/22	03/14, 02/18, 08/21, 08/22, 09/22	n/a	n/a	n/a	04/23	10/14, 03/18, n/a	11/14, 03/18

~~C.~~B. PROCEDURE:

1. The professional registered nurse ~~determines each patient's care intensity and activity of daily living (ADLs) indicators based on the RN knowledge of the patient status, the plan of care for the patient and the nursing assessment~~**will score each patient 1-4 in each acuity category based on level of care required. The higher the score the more assistance the patient requires.**
   ~~a. The Care Intensity indicator is defined by minimal, moderate, high, 1:1 and 2:1 levels~~
   ~~b. The ADL indicator is defined by minimal, moderate and high~~
   ~~c. Each care intensity and ADL indicator is specific to the NICU and has a weight associated to it that assists in determining the acuity of the patient.~~
2. ~~A task will be triggered each shift to the professional registered nurse for each patient assigned.~~ It is the responsibility of the professional registered nurse to complete the acuity of their assigned patients.
3. The ~~ANM~~ **charge nurse** or designee is responsible to verify that the ~~Acuity Powerform~~**form** is completed for each patient each shift.
4. **Staffing for the next shift will be determined** ~~The ANM or designee will complete the Staffing Calculator by 1500 and 0300 which reflects the acuity of the patient(s) as completed by the professional registered nurse(s) and the minimum number of staff required~~ based on acuity and minimum staffing ratios.
   a. **Patients with an overall acuity of 1-2 will be staffed 1 RN:3 babies**
   b. **Patients with an overall acuity of 3 will be staffed 1 RN:2 babies**
   ~~4.~~c. **Patients with an overall acuity of 4 will be staffed 1 RN:1 Baby**
~~5. This information is submitted electronically to Staffing Resource Center if completed by the time previously specified.~~
   ~~a. If the information is late in being completed the ANM or their designee is responsible for faxing a copy of their daily summary reports to the Staffing Resource Center as soon as possible.~~
5. The **NICU** Manager , ~~ANM~~ or designee **will** reviews the required staffing based on the Patient Classification tool and **minimum staffing ratios** ~~the actual staffing used~~**to appropriately staff the oncoming shift. Analyses of the trends and patterns will be used to determine future staffing needs.**
   ~~6.~~

~~7. Trends and patterns are analyzed by the NICU Manager. Problems related to balancing ratios will be brought to the Director and CNE attention. Information will be used to plan future staffing needs.~~

~~D.~~C. INTER-RATER RELIABILITY PROCESS:

1. Inter-rater reliability is defined as the degree to which two observers, operating separately and independently, assign the same ~~care~~ **acuity** level rating to the patient.
2. The purpose of this process is to ensure consistency among the registered nurses in the interpretation and use of the Patient Classification (Acuity) ~~powerform.~~**form**
~~3.~~ **The charge nurse will perform Acuity Validation each shift as appropriate. Discrepancies in scoring will be discussed with the nurse and education provided as needed.** ~~Each shift a task will be triggered by Cerner to the ANM or designee to complete an Acuity Validation on patients in the NICU.~~
~~a.~~3. ~~The task is set to randomly pick 2 NICU patients~~
4. The information is monitored on a monthly basis and reported as appropriate.
~~5. The NICU manager is responsible for ensuring completion of the validation tasks.~~

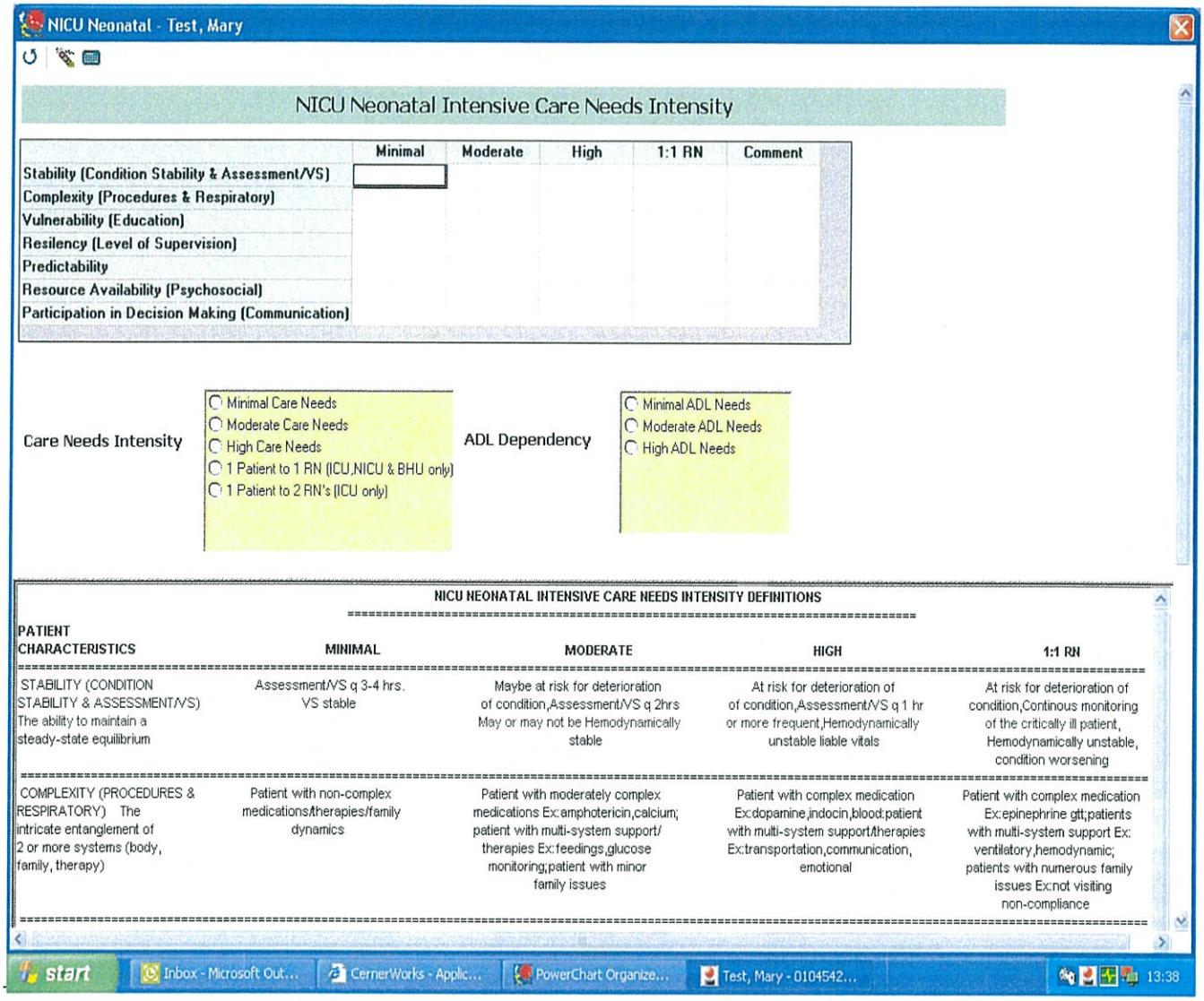
~~E. RELATED DOCUMENT(S):~~

~~1. NICU Neonatal Intensive Care Needs Intensity - Sample~~
~~2. Care Needs - Sample~~

~~F. REFERENCE(S):~~

1. Hardin, S.R., & Kaplow, R., (2005). *Synergy for Clinical Excellence: The AACN Synergy Model for Patient Care*. Jones and Bartlett. Sudbury, Ma.

~~NICU Neonatal Intensive Care Needs Intensity – Sample~~



~~Care Needs - Sample~~

~~CARE NEEDS~~	~~ADL~~	~~ACUITY~~	~~CHARGE CODE~~
~~Minimum~~	~~Minimum~~	~~1~~	~~NICU 3 Level 1~~
~~Minimum~~	~~Moderate~~	~~2~~	~~NICU 3 Level 1~~
~~Minimum~~	~~High~~	~~3~~	~~NICU 3 Level 1~~
~~Moderate~~	~~Minimum~~	~~4~~	~~NICU 5 Level 1~~
~~Moderate~~	~~Moderate~~	~~5~~	~~NICU 5 Level 1~~
~~Moderate~~	~~High~~	~~6~~	~~NICU 7 Level 1~~
~~High~~	~~Minimum~~	~~7~~	~~NICU 7 Level 1~~
~~High~~	~~Moderate~~	~~8~~	~~NICU 9 Level 2~~
~~High~~	~~High~~	~~9~~	~~NICU 9 Level 2~~
~~1:1~~	~~Minimum~~	~~10~~	~~NICU 10 Level 3~~
~~1:1~~	~~Moderate~~	~~10~~	~~NICU 10 Level 3~~
~~1:1~~	~~High~~	~~10~~	~~NICU 10 Level 3~~

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: NEW SUBJECT: Code Silver Plan

REVISION DATE:

Outpatient Behavioral Health Services Approval:	08/22
Environmental Health and Safety Committee Approval:	03/23
Division of Psychiatry Approval:	n/a
Pharmacy & Therapeutics Committee Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE:
1. To maintain safety of patients, staff and visitors and ensure efficient Outpatient Behavioral Health Services Code Silver procedures in the event of an active shooter incident

B. INTRODUCTION:
1. To improve safety, Tri-City Medical Center's Outpatient Behavioral Health Services has several safety policies addressing psychiatric emergencies, active shooter incidents, inclement weather as well aggressive or potentially violent behavior.

C. NOTIFICATION AND COMMUNICATION:
1. Outpatient Behavioral Health Services will inform law enforcement, staff, patients, visitors, hospital administration and community partners of any active shooter incident or in some cases threats of an incident.

D. ACTIVE SHOOTER PROCEDURES:
1. Operations Manager Responsibilities
   a. The Operations Manager or designee will notify all individuals on site (including patients, staff and visitors) of any current threat or active shooter presence.
   b. Staff per training will follow their training of RUN, HIDE or FIGHT by evacuating if safe, hiding and sheltering place when feasible and fighting as a last resort.
   c. Operations Manager or designee will communicate with law enforcement, hospital administration, Chief Nurse Executive and safety officer to activate the hospital command center and to coordinate evacuation plans and safe transportation of patients.
   d. Whenever feasible, close partners (such as Exodus Recovery CSU or Mental Health Systems) would be contacted to see if they can assist with keeping patients until it is safe to transport home.
   e. Individuals who can't safely evacuate will shelter in place and the facility will be placed on lockdown so that no one can enter.
   f. Whenever feasible and safe, the Operations Manager or designee will account for patients, visitors and staff.
   g. All non-essential services and treatment will be suspended
   h. Nursing staff will attend to anyone wounded and therapists will attend to the behavioral health needs to patients, staff and visitors.
   i. The Operations Manager or designee will communicate with and obtain guidance from the command center with assistance from law enforcement.
   j. Whenever feasible, the Operations Manager will designate one Administrative staff to

contact all non-present staff of the disaster and prepare for call-in procedures should they be required to call patients or attend to patients when the facility is safe

k. Whenever feasible, the Operations Manager will contact the Patient Transport Express Dispatcher to alert them to ready the vans for early departure from the program

l. The Operations Manager will relay as much information as possible to the Incident Command Center and obtain direction from them.

2. RN Responsibilities:
   a. Whenever feasible, RN's will notify the residential care providers of the disaster procedures and inform them that their residents will be leaving Program early.
   b. RN's will call Program physicians to inform them of the disaster procedures, and to obtain orders.
3. Therapist Responsibilities:
   a. When safe, the Therapists will attend to the patient's mental health needs by assessing their mental status, needs and providing crisis interventions as needed.
   b. When safe, the Therapists will prepare stable patients for departure from Program if they can exit safely and to the hospital/crisis stabilization unit if they require medical or behavioral health care.
   c. The Therapists will begin calling family members, Case Managers and Conservators to inform them of program closure for the day and to ask for assistance in supporting the mental health needs of the patients.
   d. In the event patients cannot be safely exited from the Program and delivered to their residences by hospital vans, they will be contained within the building until law enforcement notification of safe departure.
   e. Appropriate crisis intervention and de-escalation techniques will be utilized to allay panic.
4. Dispatcher and Drivers
   a. The Dispatcher will contact Patient Transport Express supervisor to collaborate with the PTE Supervisor about the needs of the vans throughout the hospital.
   b. The Dispatcher will contact all available drivers to alert them for the possibility of reporting for duty.
   c. The Dispatcher will assemble the drivers at the command center until they are able to safely transport patients.
   d. The Drivers will safely transport stable patients to their residences as per the route sheets and return to base at the hospital.
5. Administrative and Support Staff
   a. The Administrative and Support Staff will take direction from the command center
   b. If feasible, the administrative and Support staff will respond to phone calls and direct callers appropriately.
   c. The Administrative and Support staff will assist the Therapists and Drivers in boarding the patients on the vans, when law enforcement determines it is safe to do so.

E. **RELATED DOCUMENT(S)**:
1. Outpatient Behavioral Health Policy: Aggressive or Potentially Violent Behavior
2. Outpatient Behavioral Health Policy: Department Safety
3. Outpatient Behavioral Health Policy: Disaster Plan
4. Outpatient Behavioral Health Policy: Emergency Evacuation
5. Outpatient Behavioral Health Policy: Inclement Weather and Critical Incident
6. Outpatient Behavioral Health Policy: Psychiatric Emergency

Tri-City Medical Center
Oceanside, California

OUTPATIENT BEHAVIORAL HEALTH SERVICES

ISSUE DATE: 06/19~~NEW~~ **SUBJECT: Medications**

REVISION DATE: 06/19

Department Approval:	**11/20**
Division of Psychiatry Approval:	**01/23**
Pharmacy and Therapeutics Approval:	**03/23**
Medical Executive Committee Approval:	**03/23**
Administration Approval:	**04/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	

A. **PURPOSE:**

1. To identify Patient, Physician and R~~.~~N~~.~~ responsibilities regarding medication education, documentation and reconciliation.

B. **POLICY:**

1. Patients are responsible for providing their own medications needed during Program hours and, as outpatients, they, a responsible caregiver, or their licensed residential care facility assume the responsibility for administration of medications. Program physicians may prescribe medications for their patients or work in collaboration with a community physician who is the prescribing physician. Program RNs are responsible for taking medication orders, medication education, reconciliation and documentation.

C. **PROCEDURE:**

1. Who May Perform/Responsible: Physicians and R~~.~~N~~.~~
2. If medications are being managed by the attending Program physician they may enter orders for medications in the medical record, after obtaining informed consent by the patient. The prescription will be directed to the patient's pharmacy or in some circumstances, the RN may call the order in to the pharmacy.
3. In circumstances when orders are called in to a pharmacy by the RN, the medications may be delivered to the patient's place of residence.
4. The RN is responsible for assessing the patient for competency to take medications independently and educating the patient about their medications.
5. The RN maintains a current list of each patient's medications. Medications must be reconciled upon admission, when medication changes occur or routinely on a quarterly basis, and upon discharge. Reconciliation will be completed with the patient, the patient's pharmacy, other physicians who may be treating the patient concurrently, the patient's caregiver, the Board and Care Manager and upon discharge with the clinician or agency that will be treating the patient in the community.
6. The RN is responsible for completing the Medication **History**~~Reconciliation~~ within the prescribed Program timelines.
7. If the patient is co-treated with another community physician, medications must be updated and reconciled when medication changes occur.
8. Telephone and written orders are accepted only from TCMC physicians and entered in the medical record by the Program RN.
9. The Program physician may authorize the RN to notify the pharmacy for medication refills. Refills are noted in the patient's medical record.

10. Telephone orders are signed by the ordering physician within 48 hours.
11. If a patient is ordered an injectable medication, a Program RN may perform this process. All injectable medications must be verified by the issuing pharmacy for accuracy prior to the injection. Injectable medications will be stored properly and according to manufacturer's directions.
12. After opening multi dose vials, the RN will write in the expiration date on the vial (28 days from date of open unless shorter expiration date indicated on original vial)
13. The use of psychopharmacological agents for patients will be monitored for drug interactions, appropriateness and safety.
14. Physicians will review for drug interaction and appropriateness of dose during each patient visit.
15. In the event that patients receive more than seven scheduled psychotropic medications, more than two regularly scheduled psychopharmacological agents, within the hypnotics, or anxiolytic class, or more than three within the antipsychotics, mood stabilizers, and antidepressants class, then the patient is identified as receiving polypharmacy. An exception to this is an additional agent that is used only as a PRN, on an as needed basis, during periods of increased acuity of symptoms.
16. When circumstances warrant larger doses than approved by the FDA label, or a higher number of medications within the same class, the physician will review for drug interactions and appropriateness of care and will document specific rationale in the medical record.
17. It is the responsibility of the prescribing physician to order psychopharmacologic agents in an appropriate and safe manner. Appropriateness of dose and number of psychotropics will be determined at the discretion of the physician in order to address current patient condition and the severity of presenting symptoms.

D. **REFERENCE(S):**

1. Joint Commission Standards for Behavioral Health MM.01.01.05

The purpose of the Medication Error Reduction and Prevention Plan (MERP Plan) is to promote safe and effective medication use through the reduction of preventable medication-related errors and adverse events.

MERP 2023~~1~~

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Medication Error Reduction Plan: 20234 Plan & Goals

Plan Purpose and Overview:

The purpose of the Medication Error Reduction and Prevention Performance Improvement Plan (MERP Plan) is to promote safe and effective medication use through the reduction of preventable medication-related errors and adverse events.
Medication Error Reduction and Prevention Strategies focus on the core procedures and systems of the medication management process; prescribing; prescription order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and medication use.
The Medication Error Reduction and Prevention Plan is updated on an ongoing basis in consideration of the changing needs of patients, staff, quality management and performance improvement, and risk management processes. Modifications to the plan are assessed for effectiveness.

The effectiveness of the Medication Error Reduction and Prevention Plan is reviewed **annually.** The methodology used to assess the effectiveness of the plan should provide objective and relevant evidence that informs policy decision makers in the evaluation and development of corrective actions to effectively prevent and reduce medication errors.

The (MERP Plan) includes:

- Creating and embracing an accountable non-punitive culture for identifying and reporting medication errors and near miss events;
- Utilizing a "systems" approach to understanding and eliminating medication errors through multidisciplinary involvement;
- Using organization-wide quality assurance and performance improvement (QAPI) data to identify and analyze medication errors and, near miss events;
- Implementing system changes to minimize the likelihood of future medication errors and near misses;
- Involvement of multidisciplinary teams and committees to direct and monitor the medication safety and performance improvement effort.

Scope:

The Medication Error Reduction and Prevention Plan is applicable to all patients receiving care within the facility or under the licensure of the facility, including both inpatients and outpatients. The MERP Plan pertains to all areas in which medications are prescribed, prescription orders are communicated, products are labeled, packaged and nomenclature used, compounded, dispensed, stored, distributed, administered, monitored and used.

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Objectives:

- Improve error detection, reporting and analysis of data and use of information to improve medication safety.
  - Evaluate on-line reporting and enhance active reporting.
  - Enhance awareness of on-line reporting tools and methodologies for capturing data and tracking medication related events.
  - Orient and educate staff on processes for reporting medication events. Re-orient staff on a regular basis.
  - Establish a system to encourage staff to report medication errors, participate in identifying system-based causes, make recommendations to improve the system, and facilitate necessary changes.
  - Create methods to enhance error detection by capturing medication errors and near misses through computer surveillance and trigger events, Medication Administration Records (MAR) reconciliation, pharmacy interventions and competency assessment processes. Use the data to identify additional opportunities to improve medication processes.
- Emphasize an accountable non-punitive reporting process that encourages staff to report potential or actual medication safety risks.
  - Widely communicate the organization's commitment to medication safety in specific terms and with concrete examples in staff newsletters and educational programs.
  - Develop methods to obtain frontline staff feedback about medication/patient safety issues.
  - Review ***ISMP Medication Safety Alert*** and disseminate information to staff involved in the medication management process.
  - Establish a blame-free environment for responding to errors.
  - Involve staff in Root Cause Analysis and Failure Mode Effect Analysis to assist in evaluation of systems and procedures that have or may contribute to errors.
  - Incorporate patient safety tenets in evaluation of employee competence and performance evaluations. (Do not include the absence or presence of errors as a criterion.)
- Evaluate and utilize technology to reduce the risk of medication errors.
  - Maintain an up-to-date compendium of system capabilities and reporting functionalities. Set standards for medication safety alerts and educate staff on functionality.
  - Collect and analyze data to identify areas needing improvement and implement appropriate strategies for medication error reduction.
- Reduce the risk of errors with high-alert medications prescribed and administered to high-risk patient populations or at vulnerable periods of transfer through the health care system.

- Evaluate medication management processes for high-risk patients and patients receiving high-alert medications (e.g. pediatric and chemotherapy) to include the following indicators:
  - Establish maximum safe doses for high-alert medications and enter them into the order entry system to electronically alert staff to potentially toxic doses.
  - Evaluate the storage and safe use of high-alert medications and look-alike/sound-alike medications in the hospital and initiate safe practice recommendations.
  - Establish standard order sets for the use of high-alert medications, as appropriate.
  - Standardize drug concentrations of high alert medications and medications used in high-risk patient populations such as pediatrics and ICU.
  - Establish a consistent process for a cognitive, independent double check for defined high-alert medications.

- Implement safe practice recommendations from nationally recognized organizations such as ISMP, Joint Commission Sentinel Event Alerts and California Institute for Health Systems Performance.
- Ensure continuous compliance with medication management safety strategies recognized by professional and accreditation standards. Compliance measures may include:
  - Self-assessment tools and gap analysis
  - Survey preparation assessments
  - Medication Safety Checklist

Organization:

Hospital leadership is committed to maintaining an environment that emphasizes patient safety and supports ongoing error prevention and reduction activities. Hospital leaders actively encourage medication error identification and reporting by all staff. Preventing and reducing medication errors is a high priority. Errors are analyzed and processes, functions and services are established or; procedures and systems are changed to prevent recurrence and reduce risk to patients.

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Process of the Plan:

- **Plan Development:**

A multidisciplinary group comprised of MERP Plan members from the Medication Safety Team/Committee is responsible for development of the Medication Error Reduction and Prevention Plan. The core team is also responsible for recommending the MERP Plan's approval through the Medication Committee, Quality and Patient Safety Council (or equivalent), Medical Executive Committee and the Board of Directors.

Members of the MERP Plan core team includes:

- Director of Pharmacy
- Director of Quality Management and Medical Staff Services or Designee
- Director of Risk Management
- VP Patient Care Services
- Medical Staff representative(s)

- **Plan Implementation and Assessment:**

The Medication Safety Team provides primary oversight of MERP Plan. The team/committee's role is to guide and direct others within the organization towards; the provision of safe medication use; the prevention and reduction of medication errors and the improvement of medication management processes /procedures and systems.

The Medication Safety Team works collaboratively with the hospital and medical staff leadership, medical staff, and hospital staff; working across interdepartmental boundaries as needed, to address medication safety issues and to assess the effectiveness of the MERP Plan.

Methodology used to evaluate each of the eleven medication management procedures or systems to identify weakness or deficiencies which could contribute to medication errors may include but are not limited to:

- Evaluation of external alerts (e.g. ISMP Alert, FDA Alerts, etc.)
- Observation of medication pass
- QAPI studies
- FMEA studies
- Medication Use Evaluations
- Analysis of medication error reports to identify system vulnerabilities

- Root Cause Analysis
- Monitoring and adjusting implementations of practices/process changes to evaluate and enhance effectiveness
- Technology upgrade feasibility is reviewed when needed, but at least annually.
- GAP analysis of the plan is performed and priorities are established annually.

➢ **Improvement Strategies:**

Current literature is reviewed on an ongoing basis for the development and ongoing review and revision of the Medication Error Reduction and Prevention Plan's improvement strategies. The literature includes publications from the Institute of Medicine (IOM), Institute for Safe Medication Practices (ISMP), American Society of Health System Pharmacists (ASHP), the Joint Commission and other publications/organizations as appropriate.

Medication use systems and procedures are identified to include both current and future improvement strategies.

➢ **Implementation Strategies:**

Annually, improvement strategies are evaluated and resultant implementation strategies are identified. Strategies include both technology and non-technology approaches.

- Review the effectiveness of the existing plan~~,~~ and ~~make adjustments~~**adjust**, when needed, to improve the plan.
- Implement medication use safe practice recommendations
- Optimize medication error prevention and- reduction potential of technology systems
- Respond rapidly and effectively to potential errors of, and errors caused by workflow processes

➢ **Education and Awareness:**

Entity specific core curriculums are created to support the MERP Plan initiative. The following methodology will be used to assist with identifying and reporting medication errors with the goal of reducing their incidence:

- An annual medication safety assessment will be used to identify needs.
- Systems will be reviewed to identify current practice and compared to nationally recognized safe medication practices to identify gaps.
- Expected outcomes and measures of success will be defined for identification and reporting of medication errors and to identify process changes for error reduction and prevention.
- Clinical education will include medication safety core curriculum during orientation and annual competency reviews for pharmacy, nursing and other allied health professionals.

- The medical staff will be informed of MERP Plan progress via committee presentations and Medication Committee newsletters.

Monitoring:

The Medication Safety Team will monitor multiple data sources which may include:

- Adverse drug event review (medication errors, near misses, adverse drug reaction and incompatibilities). **See Addendum A**
- Concurrent chart reviews and audits (e.g. Medication Use Evaluations)
- Computerized surveillance (e.g. Trigger drug utilization, Automated Dispensing Cabinet (ADC) Reports, ~~Bar Code~~ **Barcode** Medication Verification (BMV) data reports, etc.

Reporting:

- Findings and recommendations from the Medication Safety Team are first reported to the Medication Committee, which through its representative reports to the Medical Executive Committee
- The Medication Safety Team also presents its findings to the Quality and Patient Safety Council, which are comprised of leadership from the facility's functional departments.
- The Medication Safety Team publishes quarterly newsletters to update patient care staff of MERP PIP's progress.
- If findings or recommendations have an *immediate* impact on patient safety, focused memos and direct communication to affected functional areas is utilized.

Annual Review:

The Medication Error Reduction and Prevention Performance Improvement Plan (MERP PIP) is reviewed annually and modified as needed to focus efforts to reduce medication related errors. The analysis will consist of both concurrent and retrospective review of patterns and trends of clinical care, weakness and deficiencies, and focus on procedure and system related opportunities for improvement. Individual performance issues will not be addressed during an annual review.

The annual assessment of the effectiveness of the MERP PIP will include, but not be limited to, a comprehensive review of prescribing, prescription order communication, labeling, packaging, nomenclature, compounding, dispensing, distribution, administration, patient and staff education, monitoring tools and overall medication use.

Annual review of the MERP PIP will be a function of the Medication Safety Team/Committee (or equivalent) and will be reported to the Medication Committee (P&T), the Quality and Patient Safety Council, the Medical Executive Committee and the Board of Directors.

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Prescribing							
Decrease number of duplicate medication orders	Profile review during pharmacist order verification **TJC**	**12/2013** **08/2015** **06/2016** **03/2019** 11/2019 11/2020 04/2021 **05/2022**	Tracking duplicate orders and working in conjunction with Chief of Medical Staff to evaluate causes and improvement strategies Possible retraining of providers Cerner implementation: Providers are receiving alerts of duplicate medication Cerner Community Work Go-live April 2021	Pharmacy Staff Medical Staff Regulatory Nursing Staff Information Technology	Ongoing Data source development needed. Manual Audit: Auditing an average between 30 and 40 charts per month. **02/2023: Resume manual chart audits**	Surveillance Quality Assurance & Performance Improvement (QAPI) Reports Pharmacy Reports Information Technology	**06/2016:** General consensus from pharmacists indicates there has been little improvement. Medical Quality has decided to include duplicate orders as part of the ongoing professional practice evaluation. Goal: 0 True Duplicate Therapy. **04/2017:** Continues to be discussion at Med Staff level on proper review for duplicate meds. **07/2017:** This will be part of the MD Optimization roll out. **01/2018:** With further MD input improvements being made. Continue to evaluate. **02/2023: pending results of chart audits**
~~Eliminate orders coming across as mg/kg rather than total dose~~	~~Chart Review~~	~~01/2020~~ ~~11/2020~~	~~Identified that Emergency Room patients have an estimated weight placed in Cerner and the weight used for dose calculation comes from the admission weight. As a result, currently doses entered in mg/kg remain this way unless a weight~~	~~Nursing~~ ~~Pharmacy~~ ~~Medical Staff~~ ~~IT~~	~~Ongoing~~ ~~Asking IT for details and update~~ ~~Alert: Order without weight documented~~	~~Ongoing~~ ~~RL's Reports~~	~~Now that ED is profiled, if calculation is not employed for total dose no med can be accessed in Pyxis. IT stated weight ts must be directly entered into admission, not triage.~~ ~~This finding was corrected with the implementation of Community Works.~~

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
			~~is placed in admission weight field~~ ~~Alert through Cerner: Weight to be entered. As a result the dose will be weight based~~ ~~Cerner Community Work Go-live April 2021~~				
Antimicrobial Stewardship	Antimicrobial Stewardship Program **(ASP)** Medication **Safety** Committee **(MSC)** Infection Control **TJC**	04/2020	Added recommended guidelines for use of antimicrobial agents on 2020 antibiogram Updated TDMS to PrecisePK Updated vancomycin and aminoglycoside dosing policies Updated renal dosing policy to include dosing by indication and by renal function Researched treatment regimens for COVID-19 and implemented ordering and verification procedures	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff Administration	**02/2022, 07/2022, 08/2022: Updated TCMC Adult COVID management** **05/2022: Started tracking days of therapy (DOT) of antifungal therapy and monthly medication use evaluations (MUEs) of remdesivir. Redid ASP pharmacist intervention categories in Cerner Community Works** **06/2022: Created IV to PO and renal dosing daily reports for pharmacists to review** **07/2022: Added preferred empiric regimens for selected disease states to 2021-2022 antibiogram** **10/2022: Initiated pharmacist involvement in Outpatient Parenteral Antimicrobial Therapy (OPAT).** **12/2022: Implemented quality**	ASP Committee P&T Committee Infection Prevention QAPI **Pharmacy reports**	Appropriate prescribing of empiric antimicrobial therapy Appropriate dosing of antimicrobials Appropriate monitoring of antimicrobials **05/2022: Presented ASP to TJC survey and passed** **06/2022-01/2023: Improving number of IV to PO conversions. Auditing renal dosing of antimicrobials on a quarterly basis. MUE for remdesivir shows no instances of inappropriate prescribing so no need to evaluate further** **01/2023: Created OPAT Collaborative Practice Agreement- pending approval** **02/2023: Appropriate use of antimicrobials remains stable. Pending data of QI project: extended-infusion beta-lactam**

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					improvement (QI) project: extended-infusion beta-lactams to decrease hospital length of stay (LOS) **02/2023: Updated vancomycin dosing protocol pending approval**~~Ongoing process 2020 antibiogram now includes treatment recommendations PrecisePK being used by all pharmacists Vanco and Aminoglycoside policies approved by P&T and MEC Medication dosing policy pending ASP/P&T/MEC approval~~ ~~COVID-19 treatments are verified with physician and some monitored by pharmacists (Remdesivir)~~		**antibiotics**
Prescribing restricted Antimicrobials	Chart Review **ASP**	05/2020	~~Limited ordering restricted antimicrobials to one dose stat Order reviewed by ID team~~ **Increasing prevalence of resistant microbes with limited treatment options**	Pharmacy Microbiology Infection Control Quality Risk Information Technology (IT) Medical Staff Administration	**Limited ordering restricted antimicrobials to one dose stat Order reviewed by ID team** Decreased and controlled the use of restricted antimicrobials **05/2022: Started performing monthly MUEs of meropenem and ceftazidime** **12/2022: Microbiology lab implemented use of new rapid diagnostic GenMark Blood Culture Identification (BCID) to**	ASP Committee P&T Committee Infection Prevention QAPI	Appropriate use of restricted antimicrobials **11/2022: Meropenem and ceftazidime now restricted to ID and ICU only due to reduced susceptibility compared to Scripps Encinitas and VA San Diego** **TCMC vs Scripps vs VA SD** **Ceftazidime: 87% vs 90% vs 95%** **Meropenem: 89% vs 96% vs 99%**

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					help identify organisms and resistance genes within 2 hours		**02/2023: Awaiting data to see if there is reduction in time to effective therapy and higher rate of antimicrobial de-escalation**
Wrong dosing weights input in Cerner	**MSC**	**09/2022**	**Incorrect weights are being entered in Cerner. Often, the patient's weight in pounds is entered as kg, almost doubling the dose of weight-based drugs.**	**Pharmacy Nursing IT**	**Ongoing 10/2022: Reviewing events in Med Safety to provide education to nursing staff to input weights in the correct field (pounds vs kilograms) and having pharmacists double check weights with the nurse if the weight seems high or if there is a large discrepancy (Cerner fires a task for weight discrepancies in the multi-patient task list but difficult to find)**	**RL Reports Chart review**	**01/2023: Chart review still finding instances of incorrect weight.**
Prescription Order Communication							
Improve Accuracy of Medication History and Reconciliation Process	Audit by Medical Staff **2023 National Patient Safety Goals (NPSG)**	07/2020 **01/2023**	A multidisciplinary group has been put together to address improving the meaningfulness and accuracy of the medication history and reconciliation process from admission to discharge. With Covid-19 our 2 ED pharmacy technician's positions were	Nursing Pharmacy Medical Staff **IT**	Ongoing ~~RL's Reports~~ **11/2022: Created 2 Medication History Pharmacy Technician positions Go-live November 2022 02/2023: Need to revise the process for medication history intake for when techs are not able to complete med history before a patient is transferred out of the ED and when the**	Surveillance by PI and reported to Medication Safety and P&T. Med Staff review for provider compliance of med reconciliation **RL reports**	Medication Reconciliation reports showed ..... **04/2017:** Further review on medication reconciliation not done by technicians needed. **07/2017:** Audits show we often miss the last dose given info. Continue to evaluate process Transitions of Care program is ideal. From 07/2019 through 07/2020 medication history has been

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
			eliminated. Educated nursing staff on performing the medication reconciliation upon admission and discharge **02/2023: Currently, physicians are not alerted through Cerner if there are changes to the patient's medication history. IT to investigate if this is in development.**		**med history is updated after the physician has already reconciled a patient's medications.**		performed by providers only when needed and upon transition of phase of care. **01/2023: Still receiving med error reports related to incorrect medication reconciliation.**
Improve CPOE compliance rates	ISMP	2019	Order Set Development needed for CPOE Order Sets updated regularly based on Current Guidelines and approved by P&T and MEC CPOE Compliance Rate Staff Education	Nursing Pharmacy Medical Staff	**Ongoing** 12/2020	Pharmacy Reports Community Works implementation on April 2021 **Set the rate at 90% or greater** **Will analyze the reports post Cerner implementation**	~~Set the rate at 9% or greater~~ Increased CPOE Compliance Rate ~~Will analyze the reports post Cerner implementation~~ **01/2023: CPOE rates remain above goal through Quarter 4 of 2022** **Continue evaluating**
Medication shortage communication	CDPH	06/2019 **02/2023**	Shortages needed to be communicated and managed well	Nursing Pharmacy Medical Staff	**Ongoing** 12/2020 **09/2022: Started publishing weekly drug backorder reports for ED physicians, later expanded to ICU.** **02/2023: Expand backorder**	P&T Shortage Report **Weekly backorder reports** **Discuss daily in pharmacy**	Shortages identified Coordination with the buyer Communication with med and nursing staff Looking for therapeutic alternatives Using CPS resources (Purchasing

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
					report distribution to all clinical managers and the nursing house supervisor so that nursing staff is aware of current shortages and alternatives	**huddle**	Analyst, Reports...etc., Using 503B- for sterile compounds **02/2023: Lack of knowledge of current shortage resulted in treatment delay and revealed that communication needs to be improved**
Product Labeling, Packaging, and Nomenclature							
~~Ensure proper Beyond Use Date (BUD) on product labeling~~	~~CDPH~~	~~10/2019~~	~~Repackaging oral unit dose did not have the correct BUD~~	~~Pharmacy Staff~~	~~12/2020~~	~~Education provided to staff~~	~~Started repackaging with the correct BUD~~
~~Ensure appropriate labeling process for NMB in place~~	~~CDPH Med Errors~~	~~10/2019~~	~~NMB were not labeled appropriately, nor stored accordingly~~	~~Pharmacy Staff Nursing Staff~~	~~10/2020~~	~~No NMB med errors~~	~~Stored NMB in a separate Bins Ensured they have a NMB labels Stocked only in appropriate area~~
Compounding							
~~Implement USP 797 guidelines~~	~~USP 797 Chapter~~	~~03/2019~~	~~Clean Room did not meet USP797 standards. Used glove box while the Clean Room was being built~~	~~Pharmacy~~	~~03/2020~~	~~Successful inspection from CDPH and CABOP surveys~~	~~Built a new Clean Room Successful surveys~~
Dispensing							
Review Overrides	~~Medication Safety~~**MSC**	01/2019	A high rate of medication override	Nursing Staff Medical Staff	05/2020 Reviewed Medication Override	Monitoring override rate	Decrease of inappropriate override

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
	TJC GACH				policy and list Last revision approved by P&T on 05/2020 Hired 2 ED pharmacist to review all ED orders **08/2022: Pharmacists resumed reviewing override reports**		**02/2022: Met goal <4%** **01/2023: Override rate meeting goal and continuing to trend down**
Dispensing the wrong medication	**MSC**	**10/2022**	**Identified wrong medication filled in the Pyxis. Reviews of med errors in 2022 showed other instances of medications dispensed incorrectly.**	**Pharmacy**	**Ongoing** **11/2022: Provided education and reminder to pharmacy technicians to always utilize barcode scanning when filling the Pyxis. In the instance of barcode scan failure, technicians should get a witness to verify independently without confirmation bias that the correct medication is filled. Pyxis refills of high alert medications will require pharmacist verification instead of tech-check-tech.**	**RL reports**	**10/2022-11/2022: Conducted a Failure Mode and Effects Analysis (FMEA) regarding the incorrectly filled medication. Reported findings to MSC, P&T, and pharmacy department** **01/2023: No other reported instances of wrong medications dispensed but will continue monitoring.**
Distribution							
~~Bar Code Scanning (Patient and Meds)~~	~~Leap Frog~~	~~01/2020~~	~~Not meeting Leap Frog criteria for patients and medication bar code scanning~~	~~Pharmacy Staff Nursing Staff Medical Staff~~	~~Utilized Pyxis BCS feature Educated nursing medical and pharmacy staff~~	~~Community works reports showing both rates trending~~	~~Increased medication bar code scanning rate~~

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
						~~down~~	
Administration							
Bar Code Scanning (Patient and Meds)	Leap Frog	01/2020 11/2022	Not meeting Leap Frog criteria for patients and medication bar code scanning Community Works reports showing both rates trending down 11/2022: RL reports of medication errors still showing errors related to not scanning, especially in ED.	Pharmacy Staff Nursing Staff Medical Staff	Utilized Pyxis BCS feature Educated nursing medical and pharmacy staff 11/2022: Resumed Medication Safety meetings to regularly report BMV rates. Nursing education to be provided in ED. 02/2023: May require ED pharmacist to educate nursing regarding BMV scans	Pharmacy reports RL reports	Increased medication bar code scanning rate 01/2023: ED BMV rates still far below benchmark >95% set for inpatient units. 2022 BMV scan rates for inpatient units have increased from 2021.
~~Unclamping Medication Using Alaris Pump~~	~~CDPH Med Errors~~	~~07/2020~~	~~Discussed at Medication Safety meeting~~ ~~Working to push Cerner admin times through to Pyxis in order to utilize Remove by time feature on Pyxis~~ ~~Evaluating the Pyxis Link product~~	~~Nursing Staff~~ ~~Medical Staff~~	~~Nursing Education~~ ~~Be A Champ on Clamping~~	~~Med Errors Reports~~	~~Reduction of med errors~~
Guardrails Usage	ISMP MSC	10/2022	Discussed at Medication Safety Committee meeting 10/2022: Findings from Alaris on-site representative showed that there were several	Pharmacy Nursing	Ongoing 11/2022: Set up training sessions for Guardrails Suite Editor to update the data set. 11/2022-01/2023: Added new drugs and revised limits on existing drugs in the library	Alaris reports Set Benchmark >95% Guardrails usage	02/2023: Released new Guardrails data set. Alaris pump remediation in progress to upgrade to V12.1.x Will need to evaluate once upgrade has been completed

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
			medications/therapies missing from the drug library and that the limits needed to be revised.		01/2023: Met with Alaris executive consultant who will set up clinical education and site visit in May 2023 to reevaluate Guardrails usage		
				Education			
~~Pharmacists Qualification~~	~~Request for pharmacist Code Blue and Stroke participation~~	~~01/2020~~	~~At this time the ICU pharmacist attends codes when possible. Attendance is mainly limited to ICU but occasionally other areas and only when ICU trained pharmacist is in house. The value of a pharmacist present is recognized but not all pharmacists are ACLS trained. Hired 2 ED pharmacists to attend Stroke Code.~~	~~All Pharmacists~~	~~All inpatient Pharmacists are ACLS and BLS Certified Participation in Code Blue The 2 ED pharmacists attend Stroke Code~~	~~Critical Medication Administration~~	~~Participation in Code Blue~~
				Monitoring			
~~Percentage of ED population come in for purpose of seeking opioids~~	~~Discussion with ED team regarding improvements to opioid use~~	~~01/2020~~	~~Working with ED Chief. Data Analyst and Pharmacist to see if the data can be gathered and then use it to drive prescribing habits to~~	~~Nursing Medical Staff Information Management (HIM) Pharmacy~~	~~Ongoing~~	~~Waiting for reports to be built by IT~~	~~Pending because of Covid-19~~

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
			~~some extent.~~				
Heparin for Impella device	MSC	01/2023	Medication errors regarding heparin for patients on Impella devices have been identified.	Pharmacy Nursing Medical Staff	Ongoing 01/2023: ICU pharmacists to check heparin purge solution and systemic heparin bags in the patients' rooms at least once daily and with each rate change of systemic heparin to ensure that the correct drug concentration is hanging and that they are running at the correct rates. Added sodium bicarbonate as alternative to heparin purge fluid in patients intolerant to heparin.	RL reports Chart Audits	01/2023: Heparin for Impella Device protocol approved in P&T. Sodium bicarbonate purge fluid for Impella passed P&T, awaiting CPP approval. Awaiting implementation to review efficacy
Use Strategies							
High number of opioid-related morbidities and mortalities in the community	California Department of Healthcare Services (DHCS) CA Bridge TJC	11/2022	Received approval for grant from DHCS to start an opioid stewardship program. May be renewed annually.	Pharmacy Nursing Medical Staff Quality IT	Ongoing 01/2023: Pending approval for the creation of a Substance Use Navigator position. Exploring possibility of starting a medication-assisted treatment (MAT) program to help patients with opioid use disorder	Pharmacy Reports Chart Audits	02/08/2023: First Opioid Stewardship Committee meeting was held
Technology Elements							
Lack of Anesthesia Cart in the OR,	MERP Audits of Shingle sheets	12/2019 12/2022	Review of Overrides and Discrepancies Pending Approval for	Pharmacy Nursing Medical Staff	Ongoing Pending Approval Anesthesia Carts purchased	Pharmacy Reports Chart Audits	~~Pending~~ 12/2022: Still finding undocumented narcotic waste,

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Weakness / Strategy	Methodology	Date Identified	Process	Responsible Parties	Status / Implemented Date	Measure of Success / Assessment of Effectiveness Plan	Outcome
Accountability/ Inventory Control			Anesthesia Carts Non Scan Report	Information Management (HIM) Nursing Cardio-pulmonary Laboratory Pharmacy Medical Staff IT **Quality**	**01/2023: Met with ICU manager and OR educator regarding missing OR charges and missing drug administration charting. Found that some medications are not in the Anesthesiology Drug Formulary so they cannot be added to the Anesthesiology Record. IT to work on adding these to the formulary. 02/2023: Met with representative from the anesthesiology group to discuss better documentation and accountability/inventory control. Missed OR charges, undocumented narcotic waste, and undocumented medication administration will be reported regularly to the representative from the anesthesiology group who will follow up with med staff.**		**missed OR charges, and undocumented medication administration. 01/2023: Unable to amend OR record post-discharge to add missing medication administration and charges. IT working on it.**

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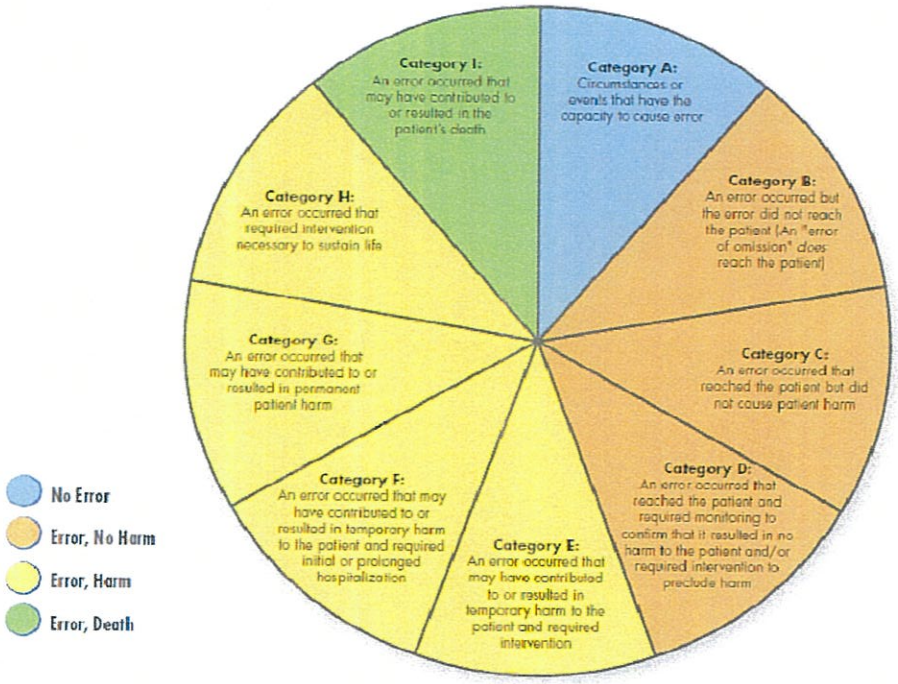
Medication Error Reduction Plan: 20234 Plan & Goals

Addendum A

NCC MERP Index for Categorizing Medication Errors



Definitions

Harm
Impairment of the physical, emotional, or psychological function or structure of the body and/or pain resulting therefrom.

Monitoring
To observe or record relevant physiological or psychological signs.

Intervention
May include change in therapy or active medical/surgical treatment.

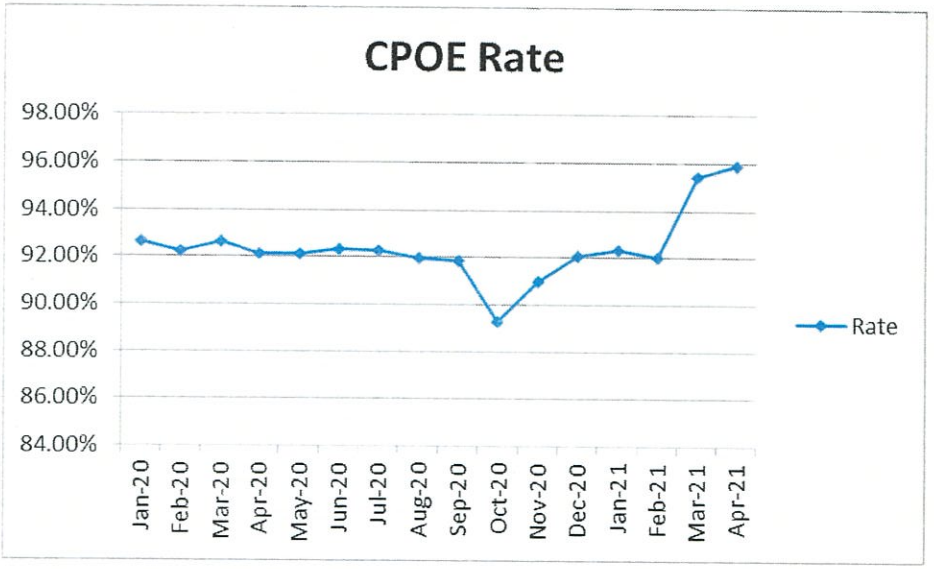
Intervention Necessary to Sustain Life
Includes cardiovascular and respiratory support (e.g., CPR, defibrillation, intubation, etc.)

Tri-City Medical Center
Medication Error Reduction Plan: 20234 Plan & Goals

~~Addendum B~~

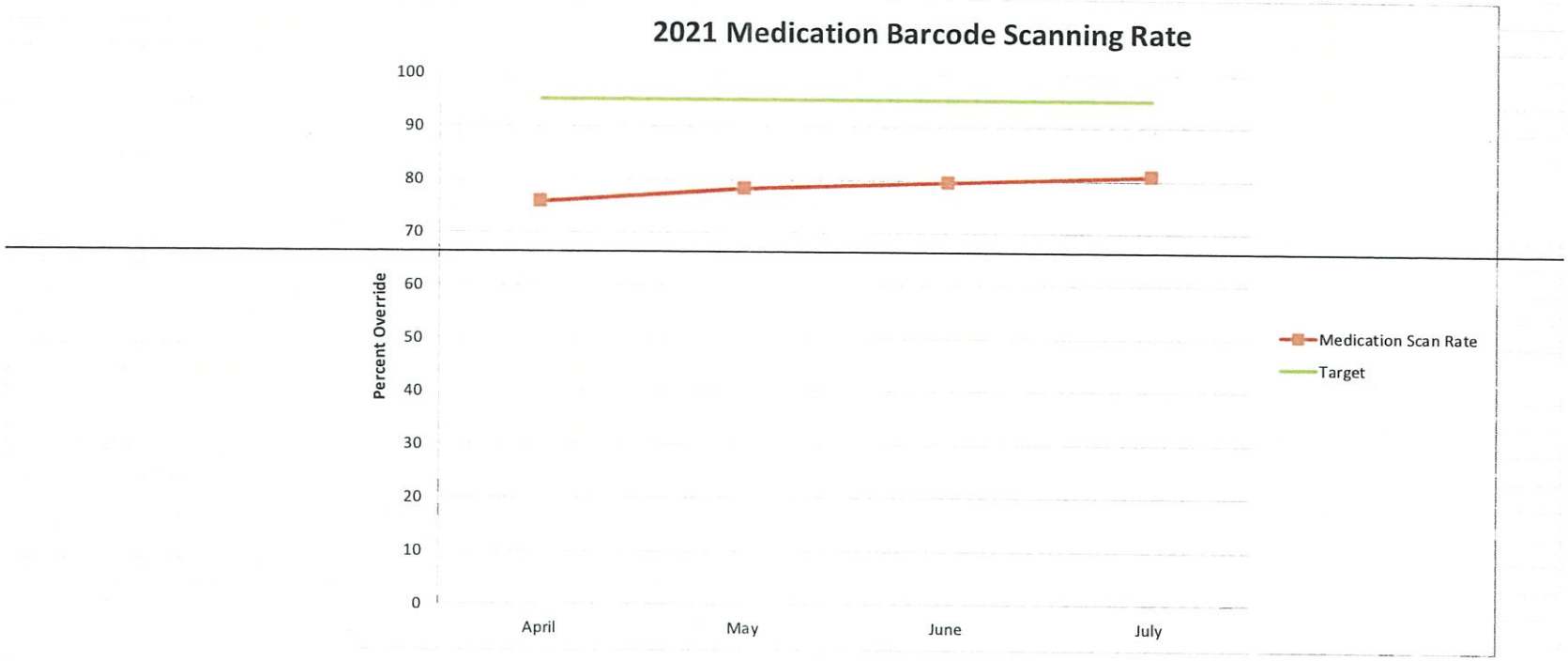
~~CPOE Rate~~

~~CPOE~~	~~Rate~~
~~Jan-20~~	~~92.65%~~
~~Feb-20~~	~~92.20%~~
~~Mar-20~~	~~92.63%~~
~~Apr-20~~	~~92.10%~~
~~May-20~~	~~92.09%~~
~~Jun-20~~	~~92.31%~~
~~Jul-20~~	~~92.28%~~
~~Aug-20~~	~~91.94%~~
~~Sep-20~~	~~91.87%~~
~~Oct-20~~	~~89.27%~~
~~Nov-20~~	~~90.96%~~
~~Dec-20~~	~~92.04%~~
~~Jan-21~~	~~92.35%~~
~~Feb-21~~	~~92.00%~~
~~Mar-21~~	~~95.44%~~
~~Apr-21~~	~~95.88%~~



Tri-City Medical Center
Medication Error Reduction Plan: 20234 Plan & Goals

	January	February	March	April	May	June	July	August	September	October	November	December
% Removal												
Medication Scan Rate				75.7	78.3	79.5	80.9					
Target	95	95	95	95	95	95	95	95	95	95	95	95



Tri-City Medical Center
Medication Error Reduction Plan: 20231 Plan & Goals

~~This plan was approved by:~~

_____

~~Director of Pharmacy~~

_____

~~Director of Patient Care Services~~

_____

~~Director of Quality and CRS~~

_____

~~Director of Medical Staff Services~~

_____

~~Pharmacy & Therapeutics Committee Chairperson~~

_____

~~Medication Safety Committee~~

_____

~~Medical Executive Committee~~

~~**Date:**~~ _____

Tri-City Medical Center	~~Distribution:~~ Women and Newborn Services
PROCEDURE:	**HUMAN IMMONUDEFIECIENCY VIRUS (HIV) INTRAPARTUM, POSTPARTUM AND NEWBORN MANAGEMENT**
Purpose:	To provide nursing guidelines for the administration of antiretroviral medications to reduce the risk of mother to child transmission of HIV.
Supportive Data:	HIV may be transmitted from mother to infant during the perinatal period. The risk of infection for a neonate born from a HIV-positive mother has been reduced from 25% to less than 2% by the use of currently recommended prenatal antiretroviral therapy and obstetric interventions for women who are aware of HIV infection early in pregnancy. It has been found that HIV prophylaxis, even when begun during ~~labor can~~**labor can** reduce mother to child HIV transmission by 50%.
Equipment:	1. Alaris pump, (2) tubing sets, and (2) Intravenous (IV) -Lines 2. Normal Saline (NS) 500 mL for dedicated infusion line for antiretroviral medication. 3. Premixed antiretroviral medication per physician/Allied Health Professional (AHP) order

A. **POLICY:**

1. **All pregnant women should be told that HIV screening is recommended during pregnancy and that an HIV test is part of the routine panel of prenatal tests unless it is declined.**
   a. **If a woman declines HIV testing, the refusal needs to documented in the medical record.**
   b. **Repeat testing in the third trimester (preferably before 36 weeks of gestation) is recommended for women in areas with a high HIV prevalence, women known to be at high risk of acquiring HIV infection, and women who declined testing earlier in pregnancy.**
2. **Any woman whose HIV status is unknown during labor and delivery should be given a rapid HIV test, unless she declines, in order to provide an opportunity to begin prophylaxis treatment before delivery if necessary.**
   a. **Rapid HIV (ordered as HIV ½ Screen) testing should be available on a 24-hour basis, with results available within 60 minutes.**
      i. **A negative rapid HIV test result is definitive.**
         1) **Antiretroviral prophylaxis should be discontinued if the rapid HIV test is negative.**
      ii. **A positive rapid HIV test result is not definitive and must be confirmed with supplemental tests after delivery, antiretroviral prophylaxis should be continued.**

~~1. Every pregnant woman shall be tested for HIV during pregnancy unless she refuses testing.~~
~~a. If she declines a HIV test, this decision should be documented in her medical record.~~
~~2. Women admitted to the hospital without receiving prenatal care will be screened with a rapid HIV test (ordered as HIV 1/2 Screen) and will be counseled about reducing the risk of mother to infant HIV transmission if indicated.~~
~~3. Women who do not have a documented prenatal HIV result available on admission to Labor and Delivery (L&D) shall be offered a rapid HIV test (ordered as HIV 1/2 Screen).~~
~~4.~~ Women who are identified as being HIV positive during prenatal screening will be referred to the University of California San Diego (UCSD) Mother, Child and Adolescent HIV program. ~~as soon as possible for prenatal management.~~

3.

~~5.~~**4.** Patient's receiving antiretroviral prophylaxis, will need to have two IV lines. (One dedicated for antiretroviral medication and a second line for any labor management needs.

WNS Content ExpertReview/ ~~Revision Date~~	Department of OB/GYN	Department of Pediatrics	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
01/10, 03/16, 04/22	01/13, 08/16, 08/22	11/16, 11/22	02/17, 11/22	05/13, 03/17, 03/23	04/23	06/13, 04/17, n/a	06/13, 04/17

~~6.~~**5.** Infants born to HIV positive mothers at Tri City Medical Center shall receive treatment and screening ~~for mother to infant transmission~~ within 6- 12 hours ~~post delivery~~**of delivery**.
   a. **Providers**~~Physicians/Allied Healthcare Professionals (AHP)~~ caring for infants can consult a Neonatologist as needed.

~~7.~~**6.** Any patient with HIV findings shall be referred to social services for needs assessment, resource ~~referral, and~~**referral, and** discharge planning **assistance**~~anticipations~~.

B. **PROCEDURE**:

1. **In HIV positive women with a viral load of 1,000 copies/mL or less**~~Intrapartum treatment for positive HIV findings in labor and not receiving HIV treatment~~:
   a. Elective delivery before 40 0/7 weeks estimated gestational age (EGA) has not been shown to lower risks of mother-to-child transmission.
      i. Delivery timing and mode are the same as HIV-negative pregnant women even in the presence of prolonged rupture of membranes.
   ~~a.~~**b.** Discuss the use of antiretroviral prophylaxis to reduce HIV transmission during labor and prepare to administer the antiretroviral therapy a minimum of **three** ~~four~~ hours prior to delivery.
   ~~b. Method of delivery considerations include:~~
      ~~i. If the amniotic fluid membranes have not ruptured, the patient shall be offered a Cesarean Section (C-Section) as a method to reduce HIV transmission.~~
      ~~ii. If the amniotic fluid membranes have ruptured less than four hours, start antiretroviral medications and prepare the patient for C-Section per physician/AHP orders.~~
   ~~iii.~~**c.** ~~If the amniotic fluid membranes have ruptured more than four hours, give antiretroviral treatment and a~~**A**void performing any procedure that may increase the risk of fetal contact with maternal blood ~~or vaginal secretions such as~~:
      ~~1)~~**i.** Fetal scalp electrode placement
      ~~2)~~**ii.** Intrauterine pressure catheter placement
      iii. Episiotomy, if possible
      ~~3)~~ **Operative assisted birth**
      ~~4) Forceps or vacuum assisted birth~~
~~c. Obtain and verify order for antiretroviral treatment from physician/AHP STAT~~
   ~~d.~~**iv.** ~~Weigh the patient and convert lbs to kg 2.2lbs = 1kg)~~
   ~~e.~~**d.** ~~Begin a~~**A**dminister~~ration~~ **IV zidovudine** (~~of intravenous antiviral infusion of~~ **ZDV**)~~Zidovudine (Retrovir/ ZIDOVUDINE)~~ in a dedicated line, **ideally for a minimum of 3 hours prior to delivery.** ~~and via an infusion pump per physician/AHP order.~~
      i. An initial loading dose of 2mg/kg over one hour followed by a continuous infusion of 1 mg/kg/**hr** until delivery **to achieve adequate levels of the drug in maternal and fetal blood.** ~~may be initiated by physician/AHP.~~
   ~~i.~~**e.** **Continue other HIV medications as prescribed through the patients intrapartum and postpartum periods.**
      ~~ii. Zidovudine does not mix well with Lactated Ringers and other medications~~
      ~~iii. "Zidovudine infusion should be administered for 3 hours pre-delivery.~~
      ~~iv. Discontinue Zidovudine after delivery~~
   ~~f. No breastfeeding. Prepare and educate mother about the risk of mother to child transmission that occurs with breastfeeding.~~

~~2.~~ **In HIV positive women with a viral load greater than 1,000 copies/mL or whose levels are unknown**~~Intrapartum treatment for positive HIV findings in labor who are taking antiretroviral therapy~~

2. ~~Method of delivery considerations include~~:
   ~~a.~~ **Patients should be counseled regarding the potential benefit of and offered a scheduled pre-labor cesarean delivery at 38 0/7 weeks of EGA to reduce the risk of mother-to-child transmission.**

~~b. The delivery plan may be individualized according to HIV plasma viral load (RNA PCR) obtained in the third trimester or the most recent RNA PCR results. If the patient has a RNA PCR <1000 copies, a C-Section provides no additional reduction in HIV transmission.~~

a.

~~i.~~b. ~~Patients who have a HIV (RNA PCR) >1000 copies should be scheduled for an elective C-Section at 38 weeks gestation.~~ **Discuss the use of antiretroviral prophylaxis to reduce HIV transmission and prepare to administer the antiretroviral therapy a minimum of three hours prior to delivery.**

~~1) This patient should have IV Zidovudine administered 3 hours before surgery~~

~~2) If the patient presents in active labor and is progressing rapidly, provide intrapartum treatment and deliver vaginally.~~

~~3) If cervical dilation is minimal and a long labor anticipated, the physician/AHP may begin a loading dose of ZIDOVUDINE and proceed with C-Section to minimize duration of ROM and avoid vaginal delivery.~~

~~ii. Patients who are admitted in labor with intact membranes, may labor~~

~~c. ROM considerations:~~

~~i. ROM > 4 hours increased the risk of perinatal HIV transmission, avoid artificial rupture of membranes (AROM).~~

~~ii. ROM > 4 hours when patient has a viral load (HIV RNA PCR) <1000 copies is unlikely to increase the risk of mother to child HIV transmission~~

~~iii. ROM is not an indication for a C-Section when the HIV RNA PCR is <1000 copies.~~

~~d. If a preterm patient presents with SROM, request immediate Perinatology consult.~~

~~e. If labor progresses and membranes are intact, avoid performing any procedure that may increase risk of fetal contact with maternal blood or vaginal secretions such as:~~

~~i. AROM~~

~~ii. Fetal scalp electrode placement~~

~~iii. Intrauterine pressure catheter placement~~

~~iv. Episiotomy~~

~~v. Forceps or vacuum assisted birth~~

c. ~~Medication considerations should include a~~Administer~~ration~~ **IV** ~~of~~ **ZDV**~~ZIDOVUDINE~~ **in**~~via~~ a dedicated line, **ideally 3 hours prior to delivery**.

i. An initial loading dose of 2mg/kg over one hour followed by a continuous infusion of 1 mg/kg/hr until delivery to achieve adequate levels of the drug in maternal and fetal blood.

d. Management of women originally scheduled for cesarean delivery who present with rupture of membranes, should have care that is individualized at the time of presentation.

~~f.~~**i. Consultation with a Perinatologist is recommended.**

~~i. Once order received by physician/AHP, stat loading dose of ZIDOVUDINE, 2mg/kg IV over one hour, followed by a continuous infusion of 1mg/kg/ hour untill delivery.~~

~~ii. Ideally, ZIDOVUDINE infusion should be given for 3 hours pre-delivery~~

~~iii. Discontinue ZIDOVUDINE after delivery~~

e. Continue other HIV medications as prescribed through the patients intrapartum and postpartum periods.

3. Postpartum considerations:

a. Methergine should not be co-administered with drugs that are potent CYP3A4 enzyme inhibitors (eg, nevirapine, efavirenz, and etravirine), including protease inhibitors (PIs).

i. This may cause exaggerated vasoconstrictive responses.

ii. If no alternative medications are available and the need for the pharmacologic treatment outweighs the risks, methergine should be used in as low a dose and for as short a period as possible.

~~iv.~~**b. Additional uterotonic agents may be needed when antiretroviral drugs that are CYP3A4 inducers (nevirapine, efavirenz and etravirine) are used because of the potential for decreased methergine levels and inadequate treatment effect.**

~~1) Medications containing ZIDOVUDINE like (Combivir/ Trizivir) can be held until ZIDOVUDINE infusion is discontinued.~~

~~3.~~**4.** Care of the HIV exposed newborn:

a. The newborn will have blood and body fluids immediately cleaned off after delivery and be bathed as soon as possible after birth.

b. The newborn can be placed skin to skin with the mother. ~~The mother shall wear her bra to prevent the infant from latching and should NOT breastfeed.~~

c. The mother should be instructed to not breastfeed until confirmation of HIV status.

i. Once that status of an unknow mother is confirmed negative for HIV then she may start breastfeeding.

~~b.~~**d. Educate the mother regarding formula feeding, preparation and storage.**

~~c. Place bottle feeding only identification on newborn crib so medical team is aware of infant feeding method.~~

~~d. Evaluate the newborn for maternal co-infections. Review maternal history for syphilis, toxoplasmosis, Hepatitis B and C, Herpes, cytomegalis virus and tuberculosis and pursue newborn testing per physician/AHP order.~~

e. Obtain the following labs before the infant is discharged per ~~physician/AHP~~**provider** ~~order.~~**order.** (These do not have to be drawn prior to the start of **medications**~~Zidovudine~~) ~~Labs can be drawn with the routine California Newborn Screen and include~~:

i. CBC with differential ~~and platelets~~

ii. HIV DNA PCR

f. Complete a social worker consult to assist newborn with California Children Services (CCS) qualifying process for the CCS HIV screening program at UCSD

i. This program should cover costs of HIV testing, medications~~,~~ and follow-up.

5. Treatment considerations for the newborn:

a. Treatment should begin within 6-12 hours of delivery.

b. The medication(s), dose and duration administered should be based on gestational age and risk of newborn exposure.

i. The newborn provider should consult with a UCSD Pediatric HIV Specialist to discuss medication options.

c. If the mother or newborn rapid test return as negative then treatment should be stopped.

~~4.~~**d. If the newborn is unable to tolerate oral medication, the newborn will be admitted to the Neonatal Intensive Care Unit (NICU) for IV administration.**

~~a. All newborns born to HIV infected mothers should receive Zidovudine at gestational age appropriate doses for six weeks. This should be initiated as close to the time of birth as possible, preferably within 6-12 hours of delivery.~~

~~b. For newborns born to the HIV infected mother who has received standard combination antiretroviral therapy during pregnancy with consistent viral suppression and there are no concerns to maternal adherence, a 4 week dose of Zidovudine may be considered.~~

~~c. Dosing considerations are per physician/AHP order and if infant is unable to tolerate oral agents, the newborn will need NICU admission for IV administration.~~

~~5. Treatment considerations to reduce the risk of HIV infections in newborns at greatest risk, can include a combination antiretroviral prophylaxis.~~

~~a. Newborns at greatest risk include:~~

~~i. When there is no maternal antiretroviral antepartum or intrapartum treatment~~

~~ii. The mother only received intrapartum treatment~~
~~iii. The mother's last HIV RNA PCR is > 10,000 copies~~
~~iv. Suboptimal maternal viral suppression and known maternal ARV drug resistant virus~~
~~v. When the newborn rapid HIV test is positive~~

~~b. Newborn physician/AHP should consult with a USCD Pediatric HIV Specialist to discuss medication options.~~

~~6. Postpartum Treatment:~~

~~a. Administer antiretroviral medication as ordered by the physician/AHP.~~
~~i. In women who are receiving a cytochrome P(CYP) 3A4 "enzyme inhibitor" such as protease inhibitor, methergine should be used only if no alternative treatments for postpartum hemorrhage (PPH) are available and the need for medication treatment outweighs the risks.~~
~~1) If methergine is used it should be at the lowest effective dose for the shortest possible duration.~~
~~ii. In women who are receiving a CYP 3A4 "enzyme inducer" such as nevirapine, efavirenz or etravirine, additional uterotonics agents may be needed because of the potential for decreased methergine levels and inadequate treatment effect.~~

~~b. Physician/AHP may review treatment plan with UCSD Mother-Child, and Adolescent HIV team~~

~~C.~~ ~~DOCUMENTATION:~~

~~1. In addition to usual unit standard documentation:~~
~~a. Document antiretroviral treatment administered, including dose and time per unit~~
~~b. Document any side effects to medication~~
~~c. Document instruction and education given to patient in medical record~~

~~D.~~C. DISCHARGE:

1. Ensure prescription for home medication is written early in hospitalization to allow time for patient to fill prescription prior to discharge. Most outside pharmacies need >48 hours to obtain zidovudine and fill the prescription.
2. -Review and verify that the family has the medication and knows how to administer it to the infant prior to discharge home.
3. Ensure that mother and her infant have been referred to and have appointments with UCSD Mother, Child & Adolescent HIV Program ~~in 4-6 weeks~~ for follow-up as directed by the UCSD HIV program staff. Call 619-543-8089 for an appointment.
4. Families shall be referred to a primary care physician~~/AHP~~ for well infant care and should have a copy of the discharge summary prepared to give to the infant's physician~~/AHP~~.

~~E.~~D. REFERENCES:

1. American Academy of Pediatrics (AAP) and American College of Obstetricians and Gynecologists (ACOG). 201~~7~~2. *Guidelines for Perinatal Care* ***Eighth*** ~~*Seventh*~~ *Edition.* Washington, DC
2. **Chadwick EG, AAP COMMITTEE ON PEDIATRIC AIDS, Evaluation and Management of the Infant Exposed to HIV in the United States. *Pediatrics*, 2020;146(5): e2020029058**
3. **Labor and delivery management of women with human immunodeficiency virus infection. ACOG Committee Opinion No. 751. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132: e131-37.**
4. **Miyashita Ochoa, A., Cordero, L., Pulsipher, C., & Paneda, C.P. (2019) California HIV Laws. http://www.chprc.org/california-hiv-laws/**
5. **National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1-888-448-8765**
6. **Panel on Antiretroviral Management of Newborns with Perinatal HIV Exposure or HIV Infection. Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection.**

Available at https//clinicalinfo.hiv.gov/en/guidelines/pediatric-arv. Accessed (April 26, 2022).

~~1.~~**7. Prenatal and perinatal human immunodeficiency virus testing. ACOG Committee Opinion No. 752. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132: e138-42**

~~2. National Institutes of Health (Aug 6, 2015) Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States. Available online at http//aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf~~

~~3. AAP Policy Statement: Evaluation and Management of the Infant exposed to HIV-1 in the United States Pediatrics 2012; 130-64: http//pediatrics.aappublications.org/content/130/6/64.full.pdf+html~~

~~4. AAP Policy Statement: Infant Feeding and Transmission of HIV in the United States. Committee on Pediatric AIDS Pediatrics 2013; 131:391. http//pediatrics.aappublications.org/content/131/2391.full.pdf+html~~

~~5. ACOG Committee Opinion: Prenatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations includes College recommendations for prenatal testing, rapid testing in labor and delivery and repeat testing in the third trimester. # 418 (9/08, Reaffirmed 2011),.~~

~~6. National HIV/AIDS Perinatal HIV Consultation and Referral Service 24 hr Hotline: 1 888 448 8765~~

Tri-City Medical Center	~~Distribution:~~ Women and Newborn Services (WNS)
PROCEDURE:	MISOPROSTOL (CYTOTEC)
Purpose:	Misoprostol may be used for ripening of the cervix, induction of labor, and postpartum hemorrhage. Cervical ripening may be used when induction of labor is indicated and the cervix is unfavorable. Misoprostol can be used in the third stage of labor to treat severe postpartum hemorrhage secondary to uterine atony.
Supportive Data:	Cervical ripening is considered after evaluation of maternal-fetal status, cervical status, gestational age and other relevant factors. Misoprostol is a PGE_1 analog (synthetic) that has been shown to be safe and effective for cervical ripening. Misoprostol is indicated for ripening of the cervix and/or induction of labor in pregnant women at or near term with a live fetus. It is also indicated for cervical ripening and/or induction of labor for a non-viable fetal demise. ~~Insertion of Misoprostol is appropriate with ruptured membranes.~~
Equipment:	1. Sterile examination glove 2. Ordered dose of misoprostol 3. Sterile lubricant

A. **POLICY:**

~~1. The initial dosage of misoprostol is administered by the physician/Allied Health Provider (AHP) when placed vaginally.~~

~~2.~~**1.** ~~Oral a~~Administration may be given ~~initially~~ by ~~a~~the Registered Nurse (RN), after a vaginal examination is done to confirm fetal position (presentation), station and cervical status (dilation, effacement, consistency and position).

~~3.~~**2.** If any examination of the cervical status is in question, it is the **providers**~~physician/AHP's~~ responsibility to verify the assessment prior to the induction~~/augmentation~~.

B. **INDICATIONS/ELIGIBILITY CRITERIA FOR USE (Includes but are not limited to the following):**

1. Singleton pregnancy
2. Normal fetal lie and documented presentation
3. Unfavorable cervix with indications for induction **(Bishop Score less than 6)**
4. Obstetrical or medical indication for induction of labor
5. Nulliparous OR Multiparous with < 7 term pregnancies
6. Category I fetal monitoring tracing **with fewer than 12 uterine contractions in an hour**
7. Premature rupture of membranes
8. Fetal Demise

C. **GENERAL PRECAUTIONS**:

1. Non-vertex presentation
2. History of:
   a. Hypertonic uterus
   b. Glaucoma
   c. Childhood asthma, even though no adult episodes
   d. Cardiac Disease
   e. Pulmonary Disease
   f. Renal Disease
   g. Hepatic Disease
3. Oligohydramnios– ≤ 5.0 cm
4. Category II fetal heart rate tracing- requires **a provider**~~physician/AHP~~ evaluation with documentation ~~of the order~~ to continue with the procedure
5. Preeclampsia

WNS Content ExpertReview/Revision Date	Department of OB/GYN	Pharmacy & Therapeutics Committee	Medical Executive Committee	Administration	Professional Affairs Committee	Board of Directors Approval
03/03, 02/06; 03/09, 12/12, 05/16; **02/20**	01/13, 08/16, **08/22, 11/22**	02/17, **01/23**	05/13, 03/17, 03/23	04/23	06/13, 04/17, n/a	06/13. 04/17

D. **CONTRAINDICATIONS (include but are not limited to the following):**

1. Previous Cesarean Section or Uterine Surgery
2. Patients with known hypersensitivity to prostaglandins
3. Category II Fetal Monitoring (FM) tracing, progressing to a Category III
~~3.~~**4.** ~~OR~~ Category III FM strip tracing~~.~~
~~4.~~**5.** Breech presentation or transverse fetal lie
~~5.~~**6.** Placenta previa/ vasa previa
~~6.~~**7.** Simultaneous use of oxytocin
~~7.~~**8.** Maternal fever (≥ 101˚ F)
~~8.~~**9.** Active herpes
~~9.~~**10.** Multiparous, **≥7** ~~> 6~~ previous pregnancies at viability

E. **PROCEDURE:** ~~**for CERVICAL RIPENING/ INDUCTION OF LABOR:**~~

1. Admit patient to Labor and Delivery and review induction plan with the patient/ family.
~~2. Confirm informed consent was provided by the physician/AHP and consent signed by the patient.~~
~~3.~~**2.** Obtain baseline assessment of maternal vital signs
~~4.~~**3.** Obtain a ~~20 minute~~**20-minute** Fetal Monitoring **Tracing**~~Strip~~, per department Fetal Heart Rate Surveillance Policy, to determine fetal well-being and uterine activity.
~~5.~~**4.** **Place intravenous (IV) catheter per provider order.** ~~Establish IV access with a 16/18 g IV catheter or place a saline lock per physician/AHP order.~~
~~6.~~**5.** Have the patient void
~~7.~~**6.** A cervical exam should be completed by the RN or ~~physician/AHP~~**provider** (Clinical Nurse Midwife (CNM) or Obstetrician) prior to administering Misoprostol to obtain a baseline **Bishop**~~BISHOPS~~ Score.
   a. An exam should also be performed prior to giving subsequent doses. Misoprostol should be discontinued once a Bishop score of greater than 8 has been achieved or a cervical exam of 80% effacement and 3 cm dilation, the patient enters active labor or the FHR demonstrates a Category II progressing to a Category III tracing or Category III tracing.

~~Oral / Buccal Administration:~~

~~Usual dosing schedule is 50 micrograms (mcg) by mouth every four hours, per physician/AHP order. DO NOT exceed a total of 300 mcg of oral Misoprostol or six doses.~~

~~**Dose should be prepared by pharmacy to ensure a consistent dose of 50mcg**~~

~~Vaginal Administration:~~

~~**Initial** Iintra-vaginal misoprostol shall be inserted by a physician/AHP initially; subsequent doses may be inserted by the RN.~~

~~Usual dosing schedule is 25 mcg intra-vaginally initially; followed by 25- 50 mcg every four hours intra-vaginally, per physician/AHP order.~~

~~**Dose should be prepared by pharmacy to ensure a consistent dose of 25mcg**~~

~~Avoid the use of lubricating gel (only a small amount or use water if necessary) and place Misoprostol tablet high into the posterior vaginal fornix.~~

~~Maintain lateral supine tilt position for 60~~**30** ~~minutes after insertion of Misoprostol.~~

7. Vital Signs: Blood Pressure, pulse, **and** respiratory rate ~~and temperature~~ are taken every 30 minutes times two after each dose, then every four hours if stable and not in active labor. Once active labor is established, follow vital sign guidelines for intrapartum management or if an epidural is placed per epidural procedure.
8. **Temperature to be obtained upon admission and every four hours.**

~~b.~~**a. Increase frequency to every 2 hours if rupture of membranes occurs.**

~~8.~~**9.** ~~Assess and d~~**Document fetal heart rate** (FHR) **assessment** and uterine activity via continuous ~~external~~ electronic fetal monitoring ~~**for two hours**~~ after ~~insertion~~ **administration** of Misoprostol

every 30 minutes for 2 hours then every 1 hour until next dose or until active labor starts.~~and per physician/AHP order.~~

a. Actions for uterine tachysystole:

i. Tachysystole is defined as > 5 contractions in 10 minutes, averaged over 30 minutes.

ii. If tachysystole occurs and FHR tracing indicates Category II, progressing to Category III ~~or III finding~~, notify the **provider and perform the following interventions.**~~physician/AHP and institute measures to remove the Misoprostol tablet and improve fetal oxygenation per physician/AHP order(s):~~

1) **Maternal reposition**~~Position laterally~~
2) Provide O_2 ~~8~~-10 liters/minute via non-rebreather mask**, for a limited time**
3) Hydrate with ~~400~~-500 mL bolus of non-dextrose solution
4) Administer 0.25 mg terbutaline subcutaneously**, if other interventions do not resolve the Category III tracing**

iii. Evaluate maternal/fetal responses to interventions and prepare for emergency Cesarean Section if indicated

~~iv. Patient assessment must be performed by the physician/AHP prior to resuming misoprostol induction.~~

~~v.~~**iv.** Allow patient to rest at minimum 4 hours prior to resumption of misoprostol induction (normal dosing interval)

10. Maintain a lateral or tilt position for 30 minutes after vaginal insertion of misoprostol.

~~9.~~ Reassessment of the clinical situation by the **provider** ~~physician/AHP~~ is necessary after 12 hours ~~or two RN administered doses~~. ~~Further administration requires a note by the physician/AHP.~~

11.

12. Oxytocin (Pitocin) may be initiated no sooner than four (4) hours after the last Misoprostol dose ~~per physician/AHP order~~.

F. INDUCTION OF LABOR/CERVICAL RIPENING:

1. **Oral/Buccal Administration:**
   - a. **Usual dosing schedule is 25 or 50 micrograms (mcg) by mouth every four hours. DO NOT exceed a total of 300 mcg of oral Misoprostol.**
   - b. **Dose should be prepared by pharmacy to ensure a consistent dose of 25 or 50mcg**
2. **Vaginal Administration:**
   - a. **Usual dosing schedule is 25 mcg intra-vaginally initially; followed by 25 or 50 mcg every four hours intra-vaginally.**
   - b. **Dose should be prepared by pharmacy to ensure a consistent dose of 25 or 50mcg**
   - c. **Avoid the use of lubricating gel (only a small amount or use water if necessary) and place Misoprostol tablet high into the posterior vaginal fornix.**

~~10.~~

~~F.~~G. INDUCTION OF INTRAUTERINE FETAL DEMISE~~MISOPROSTOL USE FOR (IUFD) INDUCTION/ PREGNANCY TERMINIATION:~~

1. For Estimated Gestational Ages (EGA) less than ~~28~~2 weeks:
   - ~~a. Apply tocodynamometer (toco) to assess uterine activity, per physician/AHP order.~~
   - ~~b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol.~~
   - ~~c.~~ Administer 400 micrograms (mcg) vaginally every three to six hours for a maximum of FIVE doses or 600 mcg vaginally every 12 hours per physician/AHP order. (Either protocol may be repeated after 24 hours if induction is not complete)
   - ~~d.~~a. ~~Women with a prior Cesarean Section who undergo labor induction for miscarriage/ fetal demise with prostaglandin (including misoprostol) have been shown to have outcomes~~

~~that are similar to those women with an unscarred uterus so its use can be considered a reasonable option in this gestation.~~

~~2. For EGA BETWEEN 23-26 weeks:~~
- ~~a. Apply toco to assess uterine activity, per physician/AHP order~~
- ~~b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol~~
- ~~c. Since the potency of Misoprostol varies with gestational age the following dosage regime may be considered: 100 mcg vaginally every 6 hours per physician/AHP order.~~
- ~~d. Women with a prior cesarean section who undergo labor induction for miscarriage/ fetal demise with prostaglandin (including misoprostol) have been shown to have outcomes that are similar to those women with an unscarred uterus so its use can be considered a reasonable option for use in this gestation.~~

~~3.~~**2.** For EGA of~~GREATER THAN~~ 28~~7~~ weeks **or greater**:
- ~~a. Apply the toco to assess uterine activity, per physician/AHP order~~
- ~~b. Perform vaginal examination for cervical assessment (effacement and dilatation) and fetal station evaluation prior to insertion of each dose of misoprostol.~~
- ~~c.~~a. **Induction should be managed according to Induction of Labor/Cervical Ripening as noted above in section F.**~~Administer 50 mcg Misoprostol, vaginally every FOUR hours for a total of SIX doses per physician/AHP order.~~
- ~~d. For patients with a prior cesarean scar who undergo labor induction for fetal demise greater than 27 weeks EGA, cervical ripening with a "transcervical Foley catheter" has been associated with uterine rupture rates comparable with spontaneous labor and should be considered a helpful adjunct in patients with an unfavorable cervical examination.~~

~~G. USE IN POSTPARTUM HEMORRHAGE (PPH):~~

~~1. Administer Misoprostol per physician/AHP's order. Usual range is 800- 1000 mcg X1 rectally (PR)~~

~~2. Monitor vital signs q 15 min x one hour or until stable per physician/AHP order.~~

~~3. Reassessment of the clinical situation by the physician/AHP is necessary after 12-24 hours or prn. Further administration requires a note by the physician/AHP.~~

H. DOCUMENTATION:

1. Document patient assessment, misoprostol insertion, fetal monitoring, nursing actions and interventions, and maternal/fetal responses in the ~~patient~~**patient's electronic health record (EHR)** ~~record as needed~~.

I. REFERENCE(S):

1. AAP & ACOG. (2014). Guidelines for Perinatal Care, 7th Edition
2. American College of Obstetrics & Gynecology (2009). Induction of Labor. ACOG Practice Bulletin, No. 107.
3. ~~Wildschut, H., Both, M., Medema, S., et al. Medical methods for mid-trimester termination of pregnancy. Cochrane Data Base System Rev 2011; CD005216.~~
4. ~~Gomez-Ponce de Leon, R., Wing, D. A., Fiala, Misoprostol for termination of pregnancy with Intrauterine Fetal demise in second and theird trimester of pregnancy – a systematic review. (2009) Contraception 79, 259-271.~~
5. Simpson, K.R. & Creehan, P.A. (201**420**). Perinatal Nursing, (4rd **5th** Edition), Philadelphia, PA: Lippincott, Wilkins & Williams.

~~Carlan, S.J., Blust, D., and O' Brien, W. F. (2002) Buccal verses instravaginal misoprostol administration for cervical ripening. American Journal of Obstetrics and Gynecology, 186: 229-233.~~

6.3. ~~**Martin, E.J (2016). Intrapartum Management Modules (5th Edition). Philadelphia, PA; Lippincott, Wilikns & William s.**~~

Tri-City Medical Center
Oceanside, California

WOMEN AND NEWBORN SERVICES (WNS)

ISSUE DATE: 07/14

SUBJECT: Umbilical Cord Blood Banking: Private Collection

REVISION DATE~~(S)~~: 04/17

Department Approval:	~~01/16~~04/20
Department of OB/GYN Approval:	02/17
Department of Pediatrics Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	~~03/17~~03/23
Administration Approval:	04/23
Professional Affairs Committee Approval:	~~04/17~~ n/a
Board of Directors Approval:	04/17

~~A.~~ POLICY~~URPOSE~~:

~~1.~~A. ~~To provide guidelines on Umbilical Cord Blood Banking~~

~~2.~~1. Patients who report to Labor and Delivery with the intent to have Umbilical Cord Blood Banking shall be supported by the hospital staff.

2. The collection process should not compromise obstetric or neonatal care or alter routine practice of delayed umbilical cord clamping with the rare exception of medical indications for directed donation.

a. It is important to inform the patient if a medical condition of the woman or neonate prevents adequate umbilical cord blood collection.

3. Umbilical Cord Blood Collection is not part of routine obstetric care.

~~4. Once considered a waste product that was discarded with the placenta, umbilical cord blood is now known to contain potentially life-saving hematopoietic stem cells. When used in hematopoietic stem cell transplantation (HSCT), umbilical cord blood (UCB) offers several distinct advantages over bone marrow or peripheral stem cells, which may be the reason the use of UBC for HSCT has grown exponentially.~~

~~5. According to the American Society for Blood and Marrow Transplantation's Position Statement in 2008, expectant parents are encouraged to donate their newborn's UBC for public banking when that option is available. Donation makes the cord blood, which is rich in hematopoietic stem cells available for life-saving treatments for others in need when there is a suitable match.~~

~~According to the American College of Obstetricians and Gynecologists Committee Opinion in March 2019 and the American Academy of Pediatrics (AAP) Policy Statement in Pediatrics 2017; "Cord Blood Banking for Potential Future Transplantation" February 2008, if a patient request information on UCB banking, balanced and accurate information regarding the advantages and disadvantages of public versus private UCB banking should be provided. Of these the AAP and HealthyChildren.org list reasons for why public cord banking is preferred to include:~~

- ~~The frequency of use of the public cord blood banking is much higher than the private banking~~
- ~~The quality of the accrediting institutions for the public cord banking usually is upheld versus the other private banking companies~~
- ~~The public cord blood banking is free where the private cord blood banking usually has a large up-front fee, and then monthly/annual fee of holding the cord blood in case anyone in the family needs it~~

~~6. Ethically, the public cord blood banking can be for anyone who needs it, and the private cord blood banking is only for the one family that drastically limits the use and possibility of it actually being utilized.~~

~~7. In lieu of these considerations, patients who report to Labor and Delivery with the intent to have UCB collected for private banking (have brought a collection kit), shall be supported by the hospital staff, when possible. The collection process shall not impede routine practice for the timing of umbilical cord clamping and specimen may be uncollectable if unexpected medical conditions arise.~~

B. PROCEDURE:

1. Prior to drawing laboratory samples, the registered nurse (RN) is to ask the patient if they are using Umbilical Cord Blood Banking.
2. The patient is to provide a kit that is approved by the Food and Drug Administration (FDA)
3. Have the patient sign the Umbilical Cord Blood Sample Collection Consent
4. The RN will open the kit and follow the collection directions provided
   a. Since the collection is an elective request, staff will do what they can to facilitate the collection process, but will not compromise the safety of the patient or newborn
5. After delivery and all specimens are collected and labeled the RN will return the completed kit to the patient.
   ~~B.~~a. The patient is now responsible for the specimen transport to the appropriate agency

~~See below for Checklist~~

~~1. Upon admission to the unit and before the birth of her baby, the patient is required to have a cord blood collection kit from a resource organization that is Food and Drug Administration (FDA) registered, which is given to a staff member to review.~~

~~2. Once received, the staff member shall notify the patient's provider and give the patient the hospital's checklist and consent form to sign (enclosure 1).~~

~~3. The nurse and/or provider shall open the cord blood collection kit before delivery to review the collection requirements and obtain the required sample collection, per collection kit instruction, when indicated.~~

~~a. Since the collection of UBCB for HSCT is an elective request, the hospital staff will do what it can to facilitate this collection process, but will NOT compromise the safety of the patient or newborn.~~

~~b. There may also be instances where the unit census, acuity level, and staffing availability prohibits accommodating the request to obtain a specimen.~~

~~4. Once the samples are obtained and labeled, these will be returned to the patient who then becomes responsible for the specimens transport to an appropriate agency.~~

~~5. Staff members can assist the patient with these arrangements by allowing her to utilize the phone to make any necessary transport arrangements.~~

~~CHECKLIST:~~

~~Unopened, FDA Registered, Umbilical Collection Kit brought by patient~~

~~A signed UCB Sample Collection Consent Form (TCMC form 7400-1072)~~

~~Samples are obtained, labeled, and returned to the patient for inclusion in the kit~~

~~6. Pick up arrangements for the kit is made by the patient and family after the cord blood is successfully collected.~~

C. FORM(S):

1. Umbilical Cord Blood Sample Collection Consent **Form 7400-1072** ~~Sample~~

D. REFERENCE(S):

~~D.~~1. Umbilical cord blood banking. ACOG Committee Opinion No. 771. American College of Obstetricians and Gynecologists. Obstet Gynecol 2019;133:e249-53.

~~1. American Society for Blood and Marrow Transplantation (ASBMT) Board of Directors. Position Statement 2008. Collection and Preservation of Cord Blood for Personal Use, Biology of Blood and Marrow Transplantation 14:364.~~

~~American College of Obstetricians and Gynecologists (ACOG) Committee Opinion #771399~~ **March 2019, Vol. 133, No. 3.** ~~(02/2008). Umbilical Cord Blood Banking.~~

~~**American Academy of Pediatrics Policy Statement. October 30, 2017. Cord Blood Banking for Future Transplantation.**~~

~~2. HealthyChildren.org~~

Umbilical Cord Blood Sample Collection Consent – Sample

Women and Children's Services Department

1. I _____ request the assistance of Tri City Medical Center's
(Patient Name)
staff to obtain an umbilical cord blood (UCB) sample after the birth of my child for private storage with
_____.
(Name of Company)

2. I have discussed and researched the advantages and disadvantages of UCB banking during my prenatal period with my provider and have brought a Cord Blood Collection Kit, with a Company that is registered with the Food and Drug Administration (FDA), with me for the staff to utilize.

3. I understand that although I have brought the collection kit for use, the staff may not be able to obtain the sample due to other medical priorities. The hospital staff, as a courtesy, will do what it can to support this request, when possible.

4. I understand that blood samples should be handled as if potentially infectious and I will not tamper with the samples in the kit once the staff returns them to me.

5. I agree to send the collected samples directly to the private UCB banking company for proper processing and storage. These samples will not be sold or distributed to third parties.

6. To the extent allowed by law, I further agree to indemnify and hold harmless Tri City Medical Center from any claims, costs, damages or expenses resulting from any collection complications, damages or loss that may arise during the specimen collection or transport processes.

By my signature below, I agree to the statements set above:

_____
Signature Date / Time

CHECKLIST

- ☐ Unopened, FDA registered, Umbilical Cord Collection Kit brought by patient
- ☐ A signed UCB Sample Collection Consent Form (current form)
- ☐ Samples are obtained, labeled, and returned to the patient for inclusion in the Kit
- ☐ Pick up arrangements for the Kit is made by the patient/family. Plan includes:

_____
Expected Date / Time By what Company / Service

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

7400-1072
(Rev. 12/13)

UMBILICAL CORD BLOOD
SAMPLE COLLECTION CONSENT

White - Chart Yellow - Patient

Affix Patient Label

Tri-City Healthc~~a~~re District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Acuity Class System**

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. **PURPOSE:**

1. The acuity classification system has been designed as a component of the productivity standard that was established to safely and effectively manage and staff the multi-service outpatient center. In addition, it also plays an important role in the plan of care for each patient for the following reasons:
   a. It defines the extent of care the patient requires with each visit.
   b. It clarifies and validates the resources/time needed for the patient's care for each visit, as well as the time needed to support the requirements for the continuum of care activities.

B. **POLICY:**

1. All patients seen in the Center will be assessed for acuity.
2. As the needs/resources/time may vary from visit-to-visit, the assessment is performed at each encounter for each patient.
3. The **Lead Nurse (LN)**~~clinician assigned to the patient~~ will perform the acuity assessment at ~~the conclusion of~~ each visit.
4. The~~-~~ **Lead Nurse**~~clinician~~ will determine the level of acuity using the hospital approved acuity system.
5. The system is comprised of:
   a. Scoring Grid
   b. Tabulation Tool
   c. Acuity Level

C. **PROCEDURE:**

1. The indicators used to assess acuity are defined as follows:
   a. Mobility – indicates the aid/support the patient requires **with clothing assistive devices and** when moving from one area to another and on/off the treatment chair/bed.
   b. Complexity of prep for treatment/exam - e.g. the number of wounds to be assessed, number and complexity of dressing to be removed, preparation for Hyperbaric Oxygen Therapy (HBOT), or any other preparation activities aside from routine activity such as vital signs.
   c. Complexity of aftercare - e.g. numbers and types of dressings, wraps, etc.
   d. Teaching required during visit - to include the need for an interpreter.
   e. **Assessment Continum of Care**~~Extent of the necessary assessment and/or follow-up needed~~ - includes time necessary for planning care taking into consideration the continuum of care.

2. The following steps are taken to determine the patient acuity:

Step 1: The Scoring Grid is used to assign acuity points to each indicator.

PATIENT ACUITY SCORING GRID					
ACUITY POINTS	**MOBILITY**	**COMPLEXITY OF PREP**	**COMPLEXITY OF AFTERCARE**	**TEACHING REQUIRED**	**ASSESSMENT/ CONTINUUM OF CARE**
0	Independent; no assistance required	No prep required other than routine, such as vital signs~~, etc.~~	No aftercare required	No teaching necessary	**Not applicable** All patients require assessment with each encounter
1	Minimal assistance for mobility (guided by 1 person)	Minimal prep required such as removal of simple dressing, 1-2 wounds to assess/ prepare~~, etc.~~	Minimal aftercare required such as simple dressing	Reinforcement of a few simple topics	Simple assessment and or follow-up required
2	Moderate assistance for mobility	Moderate prep time required, such as removal of several dressings, removal of single-layer compression wraps, **2-~~3-6~~** wounds to assess, **new problem, glucose testing,** cultures~~, etc.~~	Aftercare is moderately complicated, such as uncomplicated multiple dressings, single-layer compression wrap	Requires reinforcement of several issues/ problems and/or 1 or 2 additional topics	More extensive assessment and follow-up with several issues/ problems required
3	Maximal assistance required (2 or more patient lift)	Time-consuming or complicated prep such as HBOT, removal of multiple or complicated dressings, removal of multiple-layer compression wraps, **new visit**, 4 or more wounds, prep for Biograft, ABI/TCOM, ~~etc...~~	Time-consuming and/or complicated such as multiple complicated dressings, multi-layer compression wrap, wound **vac dressing, application** of Biograft.	Learning deficit identified requiring constant reinforcement and follow-up or several new issues/problems discussed and/or lengthy/time-consuming discussion or interpreter required	Comprehensive assessment and planning required

Step 2: The appropriate points from the Scoring Grid are applied to each indicator in the Tabulation Tool.

PATIENT ACUITY TABULATION TOOL				
MOBILITY	**COMPLEXITY OF PREP**	**COMPLEXITY OF AFTERCARE**	**TEACHING REQUIRED**	**ASSESSMENT/ CONTINUUM OF CARE**

TOTAL POINTS

Step 3: The total is then computed to determine the final acuity level as defined in the Acuity Level table below:

ACUITY LEVELS	
POINT RANGE	**ACUITY LEVEL**
0-2	I
3-5	II
6-9	III
10-12	IV
13-15	V

Step 4: Acuity levels are recorded in the database by the clinical manager for periodic and annual review and subsequently utilized for staffing and productivity standard determination.

Note: The level of acuity should directly correspond to the time spent caring for **each** patient.

3. Levels of care are delineated as follows:
   a. Level I (0-2): The patient requires little or no assistance or care. The patient presents with a minor affliction, few symptoms, and is independently mobile. Very little time *(less than 11 minutes),* is required for this type of visit.
   b. Level II (3-5): This type of visit requires *20 minutes or less* to evaluate the patient and provide any necessary care. The patient may present for a second opinion/consult or may be nearing the end of their treatment period and may require minimal assistance with mobility and very little or no planning, teaching, and follow-up.
   c. Level III (6-9): A moderate amount of time is required for this type of patient visit *(21 to 30 minutes)*. They may require more complex type of care, which may include managing uncomplicated and/or multiple dressings and wound assessments. Preparation for exam and aftercare may be moderately time consuming and the patient may require minimal to moderate assistance with mobility. An interpreter may be necessary to discuss 1 or 2 topics. Planning, follow-up, and time needed for support for the continuum of care is moderately time-consuming.
   d. Level IV (10-12): This patient requires a significant amount of time per visit *(31-45 minutes)*. They may have more complex issues to be addressed or increased care time including multiple and/or complex dressings, multiple compression wraps, HBOT, and prolonged aftercare or patient may require moderate to significant assistance with mobility. An interpreter may be used to discuss several topics, adding more time to effectively care for the patient. Also, the time dedicated to the continuum of care is significant.
   e. Level V (13-15): This typifies the very complex case, requiring the maximum amount of time for the patient's visit *(>45 minutes)* to address the care, evaluation, and follow-up. This may include very complex and time-consuming care including multiple complex dressings, multiple compression wraps, HBOT consultation, comprehensive H&P and assessment. The patient may require full assistance for mobility requiring 2 or more staff members to transfer from one area to another. A severe learning deficit is identified requiring additional time to address the education needs of the patient, and a significant amount of time may be needed for planning and addressing the continuum of care.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

RETIRE – Document now housed in WE & Cerner

ISSUE DATE: 06/07

SUBJECT: Chart Order

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

~~A. PURPOSE~~

~~1. A systematic approach to patient record keeping is necessary:~~
- ~~a. To provide consistency and orderliness~~
- ~~b. For ease of use for all staff members~~

~~B. POLICY~~

~~1. A medical record will be maintained on all patients treated at the Center.~~
~~2. Documents will be maintained in reverse chronological order in the appropriate section of the chart as designated below.~~

~~C. PROCEDURE~~

~~The order and the contents of the patient record will include, but will not be limited to:~~

~~1. Front of Chart~~
- ~~Admission face sheet~~
- ~~Managed Care/ Workers Comp auth~~
- ~~Managed Care/ Workers Comp auth~~
- ~~Copy of insurance cards~~
- ~~Copy of patient information/Intake sheet~~

~~2. Case Management~~
- ~~Medications Record~~

~~3. MD Orders~~
- ~~Physician orders~~
- ~~Patient instruction sheet~~

~~4. Progress Notes~~
- ~~Wound documentation/photograph sheet~~
- ~~Progress notes~~
- ~~Initial H&P~~

~~5. Clinician Notes~~
~~6. Labs~~
~~7. Vascular/Radiology~~
~~8. H&P~~
- ~~Admission assessment, Parts I & II~~
- ~~H&P from outside source~~

~~9. Consults/OP Reports~~
~~10. Miscellaneous/Prescriptions~~
~~11. Home Health~~
~~12. Consents~~
- ~~Outpatient clinic consent for treatment/photography~~
- ~~Conditions of Admission~~
- ~~Insurance and billing consent~~

~~13. Financial~~
- ~~Superbills~~

~~14. Hyperbaric Forms~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Collaboration

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. To outline the steps taken at the Clinic to provide for individualized patient care while still allowing patients to maintain their primary care physician/patient relationship.

B. POLICY:

1. All patients will be given an individualized plan of care that will be coordinated with the patient's primary care physician, whenever possible.
2. The clinic physician's **progress note will be faxed to the referring physician and Primary Care Physician (PCP)** ~~will communicate with the primary care physician (as well as any other physicians/medical agents/agencies involved with patient care)~~ after the initial visit, and periodically as indicated.
3. Confidentiality of patient medical information will be maintained according to State and Federal requirements.

C. PROCEDURE:

1. During the initial **intake** ~~assessment~~ process, the patient will be asked to provide names, addresses and telephone umbers of physicians currently involved in their care.
2. This information will be recorded in designated areas in the patient record.
3. ~~The clinic physician will communicate with the primary physician, ideally after the first visit, to outline the plan of care.~~
4. ~~Documentation of the communication will be addressed in the physician's notes. A copy of all correspondence will be maintained in the medical record.~~
5. ~~5.~~3. Physician progress notes, clinic H&P, pictures, etc. from the clinic record may be sent/faxed at the request of the primary care physician, after applicable signed consent from the patient, and following HIPAA guidelines/hospital policy.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Data Management

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. Effective use and management of patient data is crucial to the service appraisal process and enhancement efforts. Properly managed data can provide vital information about:
   a. The population served
   b. Patient progress/outcomes
   c. Resources utilized
   d. Resources needed
   e. Compliance with plan of care
   f. Efficacy of the treatment plan

B. POLICY:

1. It is the intent of the clinic to collect and properly manage data to benefit the patients being treated at the Center.
2. Patient information will be handled following all applicable confidentiality regulations and hospital policies.

C. PROCEDURE:

1. The patient information to be included in the data entry, but is not limited to, is:
   a. Demographics
   b. Referral source
   c. Clinic physician
   d. Primary care physician
   e. Diagnoses
   f. Diabetes information
   g. Wound assessment information
   h. Wound classification
   i. Pictures
   j. Procedures performed
   k. Insurance information
   l. Acuity of the patient
   m. Patient goals
2. Reports that may be generated by the database may include:
   a. Wound healing progress
   b. Outcome reports
   c. Utilization reports
   d. Revenue reports

e. Marketing reports

3. Data will be reviewed and analyzed by a qualified person(s) and reported to pertinent hospital committees and persons.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Discharge Instructions

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. To ensure that all patients discharged from the Center's program will have adequate instruction regarding wound prevention and/or follow-up care.

B. POLICY:

1. Patients receiving treatment at the Center will be adequately and appropriately instructed about follow-up care.
2. For continuity of care, home health agencies, case managers, and caregivers involved in the patient's care will be informed of discharge instructions.
3. At the time of discharge from the Center, Nursing will review with the patient the following as it applies:
   a. General diabetic care
   b. Return to primary physician for follow-up care
   c. Skin care
   d. Offloading/non-weight bearing
   e. Edema control measures
   f. Nutrition/dietary restrictions
   g. Activity level
   h. Continued wound care
   i. Other instruction as appropriate
4. Instruction will be documented on the approved *"Discharge Instruction"* form.
5. ~~The patient will sign the discharge form acknowledging receipt and understanding of instructions.~~
6. ~~The nurse will sign and date as required.~~
7. ~~7.~~5. The patient will be given a copy of the discharge sheet.
8. ~~8.~~6. Other healthcare providers will be provided with discharge instructions as appropriate.
9. ~~9.~~7. The discharge form or letter will remain a permanent part of the medical record.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Disseminating Medical Information

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. Patient privacy and confidentiality regulations prohibit the arbitrary sharing of medical information to protect the patient from indiscriminate use. This policy outlines the procedure the Center follows when disseminating patient information.

B. POLICY:

1. All applicable state and federal regulations and hospital policies will be adhered to when disseminating or requesting patient confidential medical data.
2. Patient information may be obtained without the patient's consent in accordance with court order, subpoena or statute.
3. The patient will be informed of the need for, or the use of, the information being requested or disseminated.
4. The patient will sign the "Authorization for Use or Disclosure of ~~Medical~~ **Health** Information" form ~~prior to~~ requesting information from another facility or releasing information, according to hospital policy **if necessary.**
5. To the extent possible, medical information will be guarded against loss, destruction, tampering, and unauthorized access.

C. PROCEDURE:

1. The physician or his/her designee will explain to the patient the need for information being requested.
2. Patients will be informed that orders will be faxed to appropriate caregivers, home health agencies, etc. (e.g., labs, radiology, etc.).
3. The patient will sign consent, per hospital policy, prior to releasing information.
4. Faxed information will be accompanied by a fax cover sheet, which states that information received in error should not be shared with anyone except with those for whom the information was intended.
   a. If it is received in error, it is requested that the Center be notified immediately by telephone and return the original message to us at the address on the form.
5. Requests for information may be mailed if fax number is not available.
6. Requests for protected information such as drug/alcohol abuse, sexually transmitted diseases, etc. will be referred to the Medical Records Director.
7. Request for clinic records will be handled, per hospital policy, with signed release.
8. Permission from the patient will be obtained prior to use of any medical information/photography for educational, research, or other purposes.

9. The database-managing agency agrees not to share patient information and states so in the contractual agreement.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Home Care Referrals

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. For optimal health and healing benefits, collaboration with other healthcare agents/agencies across the continuum of care is a vital component of an effective treatment plan. Home care referral helps to ensure continuity of care and provides an open line of communication regarding the patient's condition and progress. In addition, other home needs affecting the patient's well-being are identified and, to the extent possible, can be resolved through a concerted and collaborative effort.

B. POLICY:

1. The physician and case manager will evaluate the patient's home care needs during the initial visit and anytime during subsequent follow-up visits.
2. The selection of home care/health agencies will be based on:
   - **a.** Patient preference as the primary starting point
   - **~~a.~~b. Agency authorized by the patient's insurance when applicable**
   - **~~b.~~c.** Services provided by the agency
   - **~~c.~~d.** Ability to regularly provide necessary care and monitoring
   - **~~d.~~e.** Willingness to work closely with the Center to provide coordinated patient care
3. All applicable State and Federal privacy and confidentiality rules/regulations will be followed when dealing with home health agencies.
4. The clinical staff will address any patient issues/dissatisfaction related to home care services and make any necessary changes to the plan of care, as it relates to outside services.

C. PROCEDURE:

1. The clinic physician will order home health referrals based on his/her evaluation of the patient's resources for care at home.
2. Once the order is received, the **front office staff**~~nurse case manager/PT~~ will coordinate the home health referral for specified care by:
   a. Contacting the designated agency
   b. Providing pertinent patient information and physician's orders following the hospital's confidentiality policies
   c. Informing the patient/family of the arrangements and answer questions as needed
   d. Recording all relevant communication with outside agencies in the medical record
3. Other services/agencies that should be considered for the patient's well-being are agencies that provide:
   a. Housekeeping services
   b. Meal services

c. General home care assistance
d. Transportation

4. ~~Information regarding home care agencies will be compiled and maintained in the clinic's resource binder.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Medical Equipment Maintenance

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Due to the potential for injury that medical equipment poses, an effective preventive maintenance and equipment management program must be in place and strictly observed. All patient care equipment used by the clinic will be maintained in good working order and inspected and repaired according to hospital policy.

B. POLICY:

1. The Biomedical Department will conduct routine inspection and preventive maintenance (PM) on the Center's medical equipment on a regularly scheduled basis, according to hospital policy.
2. Staff will be trained in the proper and safe use of all medical equipment.
3. Incidents involving medical equipment will be reported according to hospital policy.
4. The clinic manager is responsible for the implementation of the program and the continued observance and monitoring of safe use of equipment.

C. PROCEDURE:

1. Prior to use, all electrical devices will be inspected and approved by the Biomed Department.
2. Staff members will be trained in the proper use of electrical (or mechanical) devices prior to use.
3. Staff members are required to pull malfunctioning equipment out of use and to notify the appropriate person (biomedical engineer, clinic manager, etc.) for repair.
4. The manufacturer's operating instructions will be followed when operating medical equipment.
5. Annually, or more frequently as indicated, equipment will be inspected per PM schedule.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Nurse-~~PT~~ Visit

REVISION DATE~~(S)~~: 12/10, 04/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. In some instances, a nurse~~/physical therapist (PT)~~ follow-up visit may be appropriate to maintain the continuity of care. This policy delineates the circumstances under which a nurse/~~PT~~ visit is appropriate and defines the extent of care allowed.

B. POLICY:

1. A nurse/~~PT~~ visit is restricted to professional instruction and limited care under the guidance of the primary Center physician. Circumstances where a nurse/~~PT~~ visit may be scheduled include:
   a. Dressing or compression wrap changes
   b. Professional instruction regarding condition or treatment plan
   c. Drop-in visit
   d. Treatments/procedures defined and approved by the medical staff and the hospital, e.g., compression therapy
   e. A nurse/~~PT~~ follow-up visit is not a substitute for a physician visit. In these instances, the physician will be notified, when indicated, and a physician follow-up visit will be scheduled.

C. PROCEDURE

1. Whenever possible the primary center physician orders a nurse **interval**/~~PT consult~~ visit.
2. In instances where an order is not obtained, such as a drop-in or emergency, a nurse/~~PT~~ visit may be conducted per approved standards/protocols and within the Nursing standard of practice.
3. The nurse/~~PT~~ will assess the condition/wound, identify any problems, take appropriate action within the scope of practice, and notify **supervising** physician, if indicated.
4. Documentation that is related to the nurse/~~PT~~ visit is recorded in the Clinician's Notes and the Progress Notes, if applicable. Documentation must include:
   a. Reason for visit
   b. Significant signs and symptoms
   c. Assessment information
   d. Procedures/treatment performed
   e. Patient education
   f. Patient response
   g. Any communication with physician
5. The patient is scheduled for a physician visit as soon as appropriate.
6. The patient will be charged appropriately using the **acuity based**~~BRIEF~~ visit code.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	SUBJECT: Outcome Designation for Non-Healing Wounds
REVISION DATE~~(S)~~: 12/10, 04/20	

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE:

1. Healing wounds utilizing aggressive wound treatment methods may not be appropriate for specified wounds/patients. In addition, because of the extent of certain wounds and/or co-morbidities, some wounds will not fully respond to aggressive wound treatment. This document defines the outcome designation of wounds/patients that have been deemed inappropriate for treatment in the Center.

B. POLICY:

1. During the initial assessment/treatment period, patients will be evaluated to determine if aggressive treatment or wound healing is a reasonable expectation.
2. Once the treating physician has determined that the patient's wounds will not respond to aggressive wound treatment, or the patient is inappropriate for treatment, the patient will be referred to their primary care physician for follow-up care.
3. A **copy of physician progress note**~~letter~~ will be sent to the primary care physician explaining the reason the patient may not be considered for aggressive wound treatment.

C. PROCEDURE:

1. The goal of the wound care program is that all patients admitted will heal within a 3- to 4-month timeframe or less.
2. During the initial treatment phase, the treating physician may determine that aggressive wound treatment is not appropriate.
3. ~~If a patient is expected to heal but the treatment period is approaching or exceeds the 3- or 4-month window, the patient should be referred to another Center physician for a second opinion/evaluation, and the subsequent treatment should not exceed a total of 6 months from admission to the program.~~
4. ~~3.~~ Wounds that are healing slowly but show significant reduction in volume (50%) after the 4-month period may continue to be treated in the Center but will be given an outlier designation (14 weeks).
   a. Per the Quality Program, the medical director and clinical manager will review outliers monthly, and recommendations will be made for continued treatment or discharge.
5. ~~4.~~ A **progress note**~~letter~~ from the treating physician will be sent to the primary care physician explaining the reason for discharge prior to healing, indicating one of the following:
   a. The patient has a living will that specifies "no extraordinary measures", and aggressive wound treatment is not consistent with the patient's expressed wishes
   b. The patient has an underlying co-morbid condition that precludes aggressive treatment because it is likely that the wound will not heal

c. The patient has a terminal illness, and wound healing is secondary to the patient's quality of life goal or is contraindicated with patient's primary treatment plan, e.g., cancer chemotherapy
d. It is unreasonable to expect a level of compliance with prescribed treatment necessary to achieve desired healing outcomes due to patient's limited personal or cognitive resources, lack of ongoing care, or appropriate care providers
e. The patient, patient's family, or care provider(s) requests conservative treatment rather than aggressive care
f. Other, as explained by the treatment physician

~~6.~~**5.** This policy applies only to the current course of treatment. Subsequent admissions will be evaluated anew.

Tri-City Healthcare District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	SUBJECT: Patient Advocacy
REVISION DATE~~(S)~~: 12/10, 05/20	
Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Consistent with the hospital policies related to vital patient advocacy issues, wound/ ostomy care and hyperbaric medicine recognizes that every patient has rights related to personal information and healthcare. Although not all-inclusive, patients seeking medical attention at the clinic can expect the following:
   a. Know and understand their rights as they relate to receiving care/services at the Center (Patient Rights policy).
   b. The right to know about and understand their disease condition and be informed of specific treatment options that are available to them (Informed Consent policy).
   c. The right to be included in their healthcare decision (Advance Directive policy)
   d. The right to be treated with respect and dignity (Patient Rights)
   e. The right to expect resolution to complaints/problems (Patient Complaint policy)
   f. The right to be protected from neglect or abuse (Mandatory Reporting of Victims of Assault, Domestic Battery & Suspected Abuse policy)
   g. The right to a safe environment when seeking healthcare at the Center, an environment where measures have been instituted to minimize or eliminate the risk for injury (Falls Prevention policy)
   h. The right to privacy and confidentiality whenever their medical information is being discussed or managed and maintained (Release of Records, Medical Records, Photography HIPAA)

B. POLICY:

1. Informed Consent: Coincident with the hospital's mission and values and state statutory regulation, the Center performs certain diagnostic or therapeutic procedures only after informed consent has been given by the patient or his/her representative (Consent for Treatment form). It is the responsibility of the clinic physician to fully inform the patient of the risks and benefits of the recommended treatment as well as any other options available to them and to obtain the patient's consent. This may be supplemented with printed material or video information. In addition, clinical staff will advocate for the patient and assist with the process by ensuring that this step has been taken and researching and/or providing additional information at the patient's request. In addition to the clinic consent for treatment, other forms will be used per hospital policy, e.g. Consent for HIV Testing, Authorization for Release of Records, etc.
2. Patient Rights: All patients will be informed of his/her rights and responsibilities upon initial presentation to the Center. These rights are posted in the patient care areas and are written in English & Spanish. All clinic staff will be informed of these rights during the hospital orientation program.

3. Advance Directive: The Center recognizes that every patient has the right to participate in his or her own healthcare decisions. They have the right of self-determination regarding health-related issues, including the right to refuse medical treatment. It is the policy of the hospital to honor a patient's wishes as it relates to healthcare decisions, including the designation of another person to direct the course of medical treatment upon his/her incapacitation. Patients (or their surrogate) presenting to the clinic for the first time will be asked if they have an Advance Directive. ~~If the patient is not aware of Advance Directives, a copy of the Advance Directive Fact Sheet will be provided to the patient or surrogate.~~
4. Patient Complaints: Every patient can expect a good-faith effort to resolve problems and an opportunity to express concerns and unmet needs. Attempts will be made to address concerns/complaints at the clinic level first. If not resolved to the satisfaction of the patient/family, the issues will be forwarded per hospital policy to the designated Administrative representative within 72 hours of receipt.
5. Reporting Suspected Neglect or Abuse: Every patient presenting to the Center for medical evaluation/treatment will be assessed for signs of abuse/neglect. All clinical staff is trained to identify signs of neglect/abuse. Any patient whom the staff suspects abuse or neglect will be reported, per hospital policy. ~~Social Services Department will be notified for assistance and guidance with the proper reporting process.~~
6. Falls Prevention: All patients are assessed for risk of falls during the initial assessment process when admitted to the clinic program **and at subsequent visits**. Prevention measures are instituted immediately to prevent injury and may include:
   a. Assisting patient on and off treatment chair/table
   b. Never leaving a confused or incompetent patient unattended in an exam room
   c. Guiding the patient while ambulating
   d. Keeping the bed **or chair** in lowest position **anytime the patient is unattended in the room.**~~until the exam/treatment time~~
   e. Bedrails in UP position at all times except during treatment
   f. Placing personal items such as purses, bags, etc. close to patient
   g. ~~When identified, t~~The risk for falls will be noted on the front ~~cover sheet~~ of the **patient** chart. ~~in the section labeled PRECAUTIONS~~.
7. Medical Record/Release of Information: To protect the confidentiality of the patient's medical information and safeguard it against loss, destruction, tampering, and unauthorized access, use or release, the clinic will follow all the requirements of the health information management system established by the hospital. All medical records will be maintained in a locked area of the clinic until the time of patient discharge. ~~Within 30 days of discharge, the patient medical record will be given to Medical Records of off-site storage for storage and safekeeping.~~ On a daily basis, the records of active patients will be readily accessible to authorized personnel for use in patient care and secured at the end of each business day. The patient's written permission or that of his/her legally qualified representative (Release of Records form) must be obtained prior to releasing medical records information of any kind to any person, institution, agency not directly related to the care of the patient. However, medical records may be removed from the clinic's/hospital's jurisdiction in accordance with court order, subpoena or statute.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Patient Charges

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Patient charges and payment processes must be delineated to:
   a. Provide guidelines for the clinic staff entering patient charges
   b. Clarify the appropriate charges for services rendered in the outpatient setting.
   c. Avoid overcharging the patient and/or the third-party payer
   d. Provide consistency in billing practices
   e. Prevent inadvertent fraudulent billing
   f. Outline the appropriate billing processes for the Center

B. POLICY:

1. The patient's insurance will be verified just prior to or at the time of the first appointment.
2. Insurance authorizations will be obtained prior to all appointments, where applicable.
3. All charges for services will be accurately recorded and processed, per the hospital Business Office.
4. All appropriate staff will be trained in the charging procedure.
5. A "superbill" format containing standard clinic procedures and charge/payment codes will be utilized for accurate billing purposes.
6. Managed-care patients will be billed according to the prevailing contract/agreement following managed-care charging/payment protocols.
7. Cash-paying patients will be billed according to hospital-approved fee schedule.

C. PROCEDURE:

1. Clinical personnel will be trained in accurate charging for services rendered.
2. The physicians will check the appropriate charges on the "superbill" at the end of each patient visit.
3. Notification of cash-paying patients will be made to the Business Office to avoid duplication of billing and/or collection notice.
4. "Superbill" forms will be complete by the end of each business day and **reviewed by** ~~forwarded to~~ the Office Coordinator for processing.
5. ~~The Office Coordinator will validate the daily "superbills" generated each day for accuracy against the list of patients treated a the Center and submit copies to the appropriate departments.~~
6. ~~The Office Coordinator reviews the posted revenue for accuracy the following business day.~~
7. ~~For the managed-care patients:~~
   a. ~~Charges are entered per clinic procedure~~

~~b. The Business Office is made aware of the managed-care patient and bills the Third-Party Administrator (TPA) for patient visit/procedure~~

~~c. The TPA bills the managed-care group~~

~~d.~~a. ~~Upon receipt of payment, the TPA disburses funds to the hospital for facility expense.~~

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

RETIRE – Document now housed in WE & Cerner

ISSUE DATE: 06/07

SUBJECT: Patient Chart

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. ~~PURPOSE~~

1. ~~This policy addresses the forms comprising the medical record for the Center and describes the assembly process that occurs for all clinic visits.~~

B. ~~POLICY~~

1. ~~Medical records will be assembled using the prescribed/approved forms in the order as described in the "Patient Record: Chart Order" policy and labeled according to hospital policy/practice.~~

C. ~~PROCEDURE~~

1. ~~The support staff will assemble and label chart forms on the day of scheduled visits.~~
2. ~~For the new patient, the following forms will be used:~~
   a. ~~Physician's orders~~
   b. ~~Patient home instructions~~
   c. ~~Superbill~~
   d. ~~Medication record~~
   e. ~~Wound documentation~~
   f. ~~Progress notes~~
   g. ~~History & Physical~~
   h. ~~Clinician notes~~
   i. ~~Admission assessment~~
3. ~~For subsequent visits, the following forms will be prepared:~~
   a. ~~Discharge instructions~~
   b. ~~Physician's orders~~
   c. ~~Patient home instructions~~
   d. ~~Superbill~~
   e. ~~Progress notes~~
   f. ~~Clinician notes~~
4. ~~In addition, each chart will include, where applicable:~~
   a. ~~Face sheet~~
   b. ~~Consent form~~
   c. ~~Conditions of Admission form~~
   d. ~~Insurance and billing information~~
   e. ~~Copy of insurance card~~
   f. ~~Insurance authorization~~

g. Intake form

5. The support staff/receptionist will forward required patient information to the Admitting clerk the day prior to the patient's first visit.
6. The Admitting clerk will create the medical record containing pertinent patient information the day of the first visit and will forward to the Center.
7. The support staff will label the necessary forms when the patient arrives for each clinic visit.
8. The outer chart will be labeled as follows:
   a. Chart spine label, which contains the patient's first and last name
   b. Chart cover sheet, which contains pertinent patient information for quick reference:
      i. Primary physician and phone number
      ii. Convalescent home, telephone number, and contact person
      iii. Home health agency, telephone number, and contact person
      iv. Transportation agency and telephone number
      v. Allergies
      vi. Precautions

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Patient Instructions

REVISION DATE~~(S)~~: 08/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval;	~~07/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	08/20

A. PURPOSE:

1. The Patient Instructions provides the patient and family/caregivers with a clear guide to understanding the physician's instructions for care after the clinic visit.
1. Guidelines for documenting physician orders for patient use.

B. POLICY:

1. All patients receiving **wound care treatment**~~hyperbaric oxygen (HBO) therapy~~ will receive clear ~~and~~ verbal and written instructions for aftercare/home care.

C. PROCEDURE:

1. The Center/hyperbaric physician will **enter**~~write~~ physician orders using the approved **electronic** physician order form after each visit/treatment, if applicable.
~~2. The licensed/HBO staff will transcribe orders for patient use on the approved "Patient Instructions" form, if applicable.~~
~~3.~~**2.** The Center/HBO staff will also provide verbal instructions for clarity and to assess patient understanding.
   a. For complex instructions (such as complicated dressings), the Center staff will ~~assist with patient instructions.~~ **demonstrate appropriate dressing procedures.**
~~4.~~**3.** The next appointment date and time will be included on the **patient instructions.**~~instruction sheet.~~
~~5.~~**4.** A copy of the instructions will be given to the patient **by the front desk staff.**
~~6. The patient will sign the form, indicating receipt and their understanding of the instructions.~~
~~7. The form will remain a permanent part of the medical record.~~
~~8.~~**5.** The patient's compliance with instructions and understanding of instructions will be assessed on each visit.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Patient Photography

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE

1. Photography is an important aspect of care in the Center's setting. The photography program is tailored to:
   a. Document the presence of wounds or other pertinent medical conditions
   b. Show the progress of the healing process or response to care
   c. Use for educational and marketing purposes
   d. Assess the quality of service provided at the Center

B. POLICY

1. Patients will consent to photography before any pictures will be taken.
2. All patients presenting to the clinic with open wounds or other pertinent medical conditions will have photographs taken on initial visit and **at each visit** ~~periodically~~ to demonstrate progress (or non-progress) and/or with any significant changes.
3. Photography of other events/conditions will occur with patient's permission as ordered by physician or at the discretion of the clinical staff.
4. Photographs will be maintained as with all confidential medical information.
5. Photographs will be released only with patient's consent.

C. PROCEDURE

1. During the initial visit, the patient will be asked to sign the Consent for Photography form.
2. A member of the clinical staff will witness the patient signature.
3. If an interpreter is used, the interpreter will sign as well.
4. Refusal to give consent for photography will be honored by the clinic staff, and no photographs will be taken. The clinical staff will note this on the consent form and on the front of the chart. ~~in section "OTHER".~~
5. Pictures will be taken using various forms of photography such as digital, Polaroid or 35mm.
6. Picture will be labeled with date, patient initials, medical record number and wound number and/or site of wound/condition.
7. Whenever a photograph is taken it will be noted in the **Treatment notes**~~Progress Notes in the~~ section **of the electronic record.**~~called Wound Assessment.~~
8. Staff members will be trained in the proper use of the cameras and in technique for good quality pictures.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Patient Reception**

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**

1. It is essential that the image we project is one that is consistent with the philosophy and mission of the hospital. First impressions set the tone for subsequent visits. Factors that may adversely affect a patient's perception are:
   a. Lack of respect when dealing with patients
   b. Long waiting periods prior to being seen by physician
   c. Not providing adequate or providing inaccurate instructions/information.
   d. Not including patient's support team (e.g., family, friend, caregiver) in the plan of care.
2. A negative impression may dissuade the patient from returning to the clinic or discourage compliance/cooperation with the plan of care. This document delineates the guidelines necessary to meet the clinic's customer service goals.

B. **POLICY:**

1. All patients seen at the Center can expect:
   a. To be treated with respect and dignity according to the values of the hospital
   b. A supportive, compassionate staff
   c. A therapeutic environment
2. All patients will be greeted professionally and with compassion.

C. **PROCEDURE:**

1. During the patient's first visit, the patient will be instructed about the initial process and oriented to the reception area (TV, reading materials, restroom, writing surfaces, etc.)
2. Patients will be asked to complete information forms and sign consent forms ~~(except consent for treatment)~~ prior to the first evaluation/exam.
3. Patients will be given assistance as needed with registration, e.g., Spanish interpretation.
4. Every effort will be made to make the patient comfortable in the waiting area. If indicated, the clinical staff will be asked to assist with comfort measures.
5. Priority will be given to the day's clinic patients to minimize waiting periods. Interruptions for telephone calls by the clinical staff will be reserved for urgent needs only in order to facilitate the clinical flow.
6. Patients will be addressed respectfully and according to their expressed wishes.
7. The patient will be informed about:
   a. The purpose of the **clinic**~~program~~
   b. The plan of care
   c. The communication procedures

8. The clinic physician will clearly define his/her recommendations for the treatment plan and include members of the patient's support team
9. Staff members will introduce themselves to the patient and explain all procedures prior to implementing them.
10. After-care instructions will always be provided in written form ("Patient Instruction" form) after each visit.
11. All patient complaints will be addressed per hospital policy.

Tri-City Health Care District
Oceanside, California

RETIRE – no longer performed at the Wound Care Center

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07

SUBJECT: Patient Survey Process

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

~~A. PURPOSE~~

~~1. The quality or effectiveness of any program is reflected in the satisfaction experienced by the client receiving service in and out of a program setting. The Center's survey process is designed to recapitulate the patient experience at the Center. Results of the survey are reviewed by qualified person(s), and opportunities to improve services are identified and corrective actions implemented.~~

~~B. POLICY~~

~~1. All patients receiving care at the Center will be asked to complete a satisfaction survey after discharge.~~
~~2. Survey results will be reviewed and tabulated by qualified person(s), per hospital procedure, and reported to pertinent hospital committee(s) and the medical staff of the Center.~~
~~3. Opportunities for improvement will be identified.~~
~~4. Corrective action will be implemented, evaluated, and reported as appropriate.~~
~~5. Patients may also express concerns anytime during their treatment period and expect resolution whenever possible.~~

~~C. PROCEDURE~~

~~1. After discharge, each patient will be handed or sent a survey and asked to complete and return before they leave or in a self-addressed envelope to the hospital.~~
~~2. The surveys will be tabulated using an approved method.~~
~~3. The results will be reviewed by the Center manager, the office coordinator, and the physician quality advocate, as well as the Center staff.~~
~~4. Opportunities for improvement will be identified by the tam.~~
~~5. Corrective actions will be implemented.~~
~~6. Ongoing monitoring will be conducted to measure the effectiveness of actions.~~
~~7. The findings will be reported to pertinent hospital committee(s) (i.e., Performance Improvement) and persons.~~
~~8. The Center staff will participate in the improvement process. The results of the surveys will be discussed at the monthly meetings.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07

SUBJECT: Patient Visual Auditory Privacy

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. This policy defines the measures taken by the Center to preserve and maintain the patient's right to privacy.

B. POLICY:

1. Every effort will be made to maintain the patient's visual and auditory privacy while being treated at the Center.
2. Immediate action, to the extent possible, will be taken when a breach of privacy is identified.
3. Employees found violating the privacy policy will be counseled and an appropriate inservice provided, if appropriate.

C. PROCEDURE:

1. Interview/counsel patients out of hearing and visual range of other patients and visitors. A private room or exam room is appropriate.
2. Do not speak above the patient's hearing level.
3. Seek patient's permission to allow students, manufacturer's representatives, or any other appropriate observers to be present in the exam room.
4. Do not call out patient information, including name, orders or treatment plan, etc. across distances within the clinic to communicate with other members of the healthcare team.
5. Provide privacy when any part of the patient's body is exposed; or if patient is disrobing by closing privacy curtain and using a sheet to cover the patient if appropriate.
6. Keep exam room door closed at all times while the patient occupies the room, unless contraindicated or at the patient's request.
7. Be sure that windows are covered appropriately to provide adequate privacy.
8. Maintain patient confidentiality with the medical record as well as all verbal and written communications.

Tri-City Healthc~~a~~re District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	SUBJECT: Program Description
REVISION DATE~~(S)~~: 12/10, 05/20	
Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. The clinic is a comprehensive advanced therapy/treatment program that addresses specific medical needs of the community. The purpose of this document is to:
   a. Describe the program
   b. Establish the mission of the program
   c. Delineate the scope of services
   d. Define the roles, responsibilities and qualifications of the medical and clinical staff
2. Mission Statement: Consistent with the mission of Tri-City Medical Center, the wound care clinic will serve the needs of this community as it relates to the treatment of chronic wounds, ostomy care and hyperbaric medicine.

B. POLICY:

1. The primary goal of the clinic is to provide vital services to the population at risk, which includes patients of multiple and differing socioeconomic and cultural backgrounds. These are patients with diabetes, renal failure, peripheral vascular disease, hypertension, and many other chronic illnesses and their sequelae.
2. Access to care for all patients including those with limited funding and transportation will be served by multiple specialists while still allowing the patients to maintain their primary care physician/patient relationship.
3. These services shall be marketed to our immediate community, insurance plans, workers' compensation programs and the State (Medi-Cal).
4. Consideration of other sources of income, i.e. clinical research programs, grants and partnering with other institutions will be further evaluated and utilized when beneficial to Tri-City Medical Center for its community.

C. ACCOUNTABILITY/REPORTING STRUCTURE:

1. The program is a hospital-based service, licensed as an outpatient program. The program is accountable to hospital administration through a reporting relationship to the Senior Director of Patient Care Services and Chief Operating Officer/Chief Nurse Executive.

D. SCOPE OF SERVICES:

1. The service model chosen by the hospital relates directly to medical information obtained from various sources, including:
   a. CDC statistics
   b. ADA
   c. Hospital DRGs

d. DHS

2. The goals of the clinic are accomplished through the services it provides, including:
   a. Management/healing of chronic wounds, including:
      i. Vascular assessment
      ii. Nutritional assessment
      iii. Infection control
      iv. Edema control
      v. Offloading methods and devices
      vi. Surgical intervention, as indicated
   b. Hyperbaric Oxygen Therapy as adjunctive therapy for **wounds meeting hyperbaric oxygen criteria.** ~~the treatment of difficult-to-treat wounds~~
   c. Diabetic self-management and education program collaborating with the patient's primary care physician to include:
      i. Diabetic education
      ii. Nutritional instruction
      iii. Disease self-management
      iv. Referral to sub-specialists for prevention of complication
   d. Ostomy care:
      ~~3.~~**i.** Pre-operative education and site marking
      ~~4.~~**ii.** Post-operative education, appliance needs, and lifestyle adaptation

E. **QUALITY MANAGEMENT/PERFORMANCE IMPROVEMENT PROGRAM:**

1. The quality management program, consistent with that of the hospital, is designed to measure outcomes and related processes of care and to seek ways to improve the quality of services provided at the clinic. The key elements of the program are:
   a. Collect meaningful data
   b. Select measurable indicators
   c. Use a valid method of data collection, management and storage
   d. Analysis of the data by a qualified person
   e. Reporting to pertinent hospital committees
   f. Corrective actions designed to improve the quality of services
2. Data sources: The primary source of information is the clinic database. The patient medical record, laboratory, radiology reports and the hospital computer information systems are utilized, where appropriate, following HIPAA guidelines. Data is collected by the program director/clinical manager and/or the clinic staff, as appropriate. Data may be concurrent or retrospective dependent on availability of data.
3. Benchmarking: The clinic results are compared to national and/or system-wide benchmarks, when available, or the clinic's own historical data. Unmet goals are perceived as opportunities for improvement. Corrective actions are relevant to improving the services rendered.
4. Reporting: The data results are reported to the pertinent hospital committees/ teams as mandated by the hospital's governing bodies and may include:
   a. The hospital Safety/Environment of Care Committee
   b. The hospital Quality Committee
   c. The Medical Executive Committee
   d. The Hospital Board of Directors

F. **STAFF QUALIFICATIONS, EDUCATION, AND TRAINING:**

1. Medical Staff
   a. Medical Director: The program is directed by a qualified medical staff member who is a clinician who may be trained in 1 or more of the following disciplines, has the responsibility to educate and train the medical staff, and works closely with the program director/clinical manager to recommend and to order the educational activities of the

clinic staff. Moreover, the Medical Director provides direction and oversight for the overall medical services.

i. Plastic and reconstructive surgery
ii. Vascular surgery
iii. Orthopedic surgery
iv. Internal medicine/**Family Medicine**
v. Infectious disease
vi. Nephrology
vii. Endocrinology
viii. Dermatology
ix. Podiatry
x. Interventional radiology
xi. Emergency medicine

b. Medical Staff Members: Relevant continuing education is required to maintain their status as medical practitioners in this specialized program (see "Credentialing Criteria for Outpatient Wound Care"). A qualified practitioner is selected based on:
   i. Proven skills in a relevant discipline
   ii. Medical or specialty experience
   iii. Established reputation in the medical community
   iv. Hospital staff privileges
   v. Ability to perform the requirements of the service to be rendered
   vi. Interest in an interdisciplinary approach and collaboration in the care of chronic diseases

2. For physicians involved with hyperbaric oxygen therapy, see "Credentialing Criteria for Hyperbaric Medicine".
   a. Clinic Staff Members
      i. Clinical Manager: The clinic is staffed with a full-time qualified Clinical Manger whose qualifications include:
         1) Education and training (RN)
         2) Previous managerial experience OR the ability to demonstrate the necessary skills to perform the managerial duties
         3) Proven skills in collaborating with the medical staff, Administration, and outside agencies that govern the standards of medical care
         4) Ability to communicate effectively with the medical and clinic staff, Administration, other departments of the hospital, and patients and their families
         5) Ability to develop and/or coordinate educational programs for clinic staff and patients
         6) Knowledge and skills in developing and implementing policies, procedures and new programs
   b. Clinic Staff: The type and number of staff members are selected based on qualifications, experience and clinic needs. Clinic needs are determined by the number of active patients in the program, the type and the acuity of patients, the type of service required by the patients, and the overall requirements of the clinic. Members of the staff may include:
      i. Office Coordinator
      ii. Registered Nurses, WOCNs~~, Physical Therapists~~
      iii. Licensed Vocational Nurses
      iv. Medical Assistants
      v. Receptionist
      vi. Clerical support staff
      vii. Certified Diabetes Educators
      viii. HBOT Safety Manager

ix. HBO Technologists

c. Each position is defined in the Job Description Manual. Overall competency of clinic staff is based on:
   i. Education, training, licensing and certification, as required
   ii. Years of experience
   iii. Ability to demonstrate the necessary skills to perform the defined duties as defined and assessed on performance appraisal
   iv. Ability to communicate effectively with the medical staff and patients and their families

G. **STAFF DEVELOPMENT:**

1. In collaboration with the Medical Director, the staff education and training schedule is developed on a monthly and as-needed basis. It is comprised of all the elements necessary to affect a quality program. The topics include, but are not limited to:
   a. Department orientation for new staff members
   b. Diabetes
   c. Negative pressure wound therapy
   ~~d. Use of chemotherapy as an adjunct to wound healing~~
   ~~e.~~**d.** Vascular assessment
   ~~f.~~**e.** Soft tissue infections/osteomyelitis
   ~~g.~~**f.** Plastic and reconstructive surgery
   ~~h.~~**g.** Off-loading wounds
   ~~i.~~**h.** Wound healing strategies
   ~~j.~~**i.** Hyperbaric oxygen therapy
   ~~k.~~**j.** Edema control
   ~~l.~~**k.** Science of wound healing
   ~~m.~~**l.** Ostomy care
2. Educational programs are also defined by the clinical staff through need assessment discussed at the monthly staff meetings.

H. **PRODUCT SELECTION:**

1. As much as possible, the products used in the clinic are selected in conjunction with the hospital's product selection process. The clinical staff actively participates in the selection process and bases its decisions on effectiveness of the products. Attention is given to cost, but benefit to the patient is the primary consideration.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	SUBJECT: Registration
REVISION DATE~~(S)~~: 12/10, 05/20	
Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Hospital or clinic registration can be a daunting and tedious task for someone whose health may be less than optimal. Every effort will be made to simplify and expedite this process. This document outlines the registration process at the Center.

B. POLICY:

1. The registration procedure will be simplified to the extent possible to minimize the stress related to initial visit procedures.
2. Every patient will be assisted, as appropriate, in completing the registration information.
3. The clerical staff will follow the hospital's procedures for data collection and electronic data entry.

C. PROCEDURE:

1. At the conclusion of the patient's first inquiry and when an appointment has been scheduled, the patient or representative will be asked to bring with them the following information:
   a. Current medication list
   b. Physician referral letter, if applicable
   c. Primary physician information
   d. Insurance card(s)/information
   e. Copy of relevant diagnostic tests
   f. A resident or qualified representative of long-term or extended-care facilities will be required to complete and return pertinent information 24 hours prior to the first visit. The facility is responsible for ensuring that the appropriate consents are signed by authorized person(s) and returned with the patient at the time of the appointment. If the patient/resident cannot speak or act for himself, he/she must be accompanied by a representative (preferably a family member) who is knowledgeable about the medical history.
      i. The Center reserves the right to cancel the appointment, if all required documentation is not available at the time of the first visit.
      ii. A family member or facility representative must always accompany patients/residents who are not oriented to person, time, or place.
2. All patients will be admitted to the Center according to hospital policy. The following forms must be signed preceding any exam/treatment:
   a. Hospital's "Conditions of Agreement"
   b. Insurance and billing information

c. Consent for Treatment (after the clinic physician has informed the patient about the plan of care).

3. The office coordinator or designee will:
   a. Ensure that verification of the insurance information/coverage is complete prior to the first visit.
   b. Obtain any necessary prior authorizations from the third-party payer.
      i. Only services authorized may be provided
   c. Copy insurance card(s) for distribution as follows:
      i. The medical record
      ii. Admitting Department
      iii. Financial folders
      iv. Physician
   d. Notify the patient and primary care physician if verification indicates that the patient has no coverage or poor coverage, and discuss payment options.
   e. In the event that an individual payment plan must be constructed, the hospital's business office will advise and develop a payment plan with the patient or representative responsible for the payment.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Scheduling**

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**

1. Establishing scheduling procedures is important for several reasons:
   a. Provides for orderly, efficient approach to patient visits
   b. Minimizes patient waiting periods
   c. Allows for adequate time for evaluation/treatment
   d. Defines a uniform approach to scheduling for staff members
   e. Assigns responsibilities to avoid duplication of effort

B. **POLICY:**

1. Patients will be scheduled appropriately, allowing adequate time between visits to prevent prolonged waiting time for all patients.
2. Patients will receive written follow-up visit appointments at the end of each visit along with their home instructions.
3. As time permits, patients will be called 1-2 days prior to the scheduled visit to confirm the appointment.
4. Patients missing scheduled appointments will be called as time permits on the same or following day to ascertain the cause of the missed appointment and reschedule the patient whenever possible.

C. **PROCEDURE:**

1. Schedule Order
   a. Patients will be instructed to check in with the receptionist upon their arrival.
   b. Patients will be seen in the order of their appointment time and not by their arrival time.
   c. The receptionist or front office support is responsible for maintaining the scheduling order for the clinic session. Working with and through the receptionist, the clinical staff may overrule the order of the schedule if deemed medically prudent.
   d. If the clinic session is running behind, the clinic staff will notify the reception/office personnel who, in turn, will inform the waiting patients and provide them with the option to reschedule their appointment.
2. Scheduling the New Patient
   a. The new patient will be scheduled with the appropriate clinic physician.
   b. The new patient will be scheduled in an open time slot that allows adequate time for comprehensive medical evaluation and workup.
3. Follow-up Appointments

a. The ~~attending nurse~~ (**Lead Nurse** ~~case manager)/PT~~ will write the timeframe of the next visit ordered by the physician on the **visit orders**~~home instruction sheet and forward to the receptionist~~.
b. The patient will be given a copy of the written home care instructions by the receptionist, which will include the follow-up appointment date and time.

4. Missed Appointments
   a. When a patient has not arrived for his/her scheduled appointment, the clinic staff will attempt to contact the patient by telephone the same or following day (as time permits).
      i. A new appointment will be scheduled, as appropriate
   b. If the patient is able to arrive the same day before the clinic physician leaves, the patient may be scheduled in at the end of the clinic session.
   c. If the patient cannot or does not want to return, the receptionist will relay the information to the nurse case manager~~/PT~~ for follow-up, as appropriate.
   d. For non-compliant patients, the clinician will record any information related to the scheduled appointment(s) in the medical record, documenting the attempts to contact the patient.
   e. The missed appointment will be recorded in the patient record **in the patient visit report and** ~~on the physician order sheet and~~ will include the reason, if ascertained.
5. Unscheduled Appointments
   a. Patients referred to the Center for a same-day visit may be accepted as time permits and if the clinic physician in session accepts the patient.
      i. The patient and the referring physician will be informed that the patient will be added to the schedule at the end of the session, or as time permits.
      ii. The clinic physician, nurse case manager~~/PT~~, or the clinic manager may overrule this policy if deemed medically prudent to see the patient sooner than at the end of the session.
6. Canceled Appointments
   a. The clinic physician will review the missed appointment list and may give instructions in addition to rescheduling the patient.
   b. The support staff will attempt to reschedule the appointment at the time of cancellation, if appropriate.
7. Patient Discontinues the Program
   a. Tracking will be done weekly by the ~~**front office staff**~~~~data coordinator~~, who will generate a report from the database that identifies patients who have not returned for follow-up care within the last ~~**30 days**~~~~4 to 6 weeks~~.
   b. The report will be given to the clinic manager for distribution and follow-up.
   c. The Center staff will make a good-faith attempt to reschedule the patients listed.
   d. Communication efforts will be documented in the medical record by the clinical staff.
   e. After a good-faith effort has been made to contact and reschedule the patient, **the chart will be closed.**~~a letter will be sent to the patient referring them back to their primary care physician for follow-up care.~~

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Staff Development

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Learning is essential to personal growth and development. The hospital recognizes that staff education enhances the quality of patient care and improves staff motivation. Other benefits include:
   a. Improved competency
   b. Increased compliance with hospital policies, state, local and federal regulations/statutes
   c. Reduction of risks associated with patient/visitor and staff safety
   d. Understanding, better awareness, and compliance with standards of practice

B. POLICY:

1. The clinic manager, in collaboration with the medical and clinic staff, will develop education calendars.
2. An educational needs assessment will be conducted at the monthly staff meetings.
3. Staff meetings will be held monthly and may include staff development topics.
4. The clinic manager is responsible for developing, implementing, and revising the staff development program.
5. All staff members will be given a thorough hospital and unit-specific orientation during the placement period.
6. Ongoing inservice education will be conducted on a monthly basis and more frequently as needed.
7. Attendance at hospital and outside educational program is encouraged.
8. The staff is encouraged to independently pursue educational opportunities to enhance their professional growth.
9. Monthly staff meetings/staff development activities may include, but are not limited to, the following:
   a. Job-related training
   b. Safety-related issues
   c. Infection control
   d. Introduction to new policies, procedures, techniques, and products
   e. Medical topics such as diabetes, vascular disease, infectious disease, wound healing, hyperbaric medicine
   f. Operational changes
   g. Pain assessment
   h. Patient advocacy issues
   i. Continuum of care
   j. Required annual training

10. Minutes of the staff meetings will be recorded and will include personnel in attendance, issues discussed, and action plans for identified problems. Associates not in attendance are required to read the minutes.
11. As much as possible, the programs/meetings will be held when most or all staff is scheduled.
12. Other miscellaneous information not included in the staff meetings, such as general hospital memos, will be included in the department communication book that is maintained by the support staff.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	**SUBJECT: Staffing Plan**
REVISION DATE~~(S)~~: 12/10, 05/20	

Department Approval:	**~~02/20~~04/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/20~~04/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. **PURPOSE:**

1. Appropriate and adequate staffing is vital to the success of the multi-service outpatient clinic. A well-planned approach must be taken to accomplish this goal, and several factors for a good staffing plan must be considered. They are:
   a. Acuity of the patients treated
   b. Level of expertise/competency of the staff
   c. Time allotted for each visit
   d. Available resources (human, financial, and otherwise)
   e. Continuous planning and assessment (daily, weekly, monthly and yearly)
   f. Frequent review and evaluation to seek opportunities to enhance the system to benefit patient care and for good stewardship of financial resources that impact clinic operations.

B. **POLICY:**

1. Acuity Classification: The Acuity Classification policy has been developed to provide for and validate adequate/appropriate resources for the plan of care for each patient who presents to the Center for treatment and to support the requirements for the continuum of care activities.
2. Staffing: In general, the type and number of staff members are selected based on qualifications, experience and clinic needs. Clinic needs are determined daily and weekly by the number of scheduled patients, the type and acuity of patients, and the type of service required by the patients. Members of the staff may include:
   a. RN Clinical Manager is empowered to run the day-to-day operations of the clinic. The manager also participates in the decision-making processes related to the selection of the clinic model and the services provided. He/she is accountable for ensuring that the clinic is adequately staffed and makes certain that patient visits are appropriate and timely.
   b. Office Coordinator has the overall responsibility for coordinating the activities of the clerical area and performs the administrative functions of the front office operations.
   c. Registered Nurse/~~PT~~ develops the plan of care for each patient using the nursing process. The RN/~~PT~~ leads and accepts responsibility for the multifaceted team to direct and evaluate the plan of care and takes the initiative to make necessary adjustments to enhance the quality of care provided and improve outcomes. The RN/~~PT~~ takes the lead in the coordination in the continuum of care.
   d. Licensed Vocational Nurse, under the supervision of the clinical manager and the direction of the RN/~~PT~~, performs duties using the nursing process to provide and

maintain individualized quality patient care and participates in the coordination in the continuum of care.

e. Medical Assistant (MA), under the supervision of the clinical manager and the direction of the RN/LVN/~~PT~~, performs tasks as assigned. The MA assists other members of the healthcare team while providing direct patient care. As a patient advocate, the MA reports observations and patient responses to care to the RN/~~PT~~/MD and assists with maintaining patient privacy/ confidentiality and reports patient complaints of pain to the RN/~~PT~~/MD.

f. Receptionist requires the coordination of the clinical, clerical and general secretarial/office duties, as well as realistic patient scheduling. As the first person the patient encounters by phone and with each visit, the receptionist must demonstrate excellent interpersonal skills.

g. Other staff members may include a nurse practitioner/physician assistant, CWOCN, enterostomal nurse, and additional clerical support staff. Competency of clinic staff is based upon:
   i. Education and training
   ii. Years of experience
   iii. Ability to demonstrate the necessary skills to perform the defined duties
   iv. Ability to communicate effectively with the medical staff and patients and their families.

3. Financial Resource Allotment for Staffing: Budget preparation for staffing the clinic is performed annually by the clinical manager with the assistance and approval of the administrative team. Budget requirement is determined by utilizing previous years' financial history and financial performance, as well as anticipated staffing needs for planned additional services, as justified by the clinical manager. Periodic adjustments to accommodate changes may be made at the discretion of the clinic manager and with the direction/approval of the administrative team.

4. Patient Scheduling: Allowing adequate time for each patient visit is necessary for patient satisfaction, convenience, and care needs and is an essential component of an efficient and smooth-running clinic. To determine the time required for/between each visit, the following general rules apply:
   a. Increased time is allowed for a new patient visit or for complex cases
   b. Less time is required for follow-up and/or less-complex cases
   c. For more specific information on patient classification, refer to the Acuity Classification policy.

5. Assignments: Assignments are planned by the clinical manager on a weekly basis and are based upon the number of patients scheduled, assessment of clinical needs of the patient, the complexity of the patient's condition, and the clinical care requirements. Staffing levels may be adjusted to correspond with the anticipated care requirements. In addition, the clinic manager reviews the changes in the daily clinic schedule and makes necessary adjustments to staffing levels.

6. Evaluation of Staffing Plan: The staffing plan is periodically reviewed and evaluated by the clinic manager. Opportunities for improvement/enhancement are identified, and changes are made consistent with the needs of the patients and the staff members.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 **SUBJECT: Telephone Management**

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. **PURPOSE:**

1. Effective management of telephone operations is key to the success of the program. The important aspects of telephone management include:
   a. Etiquette
   b. Intake/information management skills
   c. Adequate coverage
   d. Telephone triage

B. **POLICY:**

1. To promote excellence and competence in managing telephone communications:
   a. The telephone communications methods will be defined and systematic.
   b. All personnel will be trained in proper telephone etiquette and telephone information management.
   c. A designated person(s) will have full responsibility to coordinate and maintain the telephone communication program.
   d. The clinic manager will be responsible for oversight and implementation of the program.
   e. As a key customer relations/service tool, the telephone will reflect the mission and philosophy of the program:
      i. All patients will be treated with respect and dignity when communicating by phone.
      ii. All telephone messages will receive timely responses.
      iii. Telephone calls will be routed appropriately.
   f. Adequate telephone coverage will be provided during normal business hours.
   ~~g. Provisions will be made for after-hour communication.~~

C. **PROCEDURE:**

1. During business hours, the phone will be answered in a timely manner.
2. For after-business hours, a telephone recording system will be utilized to answer calls, and messages will be picked up promptly the following business day. The greeting/recording will contain instructions for emergency situations. ~~and provide the medical director's phone number for professional consultation.~~
3. Messages will be answered promptly.
4. Those responding to telephone calls will speak clearly and distinctly.
5. The general rules are:
   a. Answer the phone in a timely manner (3 rings or less is preferable)
   b. Answer the phone in a pleasant and professional manner.

c. Identify yourself and the name of the clinic.
d. Route the call to the appropriate person, i.e., physician, nurse~~/PT~~, etc. if medically related
e. Take a message when the recipient is unavailable at the time of call and will include:
    i. The name of the caller
    ii. The purpose of the call
    iii. The telephone number where they can be reached
    iv. The best time to return the call
    v. If appropriate, ask if you can assist them

6. To decrease the interruptions to the clinic session:
    a. Determine the priority or urgency of the call
    b. Explain the reason the intended recipient may not be able to answer at this time, i.e., "The doctor is with a patient at this time."
    c. Take a message, as indicated in "e." above
7. To minimize the caller's waiting time, route the calls as soon as feasible and ensure they are received.
8. For inquires about the services of the clinic:
    a. Succinctly explain the services of the clinic
    b. Determine the purpose of the inquiry
    c. Schedule an appointment, if appropriate, with the proper physician/service (clinical staff to assist with triage).
    d. Request demographic data per Intake form:
        i. Provide directions to the clinic
        ii. Instruct patient to bring medication list, insurance information/card, as well as other pertinent medical information/diagnostic tests, referral documents, etc.
        iii. Instruct patient to arrive 30 minutes early for first visit to complete necessary information forms.
9. As time permits, call all scheduled patients 1-2 days prior to their appointment to confirm date and time.
10. When a patient misses their appointment, attempt to reach the patient by phone to ascertain the cause, and reschedule the appointment.
11. Significant patient-related calls will be documented in the patient record by the clinical staff.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 6/07

SUBJECT: Transportation

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. The treatment plan may be adversely affected because of unreliable or lack of consistent transportation. This policy identifies the various resources available to meet the transportation needs of the patient.

B. POLICY:

1. Any patient seeking medical attention at the Center will be assessed for adequacy of transportation.
2. Patients with transportation requirements will be identified during the admission process and anytime while in the treatment program.
3. Reasonable effort will be made to assist patients with transportation requirements.

C. PROCEDURE:

1. During the patient telephone inquiry prior to admission, patients will be queried about their mode of transportation.
2. On admission day, patients will be asked how they will be transported for each visit.
3. While in the treatment program, patients who do not present for their scheduled visit will be queried about transportation.
4. The Center will assist patients identified with transportation needs by the following means:
   a. Use of the hospital van service, if patient lives within the service area
   b. Access transportation through the city or county programs
   c. Access transportation through the patient's managed care group, HMO, etc., if appropriate.
   d. Investigate the possibility of having family member/friend/church member committing to transport the patient
   ~~e. Contact the Social Services Department for assistance~~
5. After exhausting the above recommendations, hospital Administration will be contacted, and the patient will be evaluated; approval/disapproval for financial assistance for transportation will be obtained.

Tri-City Healthc~~-~~are District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07 SUBJECT: Wound Measurement

REVISION DATE~~(S)~~: 12/10, 05/20

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administration Approval:	~~05/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	05/20

A. PURPOSE:

1. Appropriate and consistent wound measuring is necessary to accurately assess wound healing. This document describes the appropriate procedure for obtaining wound measurements at the Center.

B. POLICY:

1. To the extent possible, clinic staff members will utilize a consistent wound measurement procedure delineated in this policy.
2. It is the responsibility of the clinical manager to ensure that clinic staff members are competent in the approved wound measurement method and follow the prescribed procedures.
3. Photographs are taken of all ~~new~~ wounds, when measurable wounds are present:
   a. A measurable wound is defined as one that measures greater than 0.5cm x 0.5cm x 0.1cm at the time of initial assessment. If clinically significant, smaller wounds are documented. Stage I (non-blanchable erythema) wounds typically are not considered a measurable open wound in the wound care program. Stage I wounds may be documented in the narrative portion of the clinician's notes.
4. Each wound will receive a number at the initial visit and when a new wound develops (the order of the numbering is not specified for the initial measurements).
5. For multiple wounds at one site, a photograph of the entire area will be taken and numbering will be done on the photo, as well as the progress notes, for reference at subsequent visits.
6. Wounds that have been debrided with an associated charge for service and/or receive dressings or treatment orders must be numbered, measured at all clinic visits, and followed to outcome.

C. PROCEDURE:

1. Materials:
   a. Disposable measuring tape
   b. Exam gloves
   c. Sterile cotton-tipped applicator
   ~~d. Progress notes~~
2. Procedure:
   a. Apply exam gloves
   b. Remove dressing
   c. Measure the wounds in centimeters or as instructed by hospital, using disposable measuring tape and cotton-tipped applicator to probe wounds as indicated. Probing is

performed using the cotton-tipped end (using the wooden end can be harmful to the tissue and may leave wood fragments in the wound).

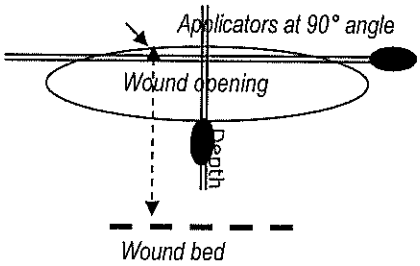
i. NOTE: Post-debridement measurements may be documented when debridement significantly alters the wound size.

d. Measure the longest axis of the wound to document length.

e. Measure perpendicular to the long axis of the wound to document width.

f. Using the cotton-tipped applicator, cotton-side down, measure the deepest part of the wound by placing the first applicator perpendicular to the wound bed and the other applicator at a 90° angle to the first applicator at the wound margin/skin surface interface for the depth. Use tape measure to measure from the tip of applicator to where the applicators intersect (90° angle).

Wound margin/skin surface:



i. Note: For data entry purposes, the minimum depth as at least 0.1cm (not zero) until the wound is healed.

g. Undermining/tunneling: probe with a cotton-tipped applicator to determine the extent of the undermining, tunneling, sinus tracts or folds. If there are multiple areas of undermining, etc., record the longest measurement obtained. If there is no undermining, etc., record **none**~~zero~~ for the entry. Document the position of the undermining, etc. using clock positions, e.g., 3 o'clock (the patient's head being 12 o'clock), as a reference for subsequent visits.

h. When the wound is healed, all measurements are zero.

i. Record all measurements in the designated ~~areas in the Progress Notes.~~**active wounds section in the electronic chart.**

j. If a wound converts to 2 or more wounds or 2 or more wounds convert to 1, close out the wound by using a **"Wound Status Converted"** ~~"C"~~, assign the next available number(s) and take a new photograph.

k. Using the numbering and location of the wounds from the previous visit, measure all active wounds at each clinic visit.

l. Measurements do not have to be taken for clinic visits scheduled for other purposes, unless ordered by physician or a significant amount of time has lapsed between visits to warrant a full assessment. The RN/case manager and/or the clinic physician will make the decision.

Tri-City Healthc~~a~~re District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE

ISSUE DATE: 06/07	**SUBJECT: Wound Staging**
REVISION DATE~~(S)~~: 12/10, 05/20	

Department Approval:	**~~02/20~~04/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/20~~04/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. PURPOSE:
1. Baseline staging/grading of wounds is necessary to:
   a. Provide a consistent method for classifying wounds
   b. Establish the degree of severity of all wounds
   c. Define/clarify interventions
   d. Assist in developing individualized treatment plans
2. This policy defines the procedure for staging/grading all wounds.

B. POLICY:
1. All wounds will have appropriate assessment to include staging or grading, as appropriate.
2. Wounds are evaluated using the Pressure Ulcer Staging System, as described in the Agency for Health Care Policy and Research (AHCPR) Guidelines.
3. Diabetic foot ulcers will be graded using the Wagner Ulcer Classification System. ~~when hyperbaric oxygen therapy may be a consideration.~~

C. PROCEDURE:
1. Staging
   a. Qualified clinical staff will stage the wounds.
   b. At the time of initial wound assessment, a stage is determined according to the table below. Note: The stage remains the same throughout the course of treatment unless:
      i. The initial stage is found to be in error - and/or
      ii. The level of tissue involvement increases during the course of treatment
   c. If the staging is changed, it is recorded in the **active wounds in the electronic chart.**~~progress notes in the designated area.~~
   d. The clinic physician will sign concurrence in the designated area of the progress notes. The clinical staff, as directed by the clinic physician, will make any adjustments to the wound description.

D. RELATED DOCUMENT(S):
~~d.~~1. ~~Wound Care Education Institute:~~ **Pressure Injury Staging Guide**

~~Staging System~~

~~STAGE~~	~~DESCRIPTION~~
~~I~~	~~Non-blanchable erythema of intact skin; the heralding lesion of skin ulceration.~~
~~II~~	~~Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.~~
~~III~~	~~Full thickness skin loss involving damage or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.~~
~~IV~~	~~Full thickness skin loss with extensive destruction, tissue necrosis or damage to muscle, bone, or supporting structures (for example, tendon or joint capsule).~~ ~~Note: Undermining and sinus tracts may also be associated with Stage IV pressure ulcers.~~
~~***Note: When eschar is present, accurate staging of the ulcer is not possible until eschar has sloughed or the wound has been debrided.***~~	

~~Source: AHCPR~~

2. GRADING
   a. The *Wagner Ulcer Classification System* will be utilized for diabetic wounds of the lower extremities.~~, when hyperbaric oxygen therapy (HBOT) is being considered.~~

Wagner Ulcer Classification System

GRADE	DESCRIPTION
1	Superficial diabetic ulcer
2	Ulcer extension involves **bone,** ligament, tendon, joint capsule or **deep** fascia **with no** ~~No~~ abscess or osteomyelitis
3	Deep ulcer **involves bone, ligament, tendon, joint capsule or deep fascia** ~~penetrates to the tendon, bone or joint~~ with abscess or osteomyelitis, **osteitis or tendonitis**
4	Gangrene to portion of forefoot
5	Extensive gangrene of foot

Reference: Wagner (1987) Orthopedic 10:163-72

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE ~~CENTER~~
& HYPERBARIC MEDICINE~~CLINIC~~

ISSUE DATE: 06/07

SUBJECT: Admission Procedure

REVISION DATE(S): 12/10

Department Approval:	~~02/20~~04/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	n/a
Administrative Approval:	~~04/20~~04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	04/20

A. PURPOSE

1. To delineate the admission procedure for all patients who will be undergoing HBOT.

B. POLICY

1. All patients under consideration for HBOT will be thoroughly assessed according to the procedure below.
2. Patients will be admitted to the Center following proper assessment and approval by the HBOT physician.

C. PROCEDURE

1. The medical record of the patient will be reviewed by the HBOT physician prior to or at the time of consultation, if applicable.
2. The HBOT physician will complete a comprehensive H&P. A history of previous thoracic surgery, pneumothoraces, seizures, and/or ear or sinus problems will be noted, as they are especially important if patient will be undergoing hyperbaric therapy.
3. The assessment will include the need for tests such as EKG or CBC. All patients over 40 years of age or those with a history of cardiac problems must have a recent EKG. A CBC may be ordered at the discretion of the physician.
4. A chest x-ray (CXR) will be ordered if the patient has not had one taken within the previous month. All patients must have a recent CXR, with results kept in the patient's chart.
5. The patient will be instructed on Valsalva techniques and will properly demonstrate the technique before treatment.
6. The patient will be oriented to the chamber and its surroundings. The patient and/or family members will be encouraged to ask questions and to voice any concerns.
7. The patient will sign the consent for HBOT and for photographing of wounds.
8. Photograph of wound and baseline measurement of wound will be taken, if indicated.
9. A copy of the HBOT brochure will be given to the patient and family, including the unit's phone number.
10. An instruction sheet will be given to the patient that details what is required.

Tri-City Health Care District
Oceanside, California

CENTER FOR WOUND CARE & HYPERBARIC MEDICINE
POLICY MANUAL

ISSUE DATE: 06/07

SUBJECT: Discharge Summary

REVISION DATE~~(S)~~:

Department Approval:	~~02/20~~03/23
Medical Staff Department/Division Approval:	n/a
Pharmacy and Therapeutics Approval:	n/a
Medical Executive Committee Approval:	03/23
Administration Approval:	04/23
Professional Affairs Committee Approval:	n/a
Board of Directors Approval:	

A. PURPOSE

1. To ensure a discharge summary is completed for each patient upon completion of therapy.

B. POLICY

1. A discharge summary will be performed by the HBO physician on each patient upon discharge from the Center.
2. The summary will include a brief history, the type of therapy performed, response to therapy, and surgical procedures performed.
3. The discharge summary shall remain a part of the patient's permanent medical record.

Tri-City Health Care District
Oceanside, California

WOUND CARE CENTER
HYPERBARIC CLINIC

ISSUE DATE: 06/07 **SUBJECT: Patient Changing Area**

REVISION DATE~~(S)~~: 12/10

Department Approval:	**~~02/20~~04/23**
Medical Staff Department/Division Approval:	**n/a**
Pharmacy and Therapeutics Approval:	**n/a**
Medical Executive Committee Approval:	**n/a**
Administration Approval:	**~~05/20~~04/23**
Professional Affairs Committee Approval:	**n/a**
Board of Directors Approval:	**05/20**

A. PURPOSE
1. To establish guidelines for keeping patients' personal belongings and for providing privacy for patient changing clothing for HBOT.

B. POLICY
1. Patients undergoing hyperbaric therapy will be required to dress in 100% cotton prior to entering the hyperbaric chamber (NFPA 99 Hyperbaric Facilities Guidelines).
2. An enclosed private area will be provided for each patient for changing into the required garments.
3. A locker or locked area will be provided for each patient undergoing HBOT.

C. PROCEDURE
1. When a patient enters the unit, the following steps will be taken to ensure they comply with the requires for approved clothing in the hyperbaric oxygen chamber and keep their valuables or personal belongings in a safe area.
   a. Patients will be provided with 100% cotton gown/scrubs by the hyperbaric staff
   b. Patients will dress/undress in the designated area.
   c. Patients shall be given a key for their lockers to ensure that their belongings are kept safe.
   d. The key is not allowed in the hyperbaric chamber, per NFPA 99. Patients may leave their keys outside the chamber within plain sight while undergoing therapy.
   e. After hyperbaric therapy, the patient shall remove their cotton gown/scrubs and place them in the provided covered soiled linen hamper.
   f. Locker keys will be turned in to the hyperbaric staff prior to the patient's departure from the Center.

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A SPECIAL MEETING
OF THE BOARD OF DIRECTORS

March 31, 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 March 31, 2023.

The following Directors constituting a quorum of the Board of Directors were present:

Director Rocky J. Chavez
Director Nina Chaya, M.D.
Director George W. Coulter
Director Gigi Gleason
Director Marvin Mizell
Director Adela Sanchez
Director Tracy 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 2:00 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Coulter and seconded by Director Gleason 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 March 31, 2023 Special Board of Directors Meeting Agenda to be discussed during Closed Session which included Public Employee Appointment: CEO, CNE and VP of Human Resources, Reports Involving Trade Secrets and one matter of Potential Litigation.

4. Motion to go into Closed Session

   It was moved by Director Mizell and seconded by Director Gleason to go into Closed Session at 2:05 p.m. The motion passed unanimously (7-0).

5. At 3:24 p.m. the Board returned to Open Session with attendance as listed above.

6. Report from Chairperson on any action taken in Closed Session.

   The Board in closed session heard an update on the appointment of the Chief Executive Officer and took no action.

The Board also discussed the Chief of Nursing position and voted 4-3 with Directors Coulter, Younger and Chaya in opposition to direct the Interim CEO to take appropriate action to fill the position on an interim basis.

The Board also discussed the position of the VP of Human Resources and directed the CEO to take appropriate action to fill the position internally on an interim basis.

The Board also heard a report concerning a potential litigation matter and took no action.

7. Adjournment

Chairperson Chavez adjourned the meeting at 3:26 p.m.

_____
Rocky J. Chavez
Chairperson

ATTEST:

_____
Gigi Gleason
Secretary

TRI-CITY HEALTHCARE DISTRICT
MINUTES FOR A REGULAR MEETING
OF THE BOARD OF DIRECTORS
March 31, 2023 – 3:30 o'clock p.m.

A Regular Meeting of the Board of Directors of Tri-City Healthcare District was held at 3:30 p.m. on March 31, 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:

Dr. Gene Ma, Interim Chief Executive Officer/Chief Medical Officer
Candice Parras, Chief Nurse Executive
Ray Rivas, Chief Financial Officer
Aaron Byzak, Chief External Affairs officer
Roger Cortez, Chief Compliance Officer
Dr. Henry Showah, Chief of Staff
Jeffrey Scott, Board Counsel
Susan Bond, General Counsel
Teri Donnellan, Executive Assistant

1. The Board Chairperson, Rocky Chavez, called the meeting to order at 3:30 p.m. with attendance as listed above.

2. Approval of Agenda

   It was moved by Director Gleason and seconded by Coulter 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 March 31, 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 Report – Linda Wolfe, President

Linda Wolfe, Auxiliary President presented an overview of the Auxiliary program. She reported in March of 2020 (pre-pandemic) there were 535 active members in 21 departments in the hospital. Today, there are 200 active members in 13 departments. The first chance that the Auxiliary had to get back on campus began with the Vaccine Clinic. Approximately 70 volunteers participated in that project. Ms. Wolfe reported the student junior volunteers have not yet returned however the hope is to bring them back in the near future. Ms. Wolfe stated as the Auxiliary is able to recruit and get more volunteers they can be fully staffed like they were pre-pandemic. Two departments that are not yet staffed are the Emergency Department and ICU.

Ms. Wolfe reported during the "quiet time" the Auxiliary Bylaws and Policies and Procedures were updated.

Ms. Wolfe reported that there are two things the Auxiliary is most proud of, one of which is the Scholarship Program. This year, 65 scholarships will be awarded to students at Palomar College, Mira Costa College and Cal State San Marcos on April 18th. The second thing is the Gift Shop, wherein profits are turned into a gift to the hospital at the end of each year.

In closing, Ms. Wolfe commented that Tri-City is a great place to volunteer and the Auxilians are happy to serve the hospital and the community in this way.

Chairman Chavez commented that everyone is extremely proud of the Auxilians and the wonderful work that they do.

b) Labor & Delivery Update – Dr. Gene Ma, Interim Chief Executive Officer

Chairperson Chavez explained Dr. Ma will be presenting information on Maternal and Newborn Services. The public will then have the opportunity to make comments followed by Board comments.

Dr. Gene Ma, Interim Chief Executive Officer provided an informational update as follows:

- Historical Overview
- Deliveries at Tri-City Over Time
- Competition from other Providers
- Present Financial Data
- Future Scenarios & Considerations
- 12 Month Projected Contribution Margin by Scenario
- Future: Executive Team Recommendation

(Today's power point presentation will be attached to the file copy of these minutes for reference.)

A recommendation is anticipated for consideration at the April Regular Board meeting.

Chairman Chavez opened the floor for comments from members of the public. He recognized the following individuals:

- Michael Williams
- Vince Loughney
- Joanna Sherman

Director Sanchez thanked today's speakers for coming and for their continued engagement. She stated the entire board is dedicated to superior health care and communication. As a board we are united in keeping open staff communication with our employees and we are dedicated to keeping OB services open here at this hospital.

Chairman Chavez provided a summary of the recent LAFCO/Palomar matter in which LAFCO upheld the "health emergency" determination, granting Palomar Healthcare District the FQHC contracts through the last quarter of 2025 even though it was clearly demonstrated there was no healthcare emergency, nor financial emergency. Chairman Chavez stated the Board hopes to take this problem and rebirth a better solution. He emphasized that the Board is committed to finding a solution. He thanked everyone who attended today and to those who made comments as there is nothing more heartfelt than taking care of this important element.

6. February, 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 – $219,476
- Operating Expense – $238,294
- EBITDA – ($2,747)
- EROE – ($12,216)

Mr. Rivas reported on the fiscal year to date Key Indicators as follows:

- Average Daily Census – 119
- Adjusted Patient Days – 57,393
- Surgery Cases – 3,563
- ED Visits – 36,619

Mr. Rivas reported on the current month financials as follows (Dollars in Thousands):

- Net Operating Revenue – $26,651
- Operating Expense – $28,560
- EBITDA – $75
- EROE – ($1,051)

Mr. Rivas reported on the current month Key Indicators as follows:

- Average Daily Census – 128
- Adjusted Patient Days – 7,008
- Surgery Cases - 406
- ED Visits – 3,870

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 to cast the ballot for the Regular and Alternate Special District Member on the LAFCO Commission

Chairperson Chavez explained that every year, each Special District gets the opportunity to weigh in on who they would like to see on the LAFCO board. Chairman Chavez gave the board the opportunity to nominate one of the candidates on the ballot,

Chairperson Chavez recognized Barry Willis, LAFCO candidate. Mr. Willis requested the Board's support.

Hearing no motion from any board member, there was no action taken.

b) Consideration to cast the ballot for the San Diego County Consolidated Redevelopment Oversight Board

It was moved by Director Chavez to cast the ballot for Patrick Sanchez for the San Diego County Consolidated Redevelopment Oversight Board. 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**

8. Old Business – None

Dr. Showah exited the meeting due to an urgent matter.

9. Chief of Staff –

a) Consideration of March 2023 Credentialing Actions and Reappointments Involving the Medical Staff as recommended by the Medical Executive Committee on March 27, 2023.

In Dr. Showah's absence, Dr. Gene Ma, Chief Medical Officer and Chief Executive Officer presented the February 2023 Credentialing Actions and Reappointments Involving the Medical Staff, as well as the Clinical Privilege Request Form. No concerns or "red flags" were raised by the Credentials Committee.

It was moved by Director Gleason to approve the March 2023 Credentialing Actions and Reappointments Involving the Medical Staff and the Clinical Privilege Request Form as recommended by the Medical

Executive Committee on March 27, 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 Coulter to approve the Consent Calendar. 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**

11. Discussion of items pulled from Consent Calendar - None

12. Comments by Members of the Public

Chairperson Chavez recognized the following individuals who also spoke in regards to Labor & Delivery services:

- Gloria Rosenthal
- Shannon Barnett
- Sara Guerling

13. Comments by Executive Leadership and Chief Executive Officer

Dr. Ma, Interim Chief Executive Officer provided a brief report, reviewing the following:

- Roll-out of 30, 60, 90-day engagement plan which includes C-Suite Chow down, midnight snacks with the C-Suite and rounding to name a few, all of which have been met with enthusiasm.
- Roll-out of community engagement plan.
- Developing Strategic Plan to have a roadmap for our future.
- Successful Radiological 3-year certification survey in which there were no findings and very positive feedback from surveyors. Dr. Ma recognized Eva England and her team for their great work.
- Dr. Ma also recognized and thanked Candice Parras, Chief Nurse Executive and Anna Aguilar, Vice President of Human Resources who are leaving the Tri-City family.

- Withdrawal of masking mandates beginning April 3rd. Intimidation or threats towards anyone choosing to wear a mask is a violation of our anti-harassment policies.
- Doctor's Day was celebrated on March 30th. Dr. Ma thanked the medical staff office for the wonderful celebration that was attended by many physicians.

15. Board Communications

Director Mizell commented on the emotion that was expressed today by members of the public. As stated by Director Sanchez and Board Chairperson Chavez, Director Mizell reiterated that the board is dedicated to finding a good solution and keeping the unit open. Director Mizell assured the public that the Labor & Delivery unit is something we all care about a great deal.

Director Coulter wholeheartedly agreed with Director Mizell. He commented on the rebirth of Behavioral Health Services following suspension of that unit and is hoping we will be able to rebirth Labor & Delivery as well.

Director Coulter thanked Dr. Ma for his leadership in his new interim role. He also congratulated Jennifer Paroly on her recent award "50 over 50".

Director Chaya thanked everyone for coming and sharing their personal stories. She specifically thanked Joanne, Gloria and Brenda (who was not in attendance) for their stories and comments. Director Chaya stated she has spent many nights on the unit with these nurses, taking care of patients collaboratively and "we give darn good care here". Director Chaya stated the board is committed to making sure the unit stays open and continues to give good care to those patients.

Lastly, Director Chaya wished a happy Doctor's Day to all the physicians that work in this hospital night and day with blood, sweat and tears to make sure the community is cared for.

Director Sanchez thanked everyone for coming and stated she is hopeful the Board can prove our dedication to making this hospital what it needs to be and for keeping that line of communication open. She expressed her appreciation to the physicians, many of which have been here at Tri-City a very long time. She recognized the two NICU physicians in attendance today for making the NICU what it is today, and for giving it the good reputation in our community and being the leaders for superiority in the NICU.

Director Gleason expressed her appreciation to all who came today and spoke. She stated the Board is in no hurry to make a decision that is negatively going to impact your lives or the lives of our community. The Board is dedicated to finding the best solution for all.

Director Younger reiterated comments made by fellow board remembers that we are all committed to making this work and we are all very passionate about Labor & Delivery. Director Younger commented on the Board's desire to be transparent.

Lastly, Director Younger wished the physicians a happy Doctor's Day and congratulated Jennifer Paroly on the "50 over 50" award.

16. Report from Chairperson

Chairperson Chavez agreed with all comments made by Board members. He thanked all the speakers for their comments and he also thanked all those who attended the LAFCO meeting to show their support.

Chairman Chavez also wished our physicians a happy Doctor's day.

In closing, Chairman Chavez encouraged everyone to keep goodness in your heart and be respectful of everyone.

17. Adjournment

There being no further business, Chairperson Chavez adjourned the meeting at 4:40 p.m.

_____
Rocky J. Chavez, Chairperson

ATTEST:

_____
Gigi Gleason, Secretary

Tri-City Medical Center ADVANCED HEALTH CARE FOR YOU

Building Operating Leases
Month Ending March 31, 2023

Lessor	Sq. Ft.	Base Rate per Sq. Ft.		Total Rent per current month	LeaseTerm Beginning	Ending	Services & Location	Cost Center
6121 Paseo Del Norte, LLC 6128 Paseo Del Norte, Suite 180 Carlsbad, CA 92011 V#83024	Approx 9,552	$3.59	**(a)**	51,751.31	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)**	45,086.06	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)**	15,377.32	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)**	27,462.02	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 Calrsbad** 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	03/31/23	**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	03/31/23	**Pulmonary Specialists of NC** 3231 Waring Court Suit D Oceanside, CA 92056	7088
Total				**256,923.35**				

(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 March 2023

Cost Centers	Description	Invoice #	Amount	Vendor #	Attendees
8660	WORKERS COMP	21523EDU	149.00	82654	CRUZ, ANA
8740	ACLS	30223	150.00	83459	SANCIANGCO, SOCORRO
8740	MEDICAL TERMINOLOGY/ANOOTOMY	30223EDU	200.00	84234	RESURRECCION R. MENDIZABAL
8740	RADIOMPATHOLOGY	30232EDU	161.45	84235	ALBERTO H. GARAY
8740	ACLS	31023EDU	150.00	84242	ELARMO RUTH
8740	FETAL	32323 EDU	130.00	80402	SCHMIERER, ELIZABETH
8740	CARD LIFE SUPP	30223EDU	150.00	80615	VELASCO, MARY JANE P.
8740	RNC	32323 EEDU	200.00	81979	AZARIAN, SUSAN

**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.